



**The effectiveness of the recruitment and
selection process in strengthening the
Community Health Workers' Programme: The case
study of Sedibeng District Municipality**

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Thesis accepted in fulfilment of the requirements for the degree
Doctor of Philosophy in Public Management and Governance at
the North-West University

Promoter: Prof LB Mzini

Graduation: May 2025

The bottom section of the cover features a blue-to-white gradient background with abstract, flowing lines, mirroring the design of the top section.

DECLARATION

I DECLARE THAT THE DISSERTATION TITLED **“THE EFFECTIVENESS OF THE RECRUITMENT AND SELECTION PROCESS IN STRENGTHENING THE COMMUNITY HEALTH WORKERS’ PROGRAMME: THE CASE STUDY OF SEDIBENG DISTRICT MUNICIPALITY”** IS MY OWN WORK AND THAT ALL THE SOURCES THAT I HAVE QUOTED HAVE BEEN INDICATED AND ACKNOWLEDGED BY MEANS OF COMPLETE REFERENCE.

DEDICATION

This study is wholeheartedly dedicated to my beloved parents, Pastor Samuel & Mrs Selloane Malise, for their unwavering support and prayers throughout this journey. Your guidance and unconditional love have played an immense role in shaping me into the woman I aspire to be.

ACKNOWLEDGEMENTS

I would like to thank and acknowledge the contribution of each of the following people in the completion of my study,

- Firstly, and most importantly my Heavenly Father, my source and my greatest help (Psalm 121). I know without a doubt that my steps are established by you (Psalm 37:34). I know my name is engraved in the palm of your hand (Isaiah 49:16). In you Lord, I find hope which does not disappoint (Romans 5:5).
- I would like to thank my mentor and promotor, Professor Lorraine Boitumelo Mzini, the journey was not without its different challenges, thank you for your constant assurance that we will indeed reach the summit. I have utmost respect for your research craft.
- My dearest parents, you are cut from a special cloth, and I will always be grateful to you for your love and continuous support.
- I had great support throughout the journey, Sedibeng Health District, thank you for trusting me enough to let me dig deep into your district and showing me support from the inception. I would like to make a special mention of the HR manager, Ms November Mamorewesi, your enthusiasm to assist from the moment I started the fieldwork is appreciated. A special thank you to Mr Modupi Madiehi for your great contribution in ensuring all the facility managers are fully available in ensuring the questionnaires are distributed efficiently.
- A great thank you to Dr. Seitshero and Pearl Research for your statistical analysis of the results. Thank you also to Professor Mhlongo for his editorial work. Thank you for the many hours spent on my document, your great insights shaped my research.
- A special thank you to my fellow colleagues of PARST (Ms Palesa Notsi, Mr. Ncamile Moss & Mr. Mavi Sintu), your great passion and support played an important role in the completion of this thesis.
- A warm thank you to my husband, Mr. Joshua Malope who definitely understood the assignment. The journey was long, but not once did you lose patience with me. Thank you for allowing this good 4/5 years to be with a lot of me in front of my laptop without a single complaint. You are a true legend. Thank you to my distinguished family and friends, for faithfully keeping me in your prayers and pushing me to complete this journey (against all odds).
- And very importantly, a huge ‘thank you’ to my great son, *Letlotlo Malope*. We should actually walk the stage side by side as we did this together. During the late night, early mornings, you would rather sleep next to me because you did not want mommy working alone. ***“You are my superhero champ”!!***

ABSTRACT

This study primarily examines the processes for recruitment and selection of Community Health Workers (CHWs). The study area is within the Sedibeng District Municipality, which is situated in the Gauteng Province. The purpose of this research is to identify factors influencing the recruitment and selection procedures used to strengthen the CHW program at the SDM Department of Health. CHWs are characterized as non-professional healthcare workers who obtain training to carry out healthcare tasks. Their responsibilities include facilitating connections between communities and healthcare systems, including healthcare education, providing home services and aiding with healthcare navigation, patient support, illness prevention, and advocating for community needs.

The primary objective of the research was to evaluate the efficacy of the recruitment and selection processes in order to enhance the CHW Program within the SDM. In order to achieve this, the research offered a theoretical justification of the concept of recruitment and selection process with reference to CHW's in the health sector, it also provided the particular recruitment requirements for the CHW programme and assessed the district's setting and strategies for creating an effective CHW programme. In order to achieve its objectives, the research employed a mixed method design with an exploratory sequential design, in which the qualitative phase of data collecting and analysis follows the quantitative phase. At the time of the research, the district consisted of 741 CHWs around 30 clinics in SDM. Aiming for 254 respondents across 20 clinics, the stratified random sample survey received favorable feedback as 257 respondents took part. The study also consisted of two (2) key informants through the use of purposive sampling. The hypothesis was tested as the study discovered that efficient recruitment and selection drive a well-organized CHW program. The CHW programme is designed to be sustainable and encourage retention through the use of programme planning, ongoing training, and CHW supervision and support and structures. The Resource Based Theory, Equity Theory, and Human Capital Theory served as the theoretical foundation for this study. The outcomes were assessed, along with the applicability of the aforementioned theories. The researcher suggested a framework for recruitment and selection based on results of the study as well as existing literature on both local and international level. The framework included six essential aspects that will further enhance the CHW programme and improve the recruiting and selection process. The study added to the body of knowledge by suggesting a framework for an efficient recruiting and selection procedure.

Key terms: recruitment; selection; community health workers (CHW); primary health care, human resource (HR), programme, effectiveness

LIST OF ABBREVIATIONS

CAB	Community Advisory Board
CBOs	Community-Based Organisations
CHC	Community Health Centre
CHF	Community Health Forum
CHVs	Community Health Volunteers
CHPA	Community health program associate
CHN	Community Health Nurse
CHW	Community Health Worker
CHAs	Community Health Assistants
DHMT	District Health Management Team
DPSA	Department of Public Service and Administration
EEA	European Economic Area
FBOs	Faith-Based Organisations
FCHV	Female Community Health Volunteer
FP	Family Planning
GIS	Geographic Information System
HSA	Health Surveillance Assistants
HR	Human Resource
HRM	Human Resource Management
IPA	Innovations for Poverty Action
LHW	Lady Health Worker
LSE	London School of Economics
MDG	Millennium Development Goals
MMR	Maternal Mortality Ratio
MOH	Ministry of Health
MTSF	Medium Term Strategic Framework
NACTE	National Council for Technical Education
NGOs	Non-Governmental Organisations
PERSAL	Personnel and Salary
PHC	Primary Health Care
PHCRE	Primary HealthCare Re-engineering
RBT	Resource Based Theory
SDG	Sustainable Development Goals
WBPHCOT	Ward-based primary healthcare outreach teams
WBSNs	Wireless Body Sensor Networks

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CHAPTER: ONE

ORIENTATION AND BACKGROUND

1.1. INTRODUCTION

This study focuses on how recruitment and selection is achieved for Community Health Workers (CHW) in the Department of Health conducted within Sedibeng District Municipality. Selection and recruitment are components of Human Resources (HR) Management process. The HR department play a crucial role to guarantee there is enough workers to supply health services to the community (Sanou, Awoyale & Diallo 2014). HR managers need to concentrate on the most effective models with the capacity to fulfill the increasing demands of the targeted workforce (Ekwoaba & Ikeije, 2015). The HR department must also adopt methods to attract, hire and retain people with the necessary abilities to meet the aims of the intended organisation. The researcher has an interest in the elements that contribute to the effectiveness of the process of recruiting and choosing candidates for the CHW programme in the public sector.

There is increasing enthusiasm for making a larger financial commitment to Community Health Worker (CHW) programmes in order to expedite the achievement of the Sustainable Development Goals (SDGs) for Primary Health Care (PHC). The programme employs specialised healthcare teams, including one of the largest Community Health Worker (CHW) networks in the world, consisting of over 222,280 CHWs. These CHWs provide home visits and services to a population of 110 million individuals (Rice-Marquez, Baker & Fischer, 1998). The research aims to comprehend the policy framework and criteria utilised in the recruitment and selection process for the development and execution of a local-level Community Health Worker (CHW) programme, with the objective of enhancing its effectiveness. The study also examines resources that could be beneficial for enhancing the CHW program. The researcher aims to comprehend the CHW recruitment regulations and selection criteria that dictate the process and location of identifying, selecting, and assigning a CHW to a community.

The following sections offer an overview of the background of the research and present a problem statement related to the study. The study presents the research questions, research objectives, and hypothesis that will be tested upon completion of the

investigation. A brief literature review, research design methodology, as well as ethical considerations is included. The chapter outline is also presented.

1.2 BACKGROUND TO THE STUDY

Currently there is a growing global interest in integrating Community Health Workers (CHWs) into the healthcare delivery system (Perry, Crigler & Hodgins, 2013; Centres for Disease Control and Prevention, 2012). Lehmann & Sanders (2007), best described CHWs as an international consensus that refers to a health care worker selected and trained by professionals. CHW operate from a community from where he or she comes from (Lehmann & Sanders, 2007). CHWs are viewed as vital as they react to the locals' socioeconomic and cultural expectations and customs (Shahidi *et al.*, 2015). Community Health Workers (CHWs) have a crucial role in enhancing the cultural relevance and effectiveness of healthcare systems in the communities they serve. CHWs also serve as liaison officers who educate patients about healthy lifestyle living by encouraging self-sufficiency (Jack *et al.*, 2017).

At least 90 years have passed since 1930, when CHWs were first used to address basic health issues (Salud, 2014; Van Ginneken, Lewin & Berridge, 2010). According to MacKinnon (2001), CHWs' have a history that dates back to the 1930s. The Alma-Ata Declaration from 1978 brought to the attention of the world community health workers' (CHWs') potential to function as the cornerstone of Primary Health Care (PHC) (Perry, 2020). In order to provide a consistent district health system, environmental wellness services, and emergency medical care, the Primary Health Care Services aims to create and oversee the application of laws, policies, systems, norms, and standards (National Department of Health, 2022:41). The fundamentals of primary healthcare are particular to the system or set of conditions. Agarwal *et al.*, (2019:2) describe primary health care as a crucial method for attaining universal health.

In addition to providing curative care for tuberculosis (TB), CHWs also provide care for patients with HIV and AIDS, control malaria, make referrals, provide education and services on reproductive health and family planning, and look after children under the age of five (Crigler, Hill, Furth, Bjerregaard, 2013). Their duties also encompass promoting health and preventing disease. After that, a great deal of CHW programs have developed

with a disease focus, especially those that deal with HIV care (Van Ginneken, Lewin & Berridge, 2010:1110). Patients may be seen by them in clinics, at homes, or in their communities (WHO, 2007). This includes populations living in remote villages that are not always easily reachable by medical institutions (Walt, 1989). In Zambia, CHWs were considered as a possible remedy for sub-Saharan Africa's formal health worker shortage (Ashraf *et al.*, 2012). Since then, the program has consistently kept up a major increase in the health status of the populace as well as universal coverage of PHC services (Rice-Marquez, Baker, Fischer, 1998; Mayberry, Baker, 2011; Cufino Svitone, Garfield, Vasconcelos, Araujo Craveiro, 2000). After being selected and trained, prospective CHWs would be returned to their local communities to work. It is believed that they are more likely to possess the required connections and to feel obligated to provide health care to underprivileged and impoverished groups in their specific areas (Ashraf *et al.*, 2012).

1.2.1 International context

As the body of evidence on the efficacy of CHW therapies grew, several countries started to invest in large-scale CHW programmes in order to enhance the health of their populations (Perry, Crigler & Hodgins, 2013). This included countries such as China, Bangladesh, Brazil, Ethiopia, Nepal, Pakistan, Rwanda, and Malawi (Perry, 2020). On an international front, China had their first CHW (referred to as “barefoot doctors”) around 1965, back then it was in a form of health workers administering the basic health needs of the community (Walt, 1988). Brazil implemented its CHW programmes called Visitadora Sanitaria programme successfully in 1987, in which these workers provided immunisations, information, and various other maternal and child health interventions (Rice-Marquez, Baker, Fischer, 1998). Pakistan also introduced the Lady Health Worker (LHW) Programme in 1992 (Perry, Crigler & Hodgins, 2013).

In the mid-1970s, Bangladesh had started a community-based Family Planning (FP) programme with an initial cadre of Family Welfare Assistants that expanded in the mid-1980s and was complemented by NGO CHWs working in FP (Perry, Crigler & Hodgins, 2013). Another notable programme that emerged in the late 1980s is Nepal’s Female Community Health Volunteer (FCHV) Program, established in 1988 engaged in FP promotion, first aid and dispensing functions (Perry, Crigler & Hodgins, 2013). By 1997,

Bangladesh had 30,000 female CHWs providing home-based FP services (Perry, Crigler & Hodgins, 2013). Each group had women who obtained special training in an area of personal interest, including various types of income-generating activities or health. Uganda introduced its Village Health Team Strategy in 2003. In 2004, Ethiopia began to train more than 30,000 Health Extension Workers (HEWs). India also initiated a Rural Health Mission in 2005 which involved support for more than 800,000 workers called Accredited Social Health Activists (ASHAs). The current CHW programme in Malawi dates back to the 1950s, Health Surveillance Assistants (HSAs) were recruited and salaried by the Ministry of Health (MOH) to provide immunizations (Nsona Mtimuni, Daelmans, et al, 2012). In the 1960s and 1970s, the HSAs played a prominent role in the smallpox eradication campaign immunisations (Nsona Mtimuni, Daelmans, et al, 2012). With financial support from the Global Fund to Fight AIDS, Tuberculosis and Malaria, in 2008, the government was able to double the size of the HSA workforce to 10,000, so that there would be one HSA for every 1,000 people (Nsona Mtimuni, Daelmans, *et al.*, 2012). In 2015, the Zambian government announced a new strategy of Community Health Workers, referred to as Community Health Assistants (CHA's). The aim was to train 5000 new workers by 2015, which was a great initiative and investment for a country which only had 6000 nurses at the time (Ashraf *et al.*, 2012 & Ashraf, Bandiera & Lee, 2018).

1.2.2 South African context

Post 1994, the new democratic South African government embraced primary health care (PHC). In the South African health context, CHW forms part of Programme 4: Primary Health Care Services (National Department of Health, 2022:41). South Africa launched its CHW programme in 2004 to help government expand its health services. This is mainly driven by five imperatives which include:

- To create work for community members and work towards fighting poverty.
- This is seen as a great tool used to improve service delivery.
- It forms part of National Human resource and skills development strategies.
- To help control the increasing complexity of the complex diseases and poverty related challenges.
- The need for health promotion activities both in the community and home based (NDoH, 2004).

Furthermore, the South African government in 2011 launched the WBPHCOT programme model for re-engineering PHC through the following three streams, namely, ward-based primary healthcare outreach teams (WBPHCOTs); school health teams; district clinical specialist teams (National Department of Health, 2018). During the 2021/22 financial year, the Department contracted 48 443 Community Health Workers (CHWs) across the country to provide primary care at household level (National Department of Health, 2022:43). A committee comprising of multi-skilled professionals from different Government Department, Academia, and civil society to support the work of the cluster in preparation for WBPHCOTs Policy Framework and Strategy review was established (National Department of Health, 2022:43). The members of the committee appointed by the Director General have begun with work related to the accreditation of the CHW training and the mid- term review of the implementation of the policy framework and strategy for WBPHCOTs (National Department of Health, 2022:43).

1.2.3 Regulatory Framework

Efforts have been made to define CHWs' and integrate them into the health workforce, although much work remains to be done (Centres for Disease Control and Prevention, 2012). The abovementioned challenges drew attention to critical systems support needed if CHW programmes were to be effective as a part of robust PHC services, operating at scale (Perry, 2020). The abovementioned provides a scientific evidence base to demonstrate the value of CHW services to improve health care outcomes and reduce costs (Centres for Disease Control and Prevention, 2012).

As countries examine strategies to improve health outcomes, they also consider using law as a tool to establish sustainable CHW programmes for developing workforce and financing mechanisms (Centres for Disease Control and Prevention, 2012). A 2016 review of state CHW laws conducted by the Centres for Disease Control and Prevention (CDC) revealed that states have taken various approaches to using laws to establish funding mechanisms for CHW services (Centres for Disease Control and Prevention, 2013). CHW models in countries have become increasingly formalised through state policy, including policies aimed at recruitment and selection and funding CHW activities (Schmit *et al.*, 2022).

Various processes unfolded to put forth the development of CHWs in the health sector in South Africa. The Constitution of the Republic of South Africa 1996 has included and indicated specific guidelines regarding the health services received at the health centres. Schedule 4 of the Constitution reflects health services as a “concurrent national and provincial legislative competence”. According to Section 27 of the Constitution, good health service is considered a basic human right and needs to be sustainable and promote a safe and healthy environment. The Constitution emphasizes the importance of each individual having access to effective health services regardless of their social standing (Andaleeb, *et al.*, 2007:265).

The South African government approved the White Paper on the Transformation of the Health System of 1997. The White Paper was developed to assist in bridging the gap of global health shortages, skill shortages, poor distribution of health workers and often undesirable work environments which served as a major impediment to appropriate service delivery (Chen, 2004:1987-1988). In South Africa, CHWs are also supported by legal institutions, such as Public Health and Social Development Sectoral Bargaining Council. The following regulatory framework were approved to support the appointment of CHWs:

- *Resolution 1 of 2018 - Agreement on the Standardisation of Remuneration for Community Health Workers in the Department of Health*
- *Resolution 1 of 2021 – Amendment to Resolution 2 OF 2020: Agreement on the Standardisation of Remuneration for Community Health Workers in the Department of Health*
- *Resolution 03 of 2022 - Extension of Resolution 01 OF 2021 Agreement on Standardisation of Renumeration of Community Health Workers*

The Presidential Health Summit, held in 2018, was also regarded as a critical consultation process which identified key challenges facing the health system, and most importantly sort solutions to prevent further deterioration of the quality of the health system (National Department of Health, 2022:18). The Medium-Term Strategic Framework (MTSF) 2019-24 commitments included aims to “Expand the primary health care system by absorbing over 50 000 CHWs into the public health system” (National Department of Health, 2022:17). Section 2 of the Resolution 1 of 2018 attest to the fact that the parties recognise

the importance of ensuring fair recruitment of CHWs in the DoH as required and guaranteed by good employment practices (Public Health and Social Development Sectoral Bargaining Council, 2018). The purpose of Resolution 1 of 2018, Section 3 seeks to:

- *Ensure the standardisation of payment of remuneration for CHWs in the DoH*
- *Ensure adequate protection for the remuneration payment of the CHWs into Personnel and Salary (PERSAL) system;*
- *Ensure appropriate implementation and management of recruitment, selection, appointment, placement, remuneration, skills development, dispute resolution and occupational health and safety processes for all members of the Ward Based Primary Healthcare Outreach Teams (WBPHOTs) (Public Health and Social Development Sectoral Bargaining Council, 2018).*

The sub-programme further successfully established a committee comprising of multi-skilled professionals from different Government Department, Academia, and civil society to support the work of the cluster in preparation for Ward Based Primary Healthcare Outreach Teams (WBPHCOT) Policy Framework and Strategy review (National Department of Health, 2022:18).

CHWs comprise a diverse category of workers but they all have limited formal training (Perry, 2020). In response of this, many initiatives have been created to train health workers and strengthen the health system (Sanou, Awoyale & Diallo, 2014). The staff development of CHWs are also supported in *Section 3.1 of the Resolution 1 of 2018. Whereby a refresher training course was offered to register CHWs on the database in 2018 (Public Health and Social Development Sectoral Bargaining Council, 2018).* In South Africa, the sub-programme of Outreach services for CHW concluded the development of the Foundation Phase Training for CHWs. The Foundation Phase is a skills-based training for every person that enters the CHW programme and those that were never trained on any of the CHW trainings (National Department of Health, 2022:18).

Establishing payment mechanisms and providing compensation ensures the CHW profession continues the momentum in recognising CHWs as critical players in advancing population health (Schmit *et al.*, 2022). CHWs may receive funding from various sources, including grant funding, non-profit contributions, general revenue, and reimbursement for services rendered (Dower, Knox, Lindler & O'Neil, 2021).

In 2014, the Centres for Medicare & Medicaid Services (CMS) established a rule expanding preventive services to cover reimbursement for CHW services; the coronavirus disease 2019 (COVID-19) pandemic has prompted calls for further expanding CMS coverage for CHW services (Kangovi, 2020). Identifying consistent and sustainable funding mechanisms for CHW services is critical to supporting and sustaining a robust CHW workforce (Alvillar, Quinlan, Rush & Dudley, 2011; Matos, Findley, Hicks, Legendre & Do Canto, 2011). Stable funding enables skilled CHWs to stay in their roles longer, allowing them to build knowledge of community resources and contacts (Schmit *et al.*, 2022). In addition, stable funding gives organisations confidence that they can integrate CHWs in care teams without workflow disruptions caused by funding fluctuations (Schmit, Washburn, LaFleur, Martinez, Thompson & Callaghan, 2022). Payment structures for CHWs vary from state to state (Spencer, 2018). There is a progression of the payment structures within the system.

The South African government began with a twelve (12) month payment schedule. Later in 2022, the appointment duration for PHSDSBC CHWs was 12 months and the PHSDSBC bargained for a three-year term. In terms of Resolution 03 of 2022, a one-year appointment agreement has proven to be administratively cumbersome and are prone to cause some instability in the department (Public Health and Social Development Sectoral Bargaining Council, 2020).

CHW and health auxiliary programmes have played and will continue to play an important role in delivering key interventions to the health system (Perry, 2020). They continue to provide health education, promote sanitation and hygiene, and conduct outreach clinics, including immunizations (Nsona *et al.*, 2012). The number of CHWs is expected to increase by 13% in the next decade (from 127 100 to 144 100 by 2029) (Schmit *et al.*, 2022). Their role also became evident during epidemic and pandemic outbreaks. The

emergence of the HIV/AIDS pandemic also played an important role in the revitalisation of CHW programmes as many NGOs in Africa, especially in South Africa, turned to this cadre of health workers to deliver specific care to those with AIDS (Perry, Crigler & Hodgins, 2013). In 1990 CHWs in Malawi were at the frontline for managing cholera epidemics in the 1970s and 1980s and were engaged in environmental health education in the 1990s (Nsona *et al.*, 2012).

In 2020, the South African CHWs were deployed for COVID-19 community screening and testing campaign (National Department of Health, 2022). At the end of March 2021, a total of 48 443 CHWs received remuneration against the Medium Term Strategic Framework (MTSF) 2024 target of integrating 50 000 CHWs into the public health system. CHWs continued to drive the implementation of COVID-19 interventions and integrating other health programmes with a focus on health promotion, prevention, and adherence to treatment in the communities (National Department of Health, 2022). CHWs have also been vital in the implementation of the National Welcome Back Campaign which is aimed at re-engaging patients lost to follow on ART and TB treatment (National Department of Health, 2022). They trace patients who have defaulted on treatment and refer them back to the clinic to re-start treatment (National Department of Health, 2022).

1.2.4 Recruitment and selection

As indicated above a renewed interest in CHWs has been seen globally (Perry, Crigler & Hodgins, 2013). National community health worker (CHW) programmes are now moving toward the centre stage of the global health arena. The World Health Assembly in 2019 highlighted the key role that CHW programmes will need to play in order to achieve Universal Health Coverage and the health-related Sustainable Development Goals (one of which is ending preventable child and maternal deaths) (Perry, 2020). In this regard, HR play a critical role in ensuring there is adequate personnel for delivering health services to the population (Sanou, Awoyale & Diallo, 2014). HR should play "a comprehensive and coherent approach to the employment and development of people (Armstrong, 2014). The recruitment process includes four steps: establishing criteria; identifying candidates; contacting, interviewing, and recruiting candidates; and hiring community health workers. Recruitment and selection are critical to building a culture of retention. However, the ultimate problem is not just finding the right staff; it is also

retaining them (Paraprofessional Healthcare Institute, 2008). Employment of individuals in health and social care organisations is a challenge given the complex nature of the goals of quality patient care and efficient utilisation of the resources, variety of professionals working in such organisations and different motivation needs of the employees (Benson-Dundis, 2003). Recruiting and selecting the most appropriate individual to fill the role of a CHW is among the most essential elements that contribute to a well-functioning community health strategy (Jaskiewicz, Deussom, Perry & Crigler, 2014).

Crigler *et al.*, (2013) defines recruitment as a process of how and from where a CHW is identified, selected and assigned to a community, including selection criteria and process. The recruitment process is followed by selection (Ekwoaba & Ikeije, 2015). Selection is the process of choosing the most capable candidates from those who came through for the open vacancy (O'Meara & Petzall 2013). The ultimate goal of this process is to ensure proficient individuals are hired. The competencies of the applicants need to be matched with the goals of the organisations. Sultana (2014) encourages companies to ensure their selection processes are fair and legal.

As stated above, the ideal CHW recruitment process entails: establishing criteria, communicating CHW opportunities to identify candidates, interviewing and selecting CHWs from candidates, and hiring selected CHWs (Jaskiewicz, Deussom, Perry & Crigler, 2014). Each programme develops criteria taking into account the service content. For this, the scope and intention of the health programme as well as the needs of the community should always drive the recruitment process (Jaskiewicz & Deussom, 2013). The recruitment strategy should be designed, implemented, and designed systematically (Adewale & Anthonia, 2013). To ensure this goal is realised, the HR team should have a powerful strategy for recruiting, selecting, and hiring the right people who have the potential to improve the level of performance (Sultana, 2014).

Before initiating the recruitment phase of any programme, it is essential to understand the specific needs and context of the CHW programme in which the CHWs will work. This strategy is necessary to ensure the human capital supply meets the targeted organisational demands (Adewale & Anthonia, 2013). In particular, this process relates

to having a clear description of the roles and responsibilities. Furthermore, effective CHW recruitment and selection are key to increasing CHW retention (Jaskiewicz, Deusson, Perry & Crigler, 2014). The requirements for selection of trainees are based upon a set of pre-defined criteria focusing mainly on the experience and qualifications of candidates (Sanou, Awoyale & Diallo, 2014). Proper planning and understanding of the unique gaps in the organisation, will enable the HR managers to be able to attract individuals with desirable skills. Sultana (2014) argues that the development of an effective recruitment approach may enhance institutions to realise the targeted goals. Such processes may be easier to minimise disruptions and promote performance. The recruitment strategy also ensures that the institution realises the targeted goals.

The strong CHW programmes in Bangladesh, Brazil and Nepal have all made vital contributions to this important achievement. They are noteworthy because they have had some of the most rapid achievements in reducing under-5 mortality in the world since 1990 (Perry, Crigler & Hodgins, 2013). As the interest in Community Health Worker programmes grew, the demand to have more adequate information grew (Salud, 2014).

While the evidence supporting the effectiveness of community health worker (CHW) programmes is substantial, there is also considerable evidence that many of these programmes have notable weaknesses that need to be addressed in order for them to reach their full potential (Kok, Crigler, Musoke, Ballard, Hodgins, and Perry, 2021). Despite the developments most of these programmes subsequently collapsed (Perry, 2020). Some major challenges that are identified for primary health care is the financial, political, human material commitments; the effective use of available resources, decentralization and sometimes ensuring effective community participation and collaboration (Dookie & Singh 2012). For good governance, the success of CHW programs also depends on sustainable financing mechanisms, unfortunately some programmes failed to receive continued funding from the government in the early 1980s (Perry, Crigler & Hodgins, 2013).

The journey has however not been without its challenges and has often been complex. This complexity involves balancing the limited resources available and competing and growing priorities (Murphy, *et al.*, 2021). Many CHW programmes were inadequately

supported and experienced high attrition (Perry, 2020). The closure of nursing colleges during the 1990's led to a reduced number of nurses (Coovadia, 2009). But over the following years it was increasingly evident that important lessons from earlier programme experiences were not consistently being acknowledged and applied (Perry, 2020). The CHW programme just like other essential health programme in South Africa, experienced significant service disruptions in the last financial year due to COVID-19. CHWs were redirected from their daily activities to support COVID-19 interventions such as community screening, contact tracing and assisted registration for the elderly for COVID-19 vaccinations (National Department of Health, 2022:18).

Policy Framework and Strategy for Ward Based Primary Healthcare Outreach Teams seeks to:

- Goal 1: Improve the working conditions of WBPHCOTS;
- Goal 2: Improve Human Resource Recruitment, Selection, Placement, Development and Management pertaining to the WBPHCOT Programme;
- Goal 3: Standardise the WBPHCOT scope of work and ensure standardized application in all nine provinces of South Africa; and
- Goal 4: Improve and maintain the monitoring and evaluation system for the WBPHCOT programme (NDoH, 2018).

Goal 2 seeks to ensure appropriate implementation and management of recruitment, selection, appointment, placement, remuneration, skills development, dispute resolution and occupational health and safety processes for all members of WBPHCOTs (NDoH, 2018).

1.3 PROBLEM STATEMENT

Despite the vital role that community health workers play in providing primary healthcare services, particularly in underprivileged communities, many locations in South Africa continue to experience a scarcity of competent and dedicated CHWs. Although there are evident attempts to improve healthcare access, many communities continue to experience major hurdles to healthcare services, resulting in poor health outcomes and rising mortality rates. The function that CHWs play in healthcare is clear, but the recruitment and selection process fails to meet the problems, namely financial and development concerns. CHWs continue to be underpaid because they are still referred to

as lay workers in most nations, providing only basic health and medical treatment. CHWs commonly get insufficient stipends, which might demotivate them.

A further drawback is that CHWs frequently lack the appropriate training, supervision, and support to deliver healthcare services, which can lead to burnout, high turnover rates, and potentially poor health results. The existing recruitment processes frequently result in high turnover rates, insufficient training, and inadequate support for CHWs, all of which have an impact on the quality of care offered to the community. As the interest in CHW programmes grew, the demand to have more adequate information grew (Salud, 2014). While the evidence supporting the effectiveness of CHW programmes is substantial, there is also considerable evidence that many of these programmes have notable weaknesses that need to be addressed in order for them to reach their full potential (Kok *et al.*, 2021).

Most CHW's programmes established lack longevity not because implementation failed, but to a certain degree the monitoring and evaluation process lacks efficiency. While studies have extensively examined the impact of CHWs programmes, there is little, or no attention paid to assessing the procedure or method of recruiting and selecting CHWs and how the programs can increase strategies in fostering the needs of a CHW. This research will identify strategies to strengthen CHW programs so that CHWs have the necessary training, support, and resources to flourish in their positions. The study will also show how an effective recruitment strategy for community health workers not only attracts top candidates, but also retains and supports skilled and dedicated individuals, with the ultimate goal of improving healthcare outcomes in underserved communities, particularly in the Sedibeng District.

This study argues that a spoilt recruitment and selection process, would only produce mediocres as CHWs, whereas a merit and credible means of employing the CHWs, would produce competent and qualified CHWs, who can positively contribute to delivery of quality health care services at the municipality level and ensure sustainability of developed programmes more especially in upcoming towns. Therefore the problem statement, is that the recruitment and selection process fails to recruit competent, and committed CHW's. This study intends to advance new knowledge on how viable and merit

system of recruitment and selection process of CHWs can promote or strengthen CHW's programme.

Based on the above, it is evident that the substantial numbers of CHWs are required within the health systems (Hodgins, Kok, Musoke, et al., 2021). This calls for the examination of the nature and the extent of recruitment and selection process for CHW programmes in the Sedibeng District Municipality. The researcher explores the contextual factors that shape the design and implementation of recruitment and selection process undertaken to deliver effective CHW programmes. Furthermore, the researcher assesses whether the recruitment and selection process contribute to WHO and NDoH strategy.

1.4 PRIMARY RESEARCH QUESTION AND OBJECTIVES

The primary research question:

How effective is the recruitment and selection process for strengthening CHW programmes in the SDM?

1.4.1 RESEARCH QUESTIONS

This research sought to respond to the following questions:

- What does the concept of recruitment and selection process require with reference to CHWs in the health sector;
- What are the specific recruitment needs for the CHW programme in SDM?
- What is the Provincial and local context and strategies for developing a successful recruitment process for CHWs programme in SDM?
- What is the selection criteria for CHWs?
- What framework regarding recruitment and selection process can be formulated for strengthening CHW programmes?

1.4.2 RESEARCH OBJECTIVES

The primary objective of the study is:

- To assess the effectiveness of recruitment and selection process for strengthening CHW programmes in the SDM?

From the questions raised above, the following objectives apply:

- To provide a theoretical explanation of the concept of recruitment and selection process with reference to CHW in the health sector;
- To describe the specific recruitment needs for the CHW programme in SDM;
- To evaluate the district's context and strategies for developing a successful recruitment process for CHWs programme;
- To identify the criteria for selecting CHWs, and
- To formulate a framework regarding recruitment and selection process for strengthening CHW programmes.

1.5 HYPOTHESIS

The following hypothesis was tested by the study:

A well-defined recruitment and selection process can serve as a tool for strengthening Community Health Workers programme.

1.5.1 Aim of the Study

The purpose of this study was to determine the factors that influence the recruitment and selection practices for strengthening the CHW Programme in the Department of Health, SDM.

1.6 SIGNIFICANCE OF THE STUDY

Recruitment and selection are critical to building a culture of retention (Paraprofessional Healthcare Institute, 2008). Recruitment holds the success of an organisation. This is mainly because one of the most valuable assets in any organisation is its employees. The study is significant because when recruitment is done effectively, it plays an important role in increased productivity, by forming teams with people who are aligned with the company's values, culture and objectives. The study aimed to evaluate key models, approaches and methods implemented which will assist with the retention of CHW's by reviewing and making suggestions on how programmes can integrate the needs of the employees as well as the community.

This study contributes to the body of knowledge in human resource on recruitment and selection and will help develop a different approach which aims to increase efficiency of the CHWs. The study describes the benefits of developing strategies for programmes in

the public sector emphasising on how managers may identify the recruitment needs for respective programmes. The research contributes to the existing knowledge that will be open to new programmes developed in new settlements. The research investigates policy framework that decision-makers and planners need to consider when designing, implementing, scaling up or strengthening a national-level CHW programme. Programmes are often well detailed theoretically, but often prove difficult to be implemented efficiently. The researcher offers an overview of specific challenges CHW programmes face and resources that may be helpful when incorporating relevant programmatic examples as much as possible (Perry, Crigler & Hodgins, 2013). This thesis contributes to the research discipline as it seeks to produce a recruitment and selection framework and process to enable governments and organisations to survey, assess, and improve the functionality of CHW programmes. The researcher intends to use the findings of this study to empower the appointed coordinators, policy developers and stakeholders at the different locations by providing recommendations based on the findings of the research and provide better aid to new programmes developed in new towns.

1.7 LITERATURE REVIEW

The study looks at the recruitment process in the health sector and more specifically the Community Health Workers. For this particular study, the literature part is reviewing older and current literature (Marie & Van Der Westhuizen, 2009:8). The sections below provide a brief discussion of the literature reviewed for the study.

Agarwal (2019), has identified the role of a CHW as being an integral part of the health system. CHWs main aim is to assist in improving health conditions and gradually reduce mortality and associated costs (Kaur 2016:55). Olaniran *et al.*, (2017), notes that CHWs play important roles in increasing coverage of basic health services. Their primary role is to provide promotional and rehabilitation care to specific communities. It is vital to have adequate number of skilled and competent CHWs who are equipped to provide services in an enabling environment in order to achieve sustainable development goals which are health related (Olaniran *et al.*, 2017). A report compiled by the World Health Organization also defines the role of CHWs' for carrying out functions related to health care delivery.

The report also speaks about training, which is a requirement for enhancing CHW programmes (Lehmann & Sanders, 2007:4).

Agarwal (2019:15) identifies the impact of the Declaration of Alma-Ata which emphasised CHWs' in low and middle income countries have been promoted to strengthen health efforts within the communities (Agarwal, 2019). Kaur (2016) emphasises on the provision of ongoing support of CHWs and continuous training in order to enhance confidence when they execute their duties (Kaur, 2016: 55-56). The role CHWs play within the communities and health care will further be noteworthy as the South African government has committed to re-engineering the primary healthcare system as part of its health strategic plan for Non-Communicable Diseases from 2012-2016 (Puoane *et al.*, 2017:170).

The HIV epidemic began to place increasing demands on the healthcare system (Friedman, 2005). CHWs have also played an active role in the Tuberculosis programme (Puoane *et al.*, 2017:170). Most of these added on responsibilities are learned on the go. As a result, the CHW's are often expected to do more (Jaskiewicz & Tulenko, 2012:51). A study conducted and reported by the Institute of Medicine, highlights that adequate training should be provided for the Community Health Workers and it should be a joint practice between the community and the health centres. This type of training helps to ensure quality, supervision and safety is met effectively (Shahadi, 2015).

The study conducted by Armstrong & Laser (2006) indicates that the majority of CHWs' are women, which make up over 70% of the health and social care workforce. Armstrong & Laser (2006) further stresses that health care is mostly done by women, and this could be due to the nature of the job where women tend to have a more natural caretaker instinct.

CHWs' are a strong source of support because of the broad scope of work which executes various health programmes (Murphy *et al.*, 2021:390). There is great evidence which supports the role of CHW's in the control of chronic diseases. Puoane *et al.*, (2017), strongly states that CHW's were initially used to promote better health in the communities during the 1980's. Studies also show that CHW's are effective in educating their communities about other health issues which include Cardiovascular Disease, asthma

and diabetes (Puoane *et al.*, 2017:171). Patient safety has and should always be seen as a national priority (Quigley, 2011:11).

Sharman (2010:8) research focused on resource allocation in the context of CHW programme which is essential for social support and relational care. Home support services are designed to help patients to receive services in the comfort of their home, the services include bathing, dressing, grooming of patients and even light household tasks which help to maintain a safe and supportive home. CHWs' often spend most of their workdays travelling by feet or in their cars to respective patients. Resource allocation on CHWs include availability and management of medication to patients' respective homes (Patrick, 2012:30). Stekelenburg *et al.*, (2003) high-lighted that a lack of financial resources makes it difficult in measuring of performances of CHWs. Financial resources play an important role in the recruitment and selection process for CHWs. A lack of these resources may hinder the actual role of the CHWs (Parker *et al.*, 2012:30). It is important to note that lack of proper management and tools will likely make it impossible for the CHW work to be done effectively (Parker *et al.*, 2012:30). For such services to be provided, the correct tools and resources need to be readily available so there is not a hold up in the delivery of services (Sharman, 2010: 8).

Recruitment forms an integral part of any organisation. Shahidi *et al.*, (2015) identified the steps used in the employment and training of CHWs'. These steps include community site identification, resident engagement, health needs assessment, CHW identification and recruitment, and Training and employment of CHWs' (Shahidi *et al.*, 2015). Some of the important reasons CHWs' are based in their own communities is to overcome barriers by improving communication gaps, reducing cultural barriers, increasing health literacy, minimising inequalities as well as promoting wellness (Shahidi *et al.*, 2015). The KZN Health Department identified the training models that are often included among in CHW development which includes: Being a Community Health Worker; Situational Analysis; Environmental Health Care; The District Health Care; Primary Health Care Concept; Acute and Chronic Diseases and management at home; T.B and DOTS; Infectious diseases; Community Development; Disabilities and HIV and AIDS including counselling and support (KZN Health Department, (2023).

According to Erasmus, Swanepoel, Schenk, van Der Westhuizen & Wessels (2005:207), recruitment can be described as activities which are undertaken to attract sufficient employees who have the potential and competencies to fulfil job requirements and to assist the public health institution in achieving its desired goals. Mullins (1999) identified that the recruitment process must be able to identify and attract potential employees who have the skills and abilities to help support the health sector to achieve its strategic goals and objectives. The workforce selected need to show competence and commitment in delivering to the public (Mullins, 1999). It is quite evident how imperative recruitment and selection is (Ekwoaba *et al.*, 2015). According to the DPSA (2008:21), having the right people can immediately improve the performance of any organisation, be it private or public. Jaskiewics & Deussom (2013) defined recruitment as a process that determines how and from where a CHW is identified, partake through a selection process and then assigned to a specific community. The KZN Health Department (2023) also identified a criterion for selection CHW including: minimum of Grade 10; needs to reside in the area of services rendered; selected by the Local Community; undergoes training for multi-skilling x12 months inclusive of practical. The selection process is guided and based on the existing policy; has job description and basic minimum conditions of employment (KZN Health Department, (2023)

It is often effective to have members of the community serving as CHW's because they know the background and evident needs of the members (Shahadi 2015). Lehmann and Sanders (2007) identified the role of community involvement in the recruitment and selection of CHW. Lehmann and Sanders (2007), argued that the shape and form that community participation takes when recruiting CHW's, may very well be an indicator of the quality, retention and performance of CHW's.

1.7.1 Theoretical framework

The study rests on Human Capital Theory, Resource Based View Theory and Equity Theory. Human Capital theory as proposed by Adam Smith (1723-1790) has the central idea that people are fixed capitals just like machine because they have skills and useful abilities that have genuine cost and yields profits. The premise in the human capital theory, according to Armstrong (2006) is that people and their collective skills, abilities and experience, coupled with their ability to deploy these in the interests of the employing

organisation, are now recognised as making a significant contribution to organisational success and also constituting a significant source of competitive advantage.

The Resource-Based View outlines that institutions should constantly evaluate their workforce to ensure that they have the right people with the right skills in the right places to ensure sustained competitive advantage (Barney, 2001) and when this is not the case, firms should make-up for the shortfall by employing appropriate recruitment and selection criteria. This is imperative because if an organisation has strategic resources but lacks the ability to effectively recruit the best candidate to meet the ever-growing needs of the health sector, it becomes futile. According to Sparrow *et al.*, 2002, technology and capital can be generated by most firms any time for a price, but it is not easy to acquire a ready pool of highly qualified and motivated employees.

Al-Zawahreh and Al-Madi (2012) observed that equity theory is gaining deserved popularity in the human resource departments as it ensures fair results for both the employer and the employee. Equity is a major issue for government, labor, and industry (Gashgari, 2016). HR managers are required to appoint CHWs in their respective areas. In these different situations, feelings of inequity may occur (Gashgari, 2016). The study conducted by Dookie & Singh (2012) advised on how recruitment can be distributed in an equitable manner, and the study further highlighted a well-structured process to improve the CHW programme.

On the principles of the Equity Theory, the best recruitment and selection criteria in the organisation is that which portrays the firm as Equal Opportunity Employer (Ekwoaba *et al.*, 2015). Naturally people require motivation in order to execute their tasks. According to equity theory, it is the perception of equitability and inequity (Al-Zawahreh & Al-Maid, 2012). Equity theory focuses on the input versus the output. In any setting an employee will most likely measure his or her jobs inputs with an output ratio. This theory is relevant to the recruitment of CHW as inequality can lead to demotivation, lack of commitment, absenteeism and resignation from an organisation (Greenburg 1999). The Equity theory has received attention from the human resource professionals regarding the fairness of outcomes. In order for CHW's to execute their roles effectively, the input

provided needs to balance with the output. In most cases, it does not meet the status quo. More in-depth discussion on the above theories in Chapter 2.

1.8 RESEARCH DESIGN AND METHODOLOGY

The sections below briefly discuss the research design and methodology used for this study.

1.8.1 Design

A mixed method research design was utilised for this study. Hanson, Creswell, Clark, Petska, & Creswell (2005: 224) provide a more rigid and operational definition of mixed method research as "the collection, analysis, and integration of quantitative and qualitative data in a single or multiphase study". A mixed method study involves the collection or analysis of both quantitative and qualitative data in a single study (Schoonenboom & Johnson, 2017). The use of mixed methods enables researchers to answer research questions with sufficient depth and breadth (Enosh, Tzafrir, & Stolovy, 2014). It also helps generalise findings and implications of the researched issues to the whole population (Dawadi, Shrestha & Giri, 2021).

1.8.2 Methodological choice: Exploratory sequential design Mixed Method

Another important issue about mixed methods is how to conduct a mixed methods study (Molina-Azorin, 2016). There are various mixed methods research designs. These designs are the convergent design, the explanatory design, the embedded design, the transformative design and the multiphase design (Creswell *et al.*, 2011). Mixed methods research requires a purposeful mixing of methods in data collection, data analysis and interpretation of the evidence (Shorten and Smith, 2017). Furthermore, there are two main factors that help researchers to determine the type of mixed methods design that is best suited to their study: priority and implementation of data collection (Molina-Azorin, 2016). For this study, the researcher considers an exploratory sequential design to undertake mixed methods research. An exploratory sequential design is a mixed methods study design, where the quantitative phase of data collection and analysis follows the qualitative phase of data collection and analysis (Fetters, Curry & Creswell, 2013). Data integration, a process of systematically merging quantitative and qualitative data can occur in numerous ways and at various levels during the study design, methods (data collection,

data analysis), and reporting/data interpretation stages (Creswell & Clark, 2011). The sections below provide an explanation for the choice made for using a mixed method approach.

Qualitative

Qualitative methods involve interview techniques, observation for data collection (Bogdan and Biklen, 1997). For this study, the researcher employed the qualitative method from a small number of individuals. The qualitative approach provides a deeper understanding of the issue being investigated, honouring the voices of its participants (Dawadi, Shrestha and Giri, 2021). This method was deemed to be better placed to best answer the meanings, concepts, definitions and descriptions in line with the recruitment and selection process. This method has assisted in answering how the effectiveness of the recruitment and selection process will improve Community Health Workers' Programme of SDM. This method also helped to analyse evidence prescribed and present findings which aim to resolve identified issues. The researcher herein made use of first-hand observation done in a form of interviews, documents, case studies and artifacts. The above-mentioned method complimented the current study in arriving at theoretical and practical conclusions which helped get to the core of the study by assisting in understanding the concepts, thoughts and experiences of the CHWs' in SDM.

Quantitative

According to Creswell (2012), quantitative research deals with numeric data which are collected from a large number of people using instruments with preset inquiries and responses. Quantitative method was also used in the study as it provided assistance by enabling the research to be conducted on a larger scale. The quantitative approach helps a researcher to collect the data from many participants; thus, increasing the possibility to generalise the findings to a wider population (Dawadi, Shrestha and Giri, 2021). This method is appropriate, as it is useful for revealing insights from a broader group of people. This method was also preferred for this study because it enabled the researcher to compare the different groups of the CHW's to understand their similarities and differences.

The researcher herein made use of survey questionnaires, and a statistical analysis was done by comparing the cause effect relationships between the recruitment officers on

their method and selection processes. This approach assisted in providing answers of how many CHWs' are recruited, the retention rate, and how much the recruitment and selection programme is used in helping to strengthen the recruitment of CHW's in SDM. This method has also assisted in answering the hypothesis of the study.

1.8.3 Study setting

This research focuses on the recruitment and selection process in the Department of Health in the Sedibeng District Municipality in Gauteng province. The community health centres are identified as a base for analysing the research question. The health sector in Gauteng province comprises of 5 health regions/districts, which provide primary health services, namely: Sedibeng Health District (SDM), Ekurhuleni Health District, JHB Health District, West Rand Health District, and Tshwane Health District. The study was conducted in the Sedibeng Health District services, operating within the SDM. The Sedibeng Health District services head office is situated at the Johan Heyns (Previously known as Vanderbijlpark Hospital) Community health services in Vanderbijlpark. Surveys were administered within the health facilities in the three municipalities of SDM, namely, Emfuleni Local Municipality (ELM), Lesedi Local Municipality (LLM) and Midvaal Local Municipality (MLM). The Sedibeng Health District comprises of +-30 public health clinics providing primary health care. In the financial year 2016/2017 the SDM appointed 1191 CHWs (Persal DHIS 2016/2017). Currently, there is an estimate of 741 CHWs within the respective public health facilities.

1.8.4 Sampling

The key informants' for this study is the District Health Manager and the Human Resource Manager who are both located at the Gauteng Department of Health, in the Sedibeng District Health Services in Johan Heyns CHC. This study considered a stratified and purposive sampling. Stratified sampling probed questions in a form of a survey to the CHWs. Purposive sampling was used to explore recruitment and selection process from the District CHW Programme Coordinator and the Human Resource Manager in the Sedibeng District Health Services in Johan Heyns CHC.

An application to seek approval for conducting research in the identified study area was submitted to the department through the office of the District Health Director/Manager.

The approval process was conducted through the National Health Research District (NHRD) website, and the permission to conduct research was approved by the District Research Committee.

1.8.4.1 Stratified sampling

Stratified sampling is a probability sampling method that is implemented in sample surveys (Parsons, 2014). Stratified sampling is one of four probability sampling techniques: Simple random sampling, systematic sampling, stratified sampling, and cluster sampling. A stratified sample ensures that subgroups (strata) of a given population are each adequately represented within the whole sample population of a research study (Crossman, 2020). Stratified sampling allows a researcher to divide the population into two or more groups (strata) according to one or more common attributes (Dudovskiy, 2019). The researcher considered the following characters to create strata based on income, gender, and race, marital status, geographic location, and number of years of experience as a CHW (Frost, 2020).

CHWs were selected for the stratified sampling, as they share the same characteristics. CHWs were appointed from both public health clinics and NGOs. The sample population of this was recruited from the public health clinics established in the SDM, to ensure a greater level of representation (Dudovskiy, 2019). A stratified sample guarantees better coverage of the population (Crossman, 2020).

Sampling Community Health Workers (254)

The study area comprises of three local municipalities, namely: Emfuleni, Lesedi and Midvaal Local Municipality. A list of clinics was retrieved from the departmental annual report to ensure understanding of the composition. The National Department of Health (2022:18) recorded a total of 48 443 CHWs who were receiving remuneration at the end of March 2021 within the nine provinces in South Africa.

There are approximately 30 clinics situated within the study area, whereby some are fixed while some are mobile points for service delivery. Each facility has an estimated allocation of 15 CHWs led by CHWs facilitators. There is an estimate of 741 CHWs appointed in the Sedibeng District Health Services: Emfuleni (572), Lesedi (99) and Midvaal (70). Emfuleni

is a largely urbanised municipality, with a high population density compared to Lesedi and Midvaal. Lesedi & Midvaal can primarily be described as an urban-rural, agricultural area. The sample composition for this study is presented in Table 1.1 below.

Table 1.1: Sample Size

Local Municipality	Population Size (CHWs)	Percentage of Sampling Size	Total Sampling size	Sample distribution	
				Number of clinics sampled per municipality	Number of participants per clinic
Emfuleni	572	77%	196	14	14
Lesedi	99	13%	33	3	11
Midvaal	70	10%	25	3	8 (*9)
Total	741	100%	254	20	254

*One participant as a round up for 8.333

Calculation of exact sample size is an important part of research design (Charan & Biswas, 2013). When thinking about sample size, the two measures of error that are synonymous with sample sizes are considered, namely: the confidence interval and the confidence level (Kibuacha, 2021). The sample size was determined by means of the application of the sample size calculator from survey monkey (SurveyMonkey, 2023). In the social research a 5% margin of error is acceptable (Taherdoost, 2017). For this study, a confidence level of 95% and a confidence interval (margin of error) of $\pm 5\%$ were used to calculate the sample size.

The study area has a diverse population. The questionnaire has a section to probe questions about the demography of the participants. The study considered the different gender, racial groups, and socio-economic characteristics with the aim to eliminate biasness and for representativeness. In this regard gender (male and female) including their ethnicity (Black, Coloured, Indian/Asian, and White) participated in the study. Participation in CHWs has an age limit. Therefore, the study considers participants who are between the ages of 20-64 years of age.

The entire population size for CHWs in the study is 741. The sample size selected for the study is 254 CHWs. The sample size was surveyed from twenty (20) clinics selected from

the 30 clinics in the study area. The sampled clinics were determined by applying a sample size calculator to have a reasonable sample without bias. The names of the participants and clinics were assigned codes to ensure the protection of their identity. The sampled clinics and participants are presented as follows:

- Emfuleni Local Municipality: 14 clinics = 14 participants per clinic. The clinics are situated in the following areas: Boipatong, Bophelong, Evaton, Evaton North, Palm Springs, Polokong, Rus-Ter-Vaal, Sebokeng Zone 7, Sebokeng Zone 17, Sebokeng Zone 13, Berverly Hills, Sharpeville, Vanderbilpark, and Vereeniging.
- Lesedi Local Municipality: 3 clinics = 11 participants per clinic. The clinics are situated in the following areas: Heidelberg, Ratanda, and Rensburg.
- Midvaal Local Municipality: 3 clinics = 8 (*9) participants per clinic. The clinics are situated in the following areas: Meyerton, Bantu Bonke and Sicelo area.

1.8.4.2 Purposive sampling

Purposive sampling is a method that can be employed in both qualitative and quantitative research methodologies (Tongco, 2007). Purposive sampling technique is convenient and known for its robustness as the method's efficiency is attributed to its inherent bias and ensuring the dependability and competency of the informant. One questionnaire is developed for the Sedibeng District Health Service. The questionnaire required the involvement of both the District CHW Programme Coordinator and the Human Resource Manager to respond to the questions posed as they pertain to the administration and recruitment and selection process for the CHW.

District CHW Programme Coordinator/Manager and Human Resource Manager

Each District Health service comprises of a District CHW Programme Coordinator who reports to the CHW Programme Director/Manager. The CHW Programme Coordinator controls the budget and ensure intra- and intersectoral collaboration for CHW programme. The office is responsible for technical support, training and monitoring of CHWs (Health Systems Trust, 2013). A face to face or telephone interview will be conducted with the office of the District CHW Programme Coordinator in the convenience of their schedule. The office will help to reach out to the clinic Facility Manager for respective facilities. The District CHW Programme Coordinator assisted in clarifying the questions relating to CHW programme.

The office of the Human Resource Manager was also invited for the interview. The office is responsible for the District Health service staffing needs including recruitment of health officers. The office is responsible for hiring and retaining of medical staff at hospitals, clinics and other healthcare facilities. The interview sought to understand the processes involved in recruitment and selection process for the CHWs. The interview was also aimed at understanding the factors influencing recruitment and retention in the health sector particularly for the CHWs.

1.8.5 Inclusion and exclusion criteria

The study area is in the SDM. The inclusion and exclusion criteria for this study is presented below. For this study, the inclusion and exclusion criteria determined which members of the target population can or cannot participate in a research study. This includes the demographic characteristics and the geographical area. The exclusion criteria can be ethical consideration, whereby identified CHWs are unable to give informed consent.

Table 1.2: Inclusion and exclusion criteria

Inclusion Criteria	Exclusion Criteria
Registered CHWs Adults ≥20 years of age	Retired CHW Adults ≥65 years of age
Males and females in their respective race and ethnicity	Refusal to give informed consent
Public domain documents and reports	Senior Officials and Managers Administrators, clinicians (nurses and doctors), general workers
Health facilities: clinics and community health centers	Hospitals, private health facilities

1.8.6 Research instruments and data collection

The different instruments are considered for collecting data for this study. The researcher considers the use of primary and secondary research for collecting data. Primary and secondary research were used to gather data from existing document.

1.8.6.1 Research instruments in qualitative research

Ary (2010) stated that the most common research instruments used in qualitative research are observation (participant observation and non-participant observation), interview, and document analysis. These instruments are discussed in Chapter 5. Non-participant observation was used to understand phenomena by studying the study area in terms of the locations in which the CHWs comes from. The second instrument is the interview which was used to collect data from participants for data collection (Godwill Fomunjong, 2013). Ary (2010) classifies interview into three types: unstructured interview, structured interview and semi structured interview. For this study semi-structured questions were used for the purposive sampling for the office of the District Health Service Manager and the Human Resource Manager. The third instrument is the document analysis which serves to inform the researcher about other methods of data collection.

1.8.6.2 Research instruments quantitative research

Research instruments in quantitative research include surveys, questionnaires, telephone, and interviews. A survey is executed as a main instrument for quantitative research. Surveys may be executed by paper or through online surveys and for this research both forms of surveys were used to ensure participants are accommodated. Surveys were considered because they reach a larger audience and are also able to make the results as subjective as possible as recipients remained anonymous. Development and adapting questionnaires are used in the mixed method approach (Shiyanbola, Rao, Bolt et al., 2021). In this regard a questionnaire is regarded as the main component of surveys for this research.

1.8.7 Reliability and Validity

Different methods are used to collect data. These methods can make the results to be more credible. Reliability and validity are two important components in research and both methods are the expected outcomes of a research. Validity ensures you are measuring that which you claimed to measure. On the opposite hand, reliability confirms that you will get the same results even when the test is repeated (Kumar, 2000). Reliability can be described as the degree to which the results are consistent and repeatable at any given time. In most cases, a researcher is likely to repeat research in different settings to compare the reliability of the study.

In a reliable and reproducible research outcome will yield new theories (Kumar 2000). In a social setting, a researcher can use different techniques which will achieve better reliable results. Although in social sciences, it is often difficult to achieve reliability because even in the same setting, human behaviours are difficult to repeat. To ensure reliability a survey will be developed by the assistance of a statistician who will assist in the development of the survey to capture the data as accurately as possible.

1.8.8 Data analysis

Data analysis is the process of converting the data gathered to meaningful information. There are different techniques which includes modelling to reach trends, relationship, and conclusions made to address the decision-making process which are employed (Start, 2006). The researcher firstly prepared the data and later converted it into a numerical format which was machine readable. The Statistical Package for the Social Sciences (SPSS) was used for the analysis of survey results.

Data Coding

The data coding process is when data is converted to numerical values, by making use of a codebook which includes different information which helps to explain the variables, format of variables and finally coding them. For this study, inductive qualitative coding was used by taking the semi-structured questionnaires and interviews with the CHWs' and the Recruitment officers by structuring it into themes and patterns for analysis. This type of coding made the analysis process more systematic and rigorous. This also increased transparency and reflexivity to the researcher and to others by enabling the researcher to find insights which are truly representative of the data and the human aspect behind them. The coded data was entered into spreadsheets by making use of statistical programme to help determine the variables.

For this study, the researcher used the predictive analysis. The researcher used this by utilising historical and current facts to reach future predictions (McGregory, 2013). By establishing past CHWs programmes and correlating them to the present, assisted in determining the best input for future setting.

Data storage

The collected data will be kept in a locked office for a period of 3-5 years after the completion of the study. It will be used for possible reviewing for referral. After the above said period, all questionnaires will be discarded by using a paper shredder to ensure data does not come into incorrect hands.

1.9 ETHICAL CONSIDERATION

This study was guided by a set of principles to guide the researcher on required practices to conduct research. The respective principles included informed consent, voluntary participation, anonymity and confidentiality. The focus of this particular study was the community health workers recruitment and selection processes. The study was guided by the health sector framework and the human resource factors. This simply meant that the scope is limited to administrative functions and not clinical issues.

Informed consent

When conducting intense research, it is imperative to adhere to ethical norms. This enables researchers to be aware of certain agreements between the researcher and the possible gatekeepers which will help determine what is proper and what is improper in the scientific enquiry (Babbie, 2011:477).

The researcher asked the participants for their informed consent. This informed consent allowed the researcher to provide the participants with adequate information about the current study (Ruback, 2013). Informed consent requires that individuals truly understand and freely and knowledgeably make choices regarding their participation in the study (Roberts, 2001). In this regard, the researcher made use of an informed consent form which outlined the aim objectives of the study. Furthermore, on the consent form, an outline of the research process was explained to the participants. The instructions were also outlined to the participants. This enabled them to read and understand the context of the study. A survey was distributed by means of a cellphone, e-mail and a hard copy was printed for participants who do not have access to the network and insufficient data to can log on.

The survey form was divided into two processes. Firstly, the form asked the CHWs if they give a consent to partake in the study. Participants (CHWs) were given a period of one week (1-week) to decide on their participation in the study. They were then required to click their survey choice, indicating either a yes or a no. Upon their acceptance to give consent, the form then allowed them to continue with the survey. Participation in the study was entirely voluntary. In an event a participant, for whatever reason would decide to not be involved or to leave the question and answer session in the middle, their decision was to be respected and borne no consequences.

Anonymity and Confidentiality

Confidentiality clause policy was always adhered to, and the researcher did not intend to harm or tarnish the name of Community Health Workers or the health sector as a whole. Everything discussed between the researcher and each participant was held with strict confidentiality and their names will not appear on any data sheet. All information obtained will remain secure throughout the duration of the project and if we come across data which is not relevant to the study, it will be immediately destroyed. Ethical norms and principles were used to guide the researcher throughout the entire project to ensure that no errors are done and that voluntarily participation is maintained at all times. The ethical norms were to ensure that no participant was forced into participation. Every participant of the study did so on their own free will. Language aspect was also considered an important part of ethics. For the purpose of this study, the researcher had questionnaires in English, but participants had the questions translated to them in a language they felt most comfortable with.

The research mainly focused on administrative and recruitment processes for Community Health workers. The main focus of the study was how effective recruitment and selection can strengthen CHWs Programme to ensure better administration. The researcher in no way aimed to harm the images of the institutions involved as well as the participants who took part in the study. In order to form solid relationships, the researcher submitted a letter to request permission from the Gauteng Department of Health. This letter clearly indicated the interest of the selected research area: Sedibeng District Municipality. The researcher intended to observe all protocols prescribed and also ensured that she remained objective during the course of the study. A letter of intent was applied for from

the Provincial District Health Services before the commencing of interviews from all the relevant departments.

1.10 OUTLINE OF THE STUDY CHAPTERS

The following are the chapter outline of the study:

Chapter 1: Orientation and background

This chapter serves as an introductory chapter. The research problem and purpose of the study is discussed. The research questions, objectives and a brief research methodology is presented.

Chapter 2: Literature Review

The chapter consists of an overview to recruitment and selection. It also presents the theoretical review, empirical review, and conceptualisation of the study. This chapter further comprise of literature reviewed on recruitment and selection and provides a summary of literature review and a conclusion.

Chapter 3: The context for community health work programmes

The chapter discusses the evolution and history of the CHW workforce. The legislative framework governing the CHWs is discussed since CHW programmes are part of public policy actions. The chapter also describes the prevailing models of care engaging CHWs as they form part of health service provision including member of care delivery team, navigator, screening and health education provider, outreach-enrolling-informing agent, and organiser. The chapter concludes with the contributions of CHW programme in the health service provision.

Chapter 4: Overview of recruitment and selection practices for Community Health Workers programme

The chapter consists of an overview of institutional framework for recruitment and selection programme in South Africa. It also provides an understanding of HR policy documents, guidelines and criteria for advancement of recruitment and selection programme in South Africa and international perspectives. The discussion of CHW recruitment process, establishing criteria, communicating CHW opportunities to identify candidates, interviewing and selecting CHW's from candidates and hiring selected CHW's.

Chapter 5: Research Design and Methodology

The chapter entails an overview of research methodology. It explains how the research was conducted. It describes the sampling procedure, data collection instruments and data analysis. The strengths of the study and possible limitations are included in this chapter. The conclusion for validity and reliability and ethical considerations are also discussed.

Chapter 6: Presentation of Results

Research results are presented in this chapter. An analysis and discussion of the results obtained from the survey and questionnaires are presented.

Chapter 7: Practice and framework for CHW recruitment and selection

In this chapter the researcher advances the understanding about enhancing recruitment and selection practices for CHW programmes. The discussion and presentation of the proposed framework of the empirical findings in relation to the research questions and relevant theories are also carried out in this chapter.

Chapter 8: Findings, conclusion and recommendations

This final chapter presents the findings of the study. The researcher also provides the key findings, outcomes and any information deemed relevant to the study. This includes the recommendations based on opinions which are supported by the research findings. The limitations and the contributions of the study are also analysed in this chapter.

1.11 CHAPTER SUMMARY

This chapter provided a detailed outline of the research study by providing the background to the study which included both the International and South African context of Community Health Workers in order to give the reader a clear concept of the role CHWs have played and continue to play. CHWs' popularity has grown steadily from when they were first introduced back in the 1930's.

There has been significant progress in making a formal structure which further highlights the important role CHWs' play within the Primary Health Care by providing basic support in an overstretched health system. This chapter also provided the main objectives and high-lighted the significance of the study and also provided the research design the study undertook.

The next chapter discusses the conceptual framework for the recruitment and selection of CHWs.

CHAPTER: TWO

A CONCEPTUAL FRAMEWORK FOR THE RECRUITMENT AND SELECTION OF COMMUNITY HEALTH WORKERS

2.1 INTRODUCTION

This study is situated in the context of human resource in the health sector seeking to understand the recruitment and selection of CHWs. This chapter provides a foundational component of the research study. The chapter begins with defining key terms of the study, including human resource for health, recruitment and selection and community health workers. The chapter comprises of sections to discuss the literature review, theoretical framework and the conceptual framework. The chapter begins with the definition of key terms to create a conceptual framework for this study on recruitment and selection and community health workers (CHWs). A review of scholarly sources is provided to understand the extent of the academic work on the selected research topic. For this chapter a literature review will be used to serve as the foundation for a theoretical framework. A foundational review of existing theories that have enriched the literature on the recruitment of CHW is presented in this chapter. The theoretical framework will be used to support the research, combine various theoretical concepts and later create a framework for this study. The chapter provides a summary of the key issues emanating from the afore-mentioned sections.

2.2 DEFINITION OF KEY TERMS

The definition below provides a brief definition of concepts related to the study. The concepts discussed includes; human resources, recruitment and selection, and community health workers.

2.2.1 HUMAN RESOURCE MANAGEMENT

Human resource management (HRM) is a systematic and cohesive approach to managing people effectively and efficiently inside an organisation so that they contribute to the companys' ability to acquire a competitive edge (Dessler, 2020). The HR manager provides various staff services to line management, including "recruiting", "selecting", "training", "compensating", "appraising", and "developing employees" (Dessler, 2020). Dessler (2020) emphasised that todays' human resource managers need the knowledge,

skills, and competencies to deal with current trends and challenges in the workforce. The following competencies, namely: strategic positioners, credible activists, capability builders, change champions, and HR innovators and integrators are highlights for executing the HR function (Dessler, 2020).

Human resource managers are more involved in helping their institutions address longer-term, strategic “big picture” issues (Dessler, 2020). A Human Resources Manager serves as an “enabler to many service delivery priorities” (WHO, 2016). It serves as an “essential pillar of any institution” (Fernandes, Augusto, Machai, *et al.*, 2023) to the delivery of services (Cometto & Campbell, 2016). The health workforce underpins the health goal (SDG 3c) to “substantially increase health financing, recruitment, development and training, and retention of the health workforce in developing countries and in least developed countries” (WHO, 2016). We see a strategic role of HRM in formulating and executing human resource policies (Dessler 2020). The HR also provide guidance to line managers to optimise employee performance and advance an organisations’ business goals (ILO, 2023:IV). Armstrong & Taylor (2020) also points the attributes of systematic and integrated approach on the role of HR within an organisation.

Capability builders seek to create a meaningful work environment and aligning strategy, culture, practices, and behaviour (Dessler 2020). Capability builders encompass behavioural aspects of individuals by guiding how people should be effectively managed (Armstrong & Taylor, 2020) and for their professional development (ILO, 2023:IV). This role seeks to ensure that fair practices, labour relations and health and safety procedures are followed accordingly (Dressler, 2011). Fair practices will relate to the recruitment of health workers, especially the CHW.

The notion of HR innovators and integrators incorporates activities pertaining to recruitment and selection processes (Dessler, 2020; Belcourt, Singh, Snell & Morris, 2022).

Several factors hinder the progress of any institution in fulfilling their organisational goals. Such factors may be associated with resource challenges to produce, hire, and the retention of qualified health workers (WHO, 2016). The role of an HR is to connect the

employer and the prospective candidates. Technological trends compel HR managers to be more efficient in executing a strategic role in respective institutions (Dessler, 2020). For recruitment, the technological trends require HR managers to create job listings on respective online platforms.

2.2.2 RECRUITMENT AND SELECTION

The recruiting and selection process is a vital and intricate component of HRM in organisations to ensure that the institutional goals are implemented. (Ma & Allen, 2009). Institutions aspire to have an equipped workforce to respond effectively to the ever growing and changing environment (Michaels *et al.*, 2001). HR managers are required to transform the recruitment and retention process for the public sector (Dessler 2020). Recruitment and selection are the indispensable functions of human resource management (Karim, Bhuiyan, Nath & Latif, 2021). Lievens & Chapman 2019 state that recruitment and selection are “commonly perceived as traditional and well-established areas of HRM”. The traditional recruitment and selection procedures appear to have persisted for many years (Kamran, Dawood & Hllal, 2015).

The process of recruiting and selecting employees is crucial in determining the efficacy and success of an organisation (Ekwoaba, Ikeije & Ufoma, 2015). Job Analysis is identified as a first step in recruitment and selection practice (Fathmath, Azam & Ahmad, 2020). It is highlighted as a process to determine who is drawn to and chosen to work for the institution (Searle & Al-Sharif 2018; Lievens & Chapman 2019). Each country may use different recruitment and selection processes for their CHW. Such perspectives will be discussed in Chapter 4. The two terms are explained in the subsequent sections to understand the concepts as they apply to the study.

2.2.2.1 RECRUITMENT

Recruitment is the initial stage undertaken to attract suitable candidates for the workforce, followed by selection and placement (Opatha, 2010). The most important five key stages of the recruitment process are recruitment “objectives”, “strategy development”, “recruitment activities”, “process variables” and “recruitment result” (Karim, Bhuiyan, Nath & Latif, 2021).

The ideal CHW recruitment process entails: “establishing criteria”, “communicating CHW opportunities to identify candidates”, “interviewing and selecting CHWs from candidates”, and “hiring selected CHWs” (Jaskiewicz & Deussom, 2013). In this process the institution defines its human resource requirements, including qualifications and competency demands (Mathis & Jackson, 2010). The job description is also created in the process to define the “sets of specific attributes for job applicants” (Gomez-Meija, Balkin, & Cardy, 2004). According to (Mathis & Jackson, 2010) the HR manager identifies the skills suitable for carrying out the tasks of an organisation. Dessler (2013) further outlines that this process seeks to “acquire applicants based on the organisations’ requirements”. The ideal recruitment process also entails “communicating CHW opportunities to identify candidates” (Jaskiewicz & Deussom, 2013). This comprises “sources of recruitment” (Karim, Bhuiyan, Nath & Latif, 2021) classified into two types, “internal and external” (Opatha, 2010). HR managers may use various forms to communicate with potential candidates through internal and external advertising (Ma & Allen, 2009). The recruitment process has changed drastically with the introduction of technology and the entry of social media (Collins & Smith, 2006).

Collins & Smith (2006) further highlights that the recruitment process can have “potentially disastrous consequences for an institutions success and long-term survival”. Various factors may impact applicants' job pursuit decisions (Ma & Allen, 2009). For the CHW context, a recruitment strategy provides guidelines on how and from where a CHW is identified, selected, and assigned to a community (Crigler, Hill, Furth & Bjerregaard, 2011). The recruitment process also identifies the target communities required (Agarwal, Sripad, Johnson, *et al.*, 2019: 8). Jaskiewicz & Deussom (2013) provides the following points to consider developing an effective and actionable recruitment strategy:

- specific recruitment needs for the CHW programme
- CHW selection criteria
- CHW recruitment process
- available resources influence CHW recruitment
- improving CHW retention

The abovementioned considerations will be discussed in Chapter 4.

2.2.2.2 SELECTION

Selection of employees is the second step of the planning process (Karim, Bhuiyan, Nath, & Latif, 2021). It is the choosing process of the suitable candidate which matches knowledge, “skills, abilities, and job requirements of the candidates” (Karim, Bhuiyan, Nath & Latif, 2021). Choosing who should be recruited is an important task (Brown, Lilford, Griffiths *et al.*, 2019) for HR managers. The selection of employees in any institution begins with the development of a fair and effective selection process (Brown, Lilford, Griffiths *et al.*, 2019) guided by policy-based selection criteria (Mupara, Mogaka, Brieger & Tsoka-Gwegweni, 2023). This process enables managers to identify the most appropriate individuals to match the right skills for the position to be filled (Okusanya & Oseji, 2012). The selection process can be implemented from several dimensions and perspectives (Breaugh, 2012). Each institution has its unique procedures (Gomex-Meija, 2004) for selecting prospective employees. The process may include an interview, group discussion, background/reference checks, medical examination, and employment background amongst others (Kamran & Dawood, 2015).

The process may comprise of differing factors to consider in selecting a candidate. When it comes to CHW selection several factors pertaining to “age”, “education” and other “policy-supported requirements” for being eligible to become a CHW are listed (Kok *et al.*, 2015; Campbell & Scott, 2011). These factors will apply to the job that will be undertaken to ensure appropriate measures are undertaken to eliminate redundancy and loss of investment within institutions. These factors will be discussed in Chapter 4. To achieve organisational strategic goal, service delivery and quality of work have an influence on the organisational workforce for recruiting candidates (Fathmath, Azam & Ahmad, 2020). With this it is important to conduct proper recruitment and selection practice to ensure that the right number of employees are hired into the organisation (Eva, 2018).

2.2.2.3 COMMUNITY HEALTH WORKERS

The WHO characterises CHWs as follows:

“Community health workers should be members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily a part of its organisation, and have shorter training than professional workers (WHO, 2007)”.

The WHO definition “confines the CHWs’ functions to health” (Nxumalo, 2013). This definition is widely accepted internationally (Lehmann & Sanders, 2007). The umbrella term of CHW embraces a variety of health auxiliaries who are selected, trained and work in the communities in which they live (Friedman, 2005). The term community health worker is currently used to cover a wide variety of cadres and programmes (Hodgins, Crigler & Perry, 2013). CHWs have been introduced as new frontier workers (American Public Health Association, 2009). CHWs play a critical role in delivering primary health care (PHC) services to vulnerable populations (Malatji, Griffiths, & Goudge, 2024). CHW have a defined role within the community and the larger health system (Crigler, Hill, Furth, & Bjerregaard, 2013;1). CHWs possess a unique understanding of the local context (Agarwal *et al.*, 2019).

The training provided to CHW is in the context of an intervention (Lewin *et al.*, 2005). CHWs training differs significantly from that of professional health workers in terms of substance and time duration (O’Brien, Squires, Bixby & Larson 2009; Singh 2012). The training received ranges from formal to non-formal training. The training has different training materials and durations (O’Brien, Squires, Bixby & Larson 2009; Singh 2012). Some Community Health Workers (CHWs) receive formal training from nationally recognised training institutions. This training includes structured curriculum and has a specific duration (O’Brien, Squires, Bixby & Larson 2009; Singh 2012).

They can help to reduce disparities in health outcomes (Lewin, Dick, Pond, et al., 2005; Lehmann & Sanders 2007). CHWs are trained to carry out functions related to health care (WHO, 2007)”. Their roles are categorised according to their service provision ranging from “Auxiliary health workers”, “Health Extension Workers”, “Community Health Volunteers-Regular”, “Community Health Volunteers-Intermittent” (Hodgins, Crigler and Perry, 2013:7). These positions enable community people to make knowledgeable decisions regarding their mental and physical health (Department of Health, 2018). CHWs offer “continuous health care and support to each one and families who are at risk because of a chronic illness or impoverished living conditions” (Department of Health, 2018).

2.3 LITERATURE REVIEW

Several authors assessed the best practices on human resources particularly on recruiting and selecting CHWs (Karim, Bhuiyan, Nath, and Latif, 2021). In this section the literature review on CHW recruitment and selection process is discussed.

Gill Walt's 1990 book "Community Health Workers in National Programmes" and Stephen Frankel's 1992 book "The Community Health Worker: Effective Programmes for Developing Countries", both take a critical look at the large-scale CHW programs that were put into place during the previous ten years. The two volumes emphasized the critical systems support needed to enable CHW programs to operate at scale as a dependable part of all-inclusive PHC services. A thorough examination of the data pertaining to CHWs was carried out in 2007 by Lehmann and Sanders (2007), and the results significantly expanded the body of knowledge regarding national CHW programs.

In 2008, Rifkin also did a comprehensive examination of Community Health Workers (CHWs). An extensive analysis of the development of national Community Health Worker (CHW) programs, published in 2014. Zembe (2009) investigated the type and extent of community participation in the recruiting and selection processes of Community Health Workers (CHWs) in KwaZulu-Natal and Western Cape. Zembe (2009) did a study that was inspired by Lund's (1987) research. Lund's study focused on evaluating community participation and the recruitment processes of Community Health Workers (CHWs) in three distant community health initiatives. Zembe's (2009) analysis found four primary themes: "Determinants of Selection Process," "Challenges to Selection," "the Role of Government Policy," and "Involvement" for recruiting and selecting CHWs.

Bhutta, Lassi, Pariyo, and Huicho (2010) published "Global Experience of Community Health Workers for Delivery of Health-Related Millennium Developmental Goals: A comprehensive analysis, including a systematic review, country case studies, and recommendations for the incorporation of this information into national health systems. The study conducted by Bhutta, Lassi, Pariyo, and Huicho in 2010 remains one of the most thorough assessments of national Community Health Worker (CHW) programs. This paper entails a comprehensive examination of the worldwide experience with national Community Health Worker (CHW) programmes. The article examined eight

country case studies from South Asia (Bangladesh, Pakistan, and Thailand), Latin America (Brazil and Haiti), and Africa (Ethiopia, Mozambique, and Uganda)” (Bhutta, Lassi, Pariyo, & Huicho, 2010). Their investigation discovered few summaries of national CHW programmes, and even less reviews of the activities. Their findings revealed that a prior research design or outcome assessment approach was not used (The Financing Alliance for Health, 2020).

A Toolkit for CHW Programme Functionality Matrix was introduced as an optimal approach for recruiting CHWs. The toolkit includes the selection process for CHWs, which are typically from the local community, and the incorporation of community members. (Crigler *et al*, 2011). The resource which is found online, "*Developing and Strengthening Community Health Worker Programs at Scale: A Reference Guide and Case Studies for Program Managers and Policymakers*" was published in 2014. The study guide provides a comprehensive examination of the subjects that need to be taken into account during the establishment, execution, improvement, and enlargement of national CHW programs (Perry and Crigler, 2014).

The resource book covers the following topics: “CHW history, arranging management, funding, collaboration and relationships, duties and responsibilities, recruitment, instruction, supervision, motivation, incentives” (Perry and Crigler, 2014). It also covers “continuation as well as interactions with other parts of the health system, involvement from the community, evaluation and monitoring, scaling-up and sustaining program effectiveness, and measurement and data use” (Perry and Crigler, 2014).

The literature on CHW recruitment is influenced by the role played by organisations and teams instituted by the state, such as The Centres for Disease Control (CDC) and the Community Preventative Services Task Force. These organisations examine the current situation and provide the government with reports and recommendations based on their observations. The two institutions identified areas where there is a lack of evidence about the strategies used to recruit CHWs (CDC) (Reininger, Barroso, Mitchell-Bennett *et al.*, 2010). This is due to the fact that several community health worker CHW recruiting initiatives commence with healthcare providers commencing the recruitment process without actively including the community that is being served (Reininger, Barroso,

Mitchell-Bennett *et al.*, 2010). Community empowerment is crucial in the initial stages of identifying and selecting Community Health Workers (CHWs) (Shahidi, Slickhora, Clancy & Nagurka, 2015).

2.3.1 Issues arising from literature for consideration on CHW Programmes

An important review that offered NGOs guidance on how to support the development of national childcare worker (CHW) initiatives was published in 2013 (Walker, Downey, Crigler & LeBan, 2013). With the WHO's recommendation, Bhutta's monograph represented a significant milestone for the global CHW movement (The Financing Alliance for Health, 2020). Furthermore, it presented a compelling argument for the inclusion of CHW programming in the nation's human resources for health planning process and underscored the significance of CHW programmes as a critical element of national health systems. Additionally, this statement called for:

- Organising CHW programmes surrounding community needs;
- Supporting robust community involvement in the recruitment of CHWs by establishing village health committees
- Training programmes that connect scientific understanding of preventative and primary medical care to regional concerns and cultural customs.
- Clearly defined procedures for CHW deployment and selection;
- Sufficient resources to support CHWs' necessary supplies and equipment;
- Developed referral practices; and
- Consistent, ongoing oversight and evaluation systems (The Financing Alliance for Health, 2020).

Perry (2020) also conducted a comprehensive analysis of the national CHW program experience, identifying three primary obstacles that were limiting the full potential of national CHW programs. These challenges include:

- inadequate preparation,
- feasible and sustainable issues, and
- and difficulty prolonging the required quality (Perry, 2020).

In many nations, there is a lack of culturally appropriate healthcare services (Cueva, Ingemann, Zaitseva *et al.*, 2021). Cueva, Ingemann, Zaitseva *et al.*, (2021) states that

CHWs are “primarily indigenous individuals who provide on-the-ground health care and health promotion services in their own communities”. It is indicated that the role of CHWs is often overlooked and underutilised. (Cueva, Ingemann, Zaitseva *et al.*, 2021). In order to ensure the effective contribution of community health workers (CHWs) to health programs, it is crucial to provide them with enough assistance (Raven, Akweongo, Baba *et al.*, 2015). The research undertaken by Cueva, Ingemann, Zaitseva *et al.*, (2021) suggests that the responsibilities of Community Health Workers (CHWs) differ between countries based on the specific needs of the communities they serve.

The study conducted by Raven, Akweongo, Baba *et al.*, (2015) emphasised that human resource management techniques do not always fulfill the expectations of community health workers (CHWs). However, programme managers and people of the community are not as involved in overseeing the CHWs (Raven, Akweongo, Baba *et al.*, 2015).

2.3.2 Human Resources Practices

The integration component of each of the six CHW programs was the exclusive subject of the reviewed studies (Mupara, Mogaka Brieger, & Tsoka-Gwegweni, 2023). Their study analysed the CHWs programmes in Ethiopia, Ghana, Malawi, Nigeria, Rwanda, and Zambia (Mupara, Mogaka, Brieger & Tsoka-Gwegweni, 2023). In a previous study by Luballo and Simon (2017, as cited in Fathmath, Azam, & Ahmad, 2020), the Remorse-Based View Theory was examined to explore the connection between management performance practices, recruitment, and selection processes in the government sector, with the aim of enhancing service quality. A 2021 study was undertaken to examine the perspectives of various stakeholders on the selection criteria and competence of Community Health Workers (CHWs) in Golestan Province, Iran. This study assessed two sub-themes, “CHW effectiveness” and “CHW sustainability” (Shakerian & Gharanjik, 2023). In addition, three main themes of “criteria for employing competent people”, “barriers to employing competent people”, and “identifying the barriers to employing competent people” were analysed (Shakerian & Gharanjik, 2023). This study found that “local hiring” and “its requirements” were significant obstacles to the competency-based CHW selection process (Perry, 2020).

The management issues in healthcare, which are comparable to those faced in managing any other health worker, pertain to enhancing recruitment, retention, and performance

(Raven, Akweongo, Baba *et al.*, 2015). Mupara, Mogaka, Brieger, & Tsoka-Gwegweni (2023) examined every CHW program component in light of the components of the WHO framework for health-related stress. Gerhart & Feng (2021) described the “interplay between RBV and strategic HR in specific areas” focusing on “HR-related firm heterogeneity”. Their research included evidence on the value created by HR. Gerhart & Feng (2021) also addressed micro foundation issues and debated whether the institution should pay more attention to competitive parity.

Raven, Akweongo, Baba *et al.*, (2015) advocated for a unified HRM strategy to assist CHWs, with HRM procedures created to guarantee that the CHW programme achieves its objectives in addition to meeting expectations. To comprehensively examine the data on the incorporation of Community Health Worker (CHW) programs that prioritize child health in Sub-Saharan Africa (SSA) into National Health Systems, we conducted a meticulous scoping study. O'Brien, Squires, Bixby, and Larson (2009) conducted a study where they developed a conceptual model of Community Health Worker (CHW) role development and performed a comprehensive analysis of the training and selection methods.

2.3.3 Development Initiatives from the literature review

Many writers have provided a variety of techniques to improve HR processes for recruiting and selecting personnel, with a special focus on Community Health Workers (CHWs). Developing an equitable and effective selection process for Community Health Workers (CHWs) is a challenging task, and there are few documented instances of such efforts (Brown, Lilford, Griffiths *et al.*, 2019). The study undertaken by Cueva *et al.*, (2021) presented a conceptual model that outlines the various routes by which the integration of Community Health Workers (CHWs) contributes to the well-being of their communities. Raven, Akweongo, Baba *et al.*, (2015) undertook a rapid national case study to examine the tactics used to attract, retain, and manage the performance of Community Health Workers (CHWs) in five African countries. The respective countries being studied were “Democratic Republic of Congo”, “Ghana”, “Senegal”, “Uganda” and “Zimbabwe” (Raven, Akweongo, Baba *et al.*, 2015). A study conducted in Uganda discovered a clear link between CHW selection criteria and clinical outcomes for HIV patients receiving CHW

services (Singh, 2016). In 2014, a research in Zambia studied how employment advertisements are worded for the same CHW post (Ashraf, Bandiera, and Jack, 2014).

Cueva and colleagues', proposed approach incorporates five methods outlining how Community Health Workers (CHWs) might contribute to promoting wellness:

- i. recruiting CHWs from inside a community strengthens the community's ability and authority;
- ii. if CHWs are assisted in uniting their communities around wellness, their position enables them to campaign for the rectification of structural and systemic injustices that fuel poor health;
- iii. CHWs may be able to empower and assist members of the community;
- iv. CHWs can create workable, successful, and culturally appropriate health promotion plans; and
- v. CHWs could strengthen existing community assets (Cueva *et al.*, 2021).
- vi. in order to effectively integrate CHWs into the health system, their model necessitated that institutions establish a process.

The model emphasises for critical examination of personnel to be integrated into health care systems. In essence their model required a standard process since the respective CHWs will interact with the community. Brown *et al.*, (2019) evaluated HRM practices in Malawi and Ghana respectively, highlighting best practices and providing advice to CHW programme sponsors looking to create their own selection procedures.

Brown *et al.*, (2019) conducted a study that detailed a five-stage process of development and initial testing of a CHW selection procedure in two CHW programmes, namely to:

- i) examine an already-existing selection procedure;
- ii) carry out a job analysis;
- iii) gather feedback from stakeholders;
- iv) co-design the selection procedure; and
- v) test the method of selection (Brown *et al.*, 2019).

Brown *et al.*, (2019) emphasised validity, reliability, equality, acceptance, and practicality as the selection process' determinants based on the aforementioned five steps. In stages

1 through 4, these things were deemed appropriate, and in stage 5, they served as a guide for the testing. Their investigation emphasised how crucial it is for stakeholders to play a part in ensuring that the selection processes created are acceptable (Brown, Lilford, Griffiths *et al.*, 2019). The RBT pinpointed resources and capabilities as components for realising institutional competitive advantage (Barney, 1991). We see Brown *et al.*, (2019) highlighting limited resources within the institution and such resources needs to be managed for effective process. Their study make provision of testing the process in order to assess if the process will bring good results. In this case the pilot process is identified.

2.3.4 Closing remarks on literature review

Evidence of integration on the majority of CHW programme integration components differed among nations, despite certain parallels being noted (Mupara, Mogaka, Brieger, & Tsoka-Gwegweni, 2023). The integration of CHWs and quality assurance of services were highlighted as essential to be observed into national planning of human resources to the health system (Singh, 2016). Singh (2016) makes emphasis of careful selection and development of CHWs, and this is seen as a major determinant for a high-quality workforce. All of the reviewed countries have their unique health systems linked to CHW programs. Varying health systems in the region have varying integrations of certain CHW program components, such as CHW recruiting, education and certification, execution of services, leadership, information management, and supplies and equipment (Mupara, Mogaka, Brieger, & Tsoka-Gwegweni, 2023).

There were papers that addressed the selection and training of CHWs. Singh (2016) emphasises that applicants should be "assessed and selected" using "structured, formalised hiring processes" that take into account their interpersonal skills as well as their expertise in order to create successful patient interactions. The most important requirement is that CHWs be citizens of the areas they work in. The literature review shows that thoughtful planning is common in all HR practices. A well thought CHW programme may also give the community substantive opportunities to engage in the process.

2.4 THEORETICAL FRAMEWORK

The aim of this section is to examine the theoretical framework that underlies research of the recruiting and selection processes. Theories include models and frameworks (Nilsen, 2015:10). The following theories are discussed as they pertain to the study:

- 'Resource Based Theory',
- 'Equity Theory', and
- 'Human Capital Theory.'

The discussions present a description of each theory, including relevant background information, current experiences, and illustrative examples. Additionally, the researcher will outline the problems and opportunities associated with each theory.

2.4.1 RESOURCE BASED THEORY

The resource-based theory (RBT) is a prominent method in strategic management (Utami & Alamanos, 2022). The Resource-Based Thinking (RBT) method emphasises the significance of organisational resources and capabilities in order to achieve both performance and a competitive advantage (Gupta, 2023). Jay Barney's evocative work is the RBT. The "dominant paradigm in strategic management and planning" was established by the development of RBT (Barney, 1991). RBT offers a framework for identifying and forecasting the "fundamentals of organisational performance" and "competitive advantage" (Utami & Alamanos, 2022). Resources and capabilities are essential for the success of any institution.

The primary goal of every institution is to maintain its relevance in the ever-evolving market trends by creating value propositions for its consumers (Gupta, 2023). Wright et al. (2001) have widely accepted the RBT as one of the most potent and prominent theories that best describes, explains, and predicts an organisation's internal relationship. The RBT has been primarily employed as a "managerial framework to ascertain the key resources necessary for a firm to establish a sustainable competitive advantage" (Utami & Alamanos, 2022). Four conditions comprise a competitive advantage for the RBT: "value."

The validation of the value of specific resources is a responsibility of HR managers. The framework simplifies the process of determining whether a specific organisational

resource is a source of long-term competitive advantage (Utami and Alamanos, 2022). It aids in the resolution of issues that require resolution, such as the value of a particular resource. Is it uncommon? Imperfectly imitable? Is the institution equipped to utilise this resource? (Utami and Alamanos, 2022). An organisations' resources are comprised of "all assets, capabilities, organizational processes, firm attributes, information, and knowledge" (Barney, 2001). In order to enhance its efficiency and efficacy, a corporation manages these resources (Barney, 2001).

Organisations establish their strategies on the basis of resources and capabilities. Makadok (2001) asserts that there is a distinct distinction between competence and resources. Nevertheless, these two fundamental components are intricately interconnected. The following section includes a comprehensive explanation of the RBT's primary components.

2.4.1.1 Resources

Resource refers to the assets of an organisation, including its magnitude, service provision, and objectives. RBT resolves an internalised approach by emphasising internal organisational assets rather than externally motivated methodologies (Kozlenkova, Samaha, & Palmatier, 2014). RBT defines "knowledge," "business processes," "capabilities," "the firm's attributes," and "resources as assets" (Barney, 1991). The RBT also delineates "information that an institution controls in order to develop and implement strategies aimed at increasing efficiency" and "effectiveness" (Barney, 1991). Corporate resources may originate from both internal and external sources. Internal resources encompass cost-effective processes, logistics, brand administration, and research and development capabilities (Kozlenkova, Samaha, & Palmatier, 2014). Suppliers, client demand, and technological advancements comprise external resources (Utami & Alamanos, 2022).

In order to achieve long-term competitive advantage and success, the organisation must alter its orientation (Utami & Alamanos, 2022). In the past, human resource (HR) research has concentrated on the individual level of analysis (Gerhart & Feng, 2021). The success of an institution is primarily determined by the resources it possesses, which are characterised by specific and distinctive qualities, as per the RBT. The resources of an

institution are categorised into three categories: physical capital resources, human capital resources, and organisational capital resources (Barney, 1991). These categories are elaborated upon below.

- Physical capital resources include plant, raw materials, location, and technological advances.
- Human capital resources include employee intelligence, training, judgment, relationships, and insights.
- According to Fathmath, Azam, and Ahmad (2020), organisational capital resources refer to a company's formal and informal structure, including planning, management, and coordination processes.

Organisational resources also include informal links between divisions within a firm, as well as relationships between a corporation and its business environment (Utami & Alamanos, 2022). Barney (1991) and Molloy et al. (2011) distinguish between two categories of institutional resources: tangible and intangible. The two types are described below. Molly *et al.*, (2011) differentiate between tangible and intangible resources by examining the possibility of simultaneous utilisation, deterioration of use, and immateriality, which are exclusively attainable by intangible resources.

- *Tangible resources*

Jurevicius (2021) defines tangible resources as physical propositions. Land, buildings, apparatus, machinery, and capital are all considered tangible assets. All of these are tangible. The physical assets are not a significant competitive advantage for the public organisation in the long term, as they can be acquired on the open market by competing companies (Rathaermel, 2012). One can cause tangible resources to degrade. It may or may not be capable of being utilised simultaneously by multiple managers as it deteriorates, and it may be exchanged for material products or commodities (Molloy et al., 2011).

- *Intangible Resources*

Intangible Resources on the other hand consists of everything else which has no physical presence but substantially form part of the assets owned by the public organisation (Barney, 1991). Intangible or non-physical assets includes brand reputation, company culture, trademarks and also intellectual property. Brand reputation is built by an institution over a long period of time, and it is something another company cannot buy

from the market. It is often specific to an institution and gives them competitive advantage over another company. It also includes trademarks, which cannot be bought or accumulated by another firm. Intangible assets are the main assets that remain within an institution, serving as the primary source of long-term competitive advantage (Jurevicius, 2021). Intangible resources are challenging to transfer, can be used concurrently by numerous managers, and do not degrade with usage (Molloy *et al.*, 2011).

2.4.1.2 Capabilities

RBT's second significant element is capabilities. A company's capabilities are its capabilities. "A special type of resource within an institution" is the definition of capabilities by Makadok (2001). In more detail, skills are the ability of a company to combine, manage, or exploit resources in a manner that adds value and, ideally, provides it with a competitive advantage (Utami & Alamanos, 2022). Capabilities are a subset of an institutions' non-transferable company-specific resources that are designed to enhance the productivity of acquiring other resources (Utami & Alamanos, 2022). Capabilities are tangible or ethereal procedures and information that allow an institution to enhance production and efficiency (Kozlenkova, Samaha & Palmatier, 2014). The two primary features of RBV can be summarised as capabilities and resources, as indicated in the antecedent sections. In order to preserve its competitive edge, each organisation endeavors to recruit the "appropriate number of genuinely skilled personnel in the appropriate location" (Fathmath, Azam & Ahmad, 2020). Capabilities must be customised to the organisations' objectives and must continue to be pertinent to the organisation (Makadok, 2001). These factors are optimal for establishing sustainable competitive advantages.

2.4.1.3 The critical assumptions of RBV

Another critical assumption of RBV is that the resources need to be both heterogeneous and immobile (Peteraf, 2008). This is critical in ensuring the resources cannot be obtained and therefore give your competitors advantage over yourself.

- Heterogeneous

According to Gupta (2023), the main diverse assumption is that public organisations' resources and fundamental competencies must differ greatly. It would be hard for institutions to use diverse strategies to surpass one another in the market field if they all had the same quantity and mix of resources (Gupta, 2023). The RBV method firmly holds

that an institution must employ its many, individually-sourced resource bundles in order to obtain an edge over another (Barney, 1991). Over time, a company with heterogeneous resources might offer its managers diverse strategic options that leverage varying degrees of economic rent (Peteraf, 2008). Because they are limited, specialised, and appropriable, institutional resources must have that edge in order to have a competitive advantage (Amit & Schoemaker 1993). However, businesses with diverse workforces can outperform one another in a similar competitive market by employing distinct approaches (Gupta, 2023). Because of their distinct community responsiveness and the resulting variety of skills required in community-based health, CHWs play a variety of responsibilities (Cueva, Ingemann, Zaitseva *et al.*, 2021).

- Immobile

The second assumption of RBT is that resources are immobile, which means that they cannot be transferred from one organisation to another, particularly in the short term (Gupta, 2023). Immobile resources encompass all of a company's intangible assets, including intellectual property, brand equity, and other assets, as well as a portion of its tangible assets (Barney, 1991). The presumption is that immobility prevents companies from replicating the resources of their competitors and employing the same strategies within their organisation. Competing firms were unable to replicate the expertise of their resources and implement an appropriate strategy as a result of this immobility (Barney, 1991). Processes, brand equity, knowledge and skills, intellectual property, and immobility are examples of intangible resources that have been discussed (Amit & Shomaker, 1993).

2.4.1.4 Application of Resource Based View on Human Resource Management

A theoretical perspective in Strategic Human Resource Management (SHRM) is still being advocated in the literature. RBT has been implemented and adopted in a variety of company management areas, both qualitatively and quantitatively, in addition to strategic management (Gupta, 2023). By incorporating contemporary business environment advancements, including technology and innovation, the theory has been employed to examine business resource and capabilities strategy. The RBT is considered a suitable framework for emphasising performance management practices and recruiting and selection processes in order to deliver high-quality services within the country of

government (Fathmath, Azam, & Ahmad, 2020). The theory offers a critical framework for the explanation and prediction of the fundamentals of institutional performance and competitive advantage. The RBT allows managers to assess the strengths and weaknesses of their resources. In these instances, resource managers can leverage the capabilities of their primary and auxiliary workforces to successfully complete critical multifaceted projects.

One can look at integrated theoretical frameworks as a source which will help focus and organise research attempts in such a way which will enable the Human Resource practice to truly stand out in its strategic discipline (Colbert 2004). There are two fundamental declarations dominant in SHRM, firstly the main idea supports that an institutions human resource is of strategic importance. This is primarily due to the fact that the skills, behaviors, and interconnections of employees have demonstrated the potential to provide both the foundation necessary for strategy formulation and the method for strategy implementation. The second fundamental declaration is the conviction that the strategic capacity of a companys' human resources has been significantly enhanced by the companys' human resource management practices. The first declaration will be secured by establishing a more robust theoretical foundation, which will subsequently link it to the second declaration, thereby enhancing the efficacy of HRM research and the primary practices. Organisations will also be able to thrive more effectively in their specific operational contexts as a result of a more robust theoretical framework.

The Resource-Based View (RBV) of emphasising competitive advantage in the market field is inherent to the fundamental concepts of SHRM (Barney 1991). The primary proponents of RBV contend that "a sustained competitive advantage can be derived from an organisation's resource base," which in turn emphasises the "internal working capacity of an organisation" (Colbert, 2004). According to Colbert (2004) this notion "places emphasis on the role of managers involved in the selection, development and deployment of a companys' resources and not just on selecting its competitive position in the operational environment".

RBV has helped develop an integrating groundwork for the SHRM over the past decade (Write, Dunford & Snell, 2001). There are several questions one may ask when making

reference to HRM practices within an organisation which ultimately fuels the organisational effectiveness. These are, among others:

- What is the impact of HR practices on the development of an institution's human resources?
 - Which HR practices have the potential to increase organisational efficiency?
 - To what extent is this contingent upon the HR strategy?
 - How is an organisation ensuring that its HR practices are in alignment with its primary strategies?
 - How can it guarantee that the individual HR practices are in harmony with one another, or is compatibility not a requirement when evaluating HR practices?
- (Colbert, 2004)

These questions are key when considering the link between HR practices and the RBV holistic view. Organisational theory encompasses various perspectives, such as institutional theory (Wright & McMahan, 1992 in Colbert 2004:343), contingency theory by Langnick-Hall & Langnick-Hall, 1998 in Colbert 2004), configurational approaches (Doty *et al.*, 1993), and transaction cost analysis (Jones, 1984 in Colbert, 2004).

2.4.1.5 Limitations of the Resource Based View

The RBT saw its heights gaining rapid momentum and has notably matured over the decades (Kraaijenbrink *et al.*, 2010). However, the scope of practice becomes limited to implement organisational goals. It is essential to recognise the challenges and potential limitations associated with the implementation of RBT (Gupta, 2023). The limitations and criticism are discussed below.

- *Resource Based Theory lacks Managerial Implications*

The RBT is neither operationally valid nor reliable. The RBT underscores the importance of an organisations' development in a manner that is appropriate, as it encourages managers to create strategic resources that meet the VRIN criteria, which are valuable, rare, difficult to imitate, and non-substitutional. Despite the validity of the principles, the theory fails to provide a clear indication of how managers can achieve this (Conner, 2002; Priem & Butler, 2001).

- *Infinite Regress*

Priem & Butler (2001) suggests that the RBV consists of infinite regress or has the potential of moving backwards. This is because based on the theory, public organisations

who have a capability that can put in practice best, can still be overtaken by an organisation which can develop that same capability in a more efficient manner, than a company which is actually better in practice. Collins (2002) refers to this as second order capabilities. Because ultimately it is not your capability which will make you the most efficient or sustainable company when the very same capability can be better enhanced.

- *The application is limited*

There are three points of criticism when addressing the application of the theory. Firstly Conner (2002), critics that the RBT does not apply to small companies, because sustained competitive advantage makes it impossible to be based on strategic resources and therefore does not fit into the RBV (Resource Based View) criteria. Secondly, Miller (2003) contends that the perspective is that a company must establish an enduring competitive advantage; however, these resources are notoriously difficult to acquire. Miller recognises that the only firms that are capable of acquiring additional VRIN resources are those that already have a competitive advantage. Otherwise, it would be straightforward for their competitors to acquire them as well. Miller highlights the fact that the implicit dependency path of RBV in that a company is shaped by its past in order to predict its future performance. If the RBV's manner includes individual resources as well as capabilities which constituted a firm, there is no reason why this should not continue, and therefore this should also apply to newly developed firms (Conner, 2002).

- *Overemphasis on internal factors*

Another limitation of the RBV is that it primarily concentrates on the internal organisation of an institution or firm, and it appears to disregard the external factors, which may include the demand side of the business. This essentially implies that a firm may have the necessary resources and capabilities to obtain a competitive advantage, but the demand may still be low due to the model's failure to account for the most critical factor, which is the outside or external customers' need (Conner, 2002).

The Resource Based View's restricted capacity to generate credible forecasts is the final constraint to evaluate (Priem & Butler, 2001). Barney (2001) posits that the resource-based perspective can assist managers in comprehending the categories of resources that can be used to generate effective strategic advantages. It can also assist them in utilising this knowledge to assess the full spectrum of available resources within the

company and subsequently capitalise on those that have the potential to generate strategic and competitive advantages.

2.4.2 EQUITY BASED THEORY

Equity Based Theory is another theory the study is led by. The Equity Theory assumptions are based on the notion that, in addition to receive incentives for achieving acceptable outcomes, management also seeks fairness and alignment with the recognition given to colleagues in similar roles and industries (Rauf, 2007; Robbins, 2005). Thus, the yearning for fair procedures serves as the foundation of equity theory. Furthermore, the equity theory argues that individuals make effort in order to achieve and maintain a state of fairness with the aim of preserving psychological well-being (Armstrong, 2006).

When individuals are motivated, they frequently make their most excellent endeavors. "It is the perception of equity and inequity," according to equity theory. (Al-Zawahreh & Al-Mad, 2012). Equity Theory's most critical aspect is its emphasis on the input and the outcome (Al-Zawahreh & Al-Madi, 2012). Equity Theory is a social exchange theory that is highly influential, and it delineates the conditions that lead individuals to perceive a situation as inequitable (Van Dierendonck, Schaufeli & Buuunk, 2001).

In accordance with the Equity theory, an individual will assess their work relationship in comparison to that of others, as well as the rewards, investments, expenses, and profit that are associated with it. The primary premise of equity theory is that individuals frequently experience distress when they perceive their relationships as inequitable (Van Dierendonck, Schaufeli & Buunk, 2001). It is only natural for an employee to compare the input of their employment with the outcome. Consequently, employees are inclined to self-correct inequality when they perceive it. Equity theory is primarily concerned with human motivations, but it also has a broad range of applications in the comprehension of organisational behavior. The Human Resource Department (HRD) is responsible for administering tasks such as pay, promotions, and employee recognition, and equity theory is a critical factor that must be carefully considered. In other instances, equity development is influenced by training, development, and advancements (Al-Zawahreh & Al-Madi, 2012).

Equity theory is primarily concerned with an exchange relationship in which an individual provides something in exchange for something else, as per Adams (1965). What an individual provides is considered inputs. The individual who is given and the individual who receives on the other side are referred to as "outcomes." A third and equally significant variable is an individual or group. This group may consist of a few colleagues, a relative, a neighbor, or a coworker. A person in a distinct social role or occupation may comprise the third variable. The matrix in Table 2.1 below provides a more detailed list of the inputs and outcomes.

From the above description in the table of inputs and outputs, it can be noted that if an individual perceives any of the above to be an input, then it is an input and as a result, he or she naturally expects an equal return or output for it. The problem with the above scenario is when only the employee regards a specific input, but not the employer. In this particular case, the employee experiences injustice more especially when an employer may base a promotion on the level of seniority rather than promotion, the employee immediately feels a sense of injustice (Adams, 1965; Freedman & Monatanari, 1980).

Table 2.1: Inputs and Outcomes of Equity Theory

Inputs	Outputs
Inputs can include education, skills, intelligence, experience, age, training, ethnic background, social status, job effort, health, seniority, spouses' characteristics	Similarly, the outputs can include pay, rewards, bonuses, satisfying supervision, special benefits, fringe benefits, status symbols, job perquisites, uncertainty, poor working conditions, monotony

Konopaske & Werner (2001) supports Adams theory in that employees will most certainly assess their inputs and outcomes and judge the fairness by comparing them against each other. Naturally if an employee feels under or overcompensated there will be a feeling of inequity which causes tension. This particular tension will encourage employees to either reduce discord by altering their individual inputs and or outputs, change other inputs or outputs by making comparisons, or use discord to alter the inputs and/or outputs which is in comparison or leave the organisation completely (Konopaske & Werner, 2001).

In other scenarios, some employees will restrict their inputs to a level which they feel is in line with the outputs they receive. Similarly, others will verbally negotiate with their managers or supervisors for a better deal, meaning there is a struggle between work and reward. Inequity can often cause distress which can lead to one quitting the organisation. Bell argues that even though Adams's Equity Theory has been part of management literature since the 1960's, some managers still cannot strike a healthy balance and fail to effectively deal with employee's feelings of inequity (Bell, 2011).

According to Harter, Schmidt & Hayes (2002), job satisfaction is one of the most critical employee outcomes. The fostering of job satisfaction among employees which includes all age groups is one of the most challenging aspects for organisations as it directly impacts the important outcomes which are substantial which includes job performance, employee turnover, profitability, employee health and customer satisfaction which is key (Harter, Schmidt & Hayes 2002; Judge, Thoreson, Bono & Patton, 2001; Kollmann, Stöckmann, Kensbock, & Peschl, 2020).

2.4.2.1 Equity Theory on recruitment and selection

The recruitment and selection of CHWs emphasises equity-based theory, which underscores the significance of tackling social disparities and fostering workforce diversity. This approach acknowledges the fact that healthcare systems have traditionally maintained health inequalities and emphasises the importance of having a workforce that is representative of the populations it serves (Rauf, 2007). Below the researcher analyses the 7 key principles of Equity Based Theory which are imperative in the recruitment and selection of CHW:

- *Cultural Performance*

Community Health Workers (CHWs) from the same populations they serve, in order to guarantee understanding and empathy (Rauf, 2007).

- *Language Diversity*

Ensuring that Community Health Workers (CHWs) are fluent in the languages spoken by the populations they serve (Rauf, 2007).

- *Inclusive hiring strategies*

This involves actively finding and supporting candidates from underrepresented groups (Rauf, 2007).

- *Reducing systemic barriers*

Offering training and tools to tackle inherent obstacles, such as racism and sexism (Rauf, 2007).

- *Community engagement:*

Recruiting community members in the process of recruiting and selecting individuals.

- *Place emphasis towards aptitudes and potential*

Prioritize the highlighting of abilities and potential rather than formal degrees or certificates (Armstrong, 2006; Armstrong, 2010)

- *Mentoring and support*

Offering continuous training, guidance, and support to Community Health Workers (CHWs) (Armstrong, 2006).

2.4.2.2 Limitations of Equity Theory

The equity theory develops a balance between employer and employee but does not consider employee age between individuals which may make a difference in terms of employee expectations. Due to this gap on equity theory, it is important to understand job satisfaction between younger employees versus older employees, therefore equity theory needs to be broadened by an age perspective.

There is an evident shift in goals and motivation as individuals grow older (Kooij *et al*, 2001). An age factor is important to note because as people get older, there is a significant change in a number of different aspects which ultimately affects, their work outcomes (Kanfer & Ackerman, 2004). Among other factors, with age increase, individuals tend to lose intellectual abilities (Kollmann, Stöckmann, Kensbock, & Peschl, 2020), but in the same spectrum, they gain knowledge and experience (Charles, Reynolds & Gats, 2001). There is also noticed changes in personality, effect as well as emotion (Luchman, Kaplan & Dalal, 2012).

In the work environment, older individuals can be seen with more positive job attitudes and often experience fewer negative emotions, and they often describe their work environments in a more positive or favourable manner when compared to their younger counterparts (Kim & Kang, 2017). As a result to this perception, an individual's motivation, goal setting, interactions and emotion will also change with age (Kanfer & Ackerman, 2004; Rudolph, 2016). At a young age, when opportunities and time horizons are not

constrained or limited, individuals are likely to focus on longer term goals, which includes expanding their resources, getting new skills, investing in training, knowledge and experience (Cartensen, Fung & Charles, 2003).

In contrast, as one ages, and time is limited, an older individual will start making shorter term goals which are directed at maintaining their positive emotions and priorities change as they tend to consider their psychological wellbeing as being more important (Cartensen et al., 2003). Other changes which are age related include a shift in values, goals and an individual's motives (Luchman, Kaplan & Dalal, 2012). Thielgen *et al.*, 2015 suggests that employees will place different value on the outcome side (rewards) and the input side (contributions) in their work relations due to the difference in priorities determined by age.

There are several ways job satisfaction can be achieved besides reward system. Another way job satisfaction is reached is when individuals give something back to their organisations. The feeling one receives from making meaningful contributions at work by performing well and going above and beyond the line of duty, as in how the CHW's do even when remuneration is not high. But that feeling of giving back to their community is rewarding on its own, which ultimately leads to job satisfaction and general well-being of the individual (Arnold, Turner, Barling, Kelloway & McKee, 2007; Judge et al., 2001).

When ones contribution is regarded as significant to an organisation, it is fulfilling, and makes one to feel that their work input is being acknowledged and competence is demonstrated (Van den Broeck, Vansteenkiste, Witte, Soenens & Lens, 2010). Similarly, if an employee feels that his or her work input does not make a significant contribution or is not recognised or acknowledged can lead to feelings of isolation and rejection (Shuck, Reio Jr & Rocco, 2011). As mentioned above, job satisfaction can and is mostly determined by age. This is because theoretically the positive experience which surrounds task contributions are critical in the satisfaction of older employees more than the younger ones, mainly for two reasons:

Firstly, when considering the socioemotional selectivity theory, it is evident that older individuals are likely to be more aware of their own fatality. And consequently, older

employees or individuals tend to prioritize making meaningful contributions to their environment at large, which they hope can outlive them. In other words, they wish to leave a legacy for future generations, which already gives them a sense of satisfaction to some degree (Grant & Wade-Benzoni, 2009). Their main desire is to provide guidance to the next generation, so their motives are often different in that sense (Grant & Wade-Benzoni, 2009). Older individuals are inspired or motivated by taking the opportunity to transfer their knowledge and skills to the younger generations (Arnold & Clark, 2015). Kooij et al., 2011 further supports this sentiment in that for older workers, accomplishment and having some kind of achievement is more important. In older workers a stronger demonstration of career identity and job engagement is evident (Kim & Kang, 2017).

Secondly, older workers are affected by task contributions as they consider the role of employers portraying stereotyping against them. The negative stereotype for older employees is often the idea that they are very warmly but can lack competence and therefore deliver poor job performance, this is demonstrated by a study across the different cultures (Cuddy, Noron & Fiske, 2005; Cuddy & Fiske, 2002). A negative stereotype keeps coming up that poor job performance and lower competence is found among older employees. This persists even though studies (including a study by Ng & Feldman, 2008, which have shown that age is not related to job performance. As a result, we can conclude that older employees who make significant contribution to an organisation are generally more satisfied, as the successes they feel generally overcomes the negative stereotype which is held by the demographic group (Von Hippel, Kalokerinos & Henry, 2013; Guillen & Kunze, 2019). Therefore, older employees are satisfied in their job based on their task contributions, in other words their input which is invested into their work relationships. For older employees, the output is not monetary, but a feeling of personal fulfilment outweighs monetary value they may receive.

2.4.3 HUMAN CAPITAL THEORY

Perera & Weerakkody (2018) define Human Capital (HC) as the measurable value that an individual brings, encompassing their knowledge, skills, and credentials acquired via education, training, and experience. It is crucial to emphasise that an individual's capabilities might be either innate or acquired (Hossain & Roy, 2016). Human capital is the collective term for the knowledge, skills, and expertise that an individual acquires via

education and training (Armstrong 2010; Odhong *et al.*, 2014). Human capital refers to the collective skills, knowledge, and abilities possessed by the workforce. The tangible aspect of an institutions' human capital is only significant during the recruitment and selection phases of human resource practices. In the future, attention will be directed towards the flexible qualities of human resources, which are demonstrated by their expertise, awareness, and competence in order to fulfil any function necessary for achieving institutional goals (Wright & McMahon, 1992).

Figure 2.1: Human Capital Strategy



Source: <http://www.trinet.com/insights/human-capital-strategy>

The core principle of human capital theories is that people's learning capacities are linked to the resources used in the creation of goods and services rendered. In other words when the resources are used effectively, the results are beneficial for the individual, the organisation as well as the society at large (Armstrong, 2010). Based on the preceding assumptions, one may conclude that HCT improves the base of education and training by increasing human capital, which also leads to a higher productivity rate, which in turn brings more financial freedom to an individual because of the higher pay they receive (Garibaldi, 2006; OECD, 2001). A question one may ask when deliberating the HCT is “why do some people acquire more education and skills than others”. We suppose that individuals select the degree of human capital that represents or maximises the present value of lifetime utility or the desire for happiness. Based on the HCT, we can conclude that education is generally beneficial for economic growth and development. However, the question remains whether this also affects the balance in other areas. Babalola (2009)

suggests that a shortage of educated or skilled individuals may limit the optimal growth, while on the opposite spectrum, excess supply of it could lead to higher unemployment which could still limit economic growth and development (Babalola, 2009).

Aliaga (2001) supports the view by describing Human Capital Theory as seeking to explain the gains of education and training offered as some type of investment for human resource. People are assets to institutions and can be seen as capital for development (Hendricks, 2002; Aliaga, 2001; Engelbrecht, 2003). This perspective can prove the importance of investment done through education and schooling as a means to prepare individuals for labour force, increase in productivity for individuals and organisations. As a result, this encourages development and growth on both local and international level (Hendricks, 2002).

2.4.4 HUMAN CAPITAL THEORY ON RECRUITMENT OF CHW's

The application of human capital theory is particularly pertinent to the recruiting and selection process for Community Health Workers (CHWs). This is because according to human capital theory, the skills, knowledge, and abilities possessed by individuals (referred to as their human capital) are important assets that enhance their productivity and effectiveness in their respective professions (Rowe, Kelly, Olewe, Kleinbaum, McGowan, McFarland, Rochar & Deming, 2007). When it comes to Community Health Workers (CHWs), the recruiting and selection process should prioritise identifying applicants who possess the necessary human capital to succeed in the role. Human capital theory can provide valuable insights for optimising the recruiting and selection process of Community Health Workers (CHWs).

Human capital theory highlights the significance of skills and knowledge in improving productivity. When selecting Community Health Workers (CHWs), organisations should ascertain the precise skills and expertise necessary for successful implementation of community health initiatives. These talents may encompass effective communication, cultural proficiency, fundamental medical expertise, empathy, analytical thinking, and comprehension of community dynamics (Armstrong, 2010).

2.4.4.1 Training and Development

According to human capital theory, investment in training and development can strengthen individuals' human capital, resulting in an increase in productivity (Hollenbeck & Jamieson 2015). Organisations should evaluate candidates' capacity for advancement and improvement during the recruitment process for Community Health Workers (CHWs). It is imperative that they offer comprehensive training programs to augment the abilities and knowledge of CHWs, guaranteeing their ability to properly carry out their responsibilities (Mwangi & Oluoch, 2022; Hollenbeck & Jamieson, 2015).

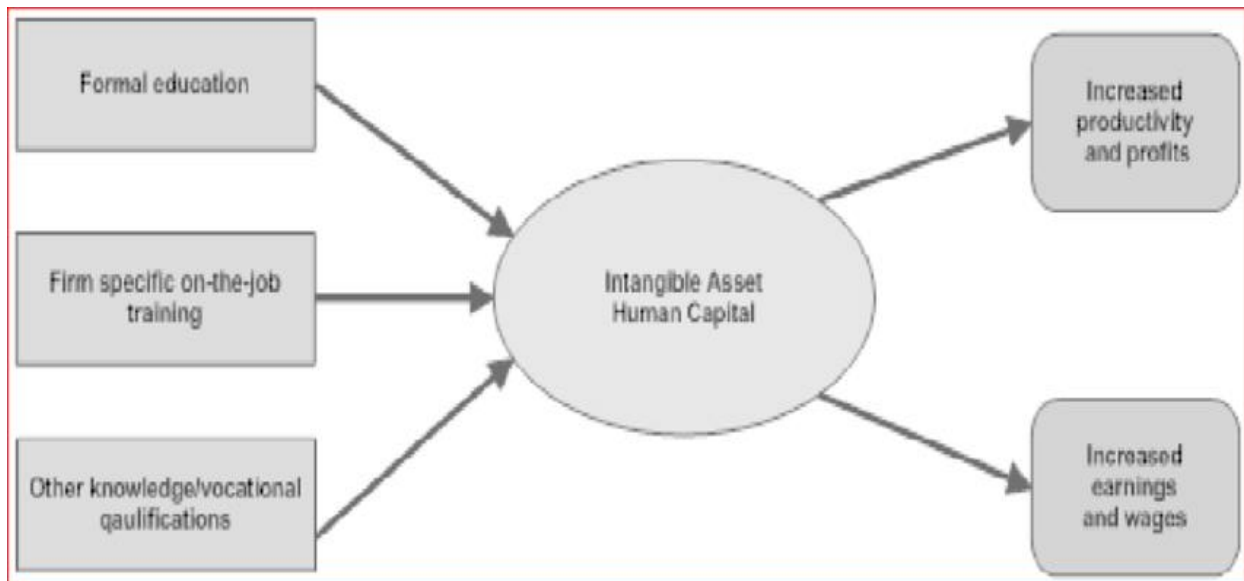
2.4.4.1.2 Performance evaluation

Performance evaluation is crucial in measuring the productivity and effectiveness of individuals, as emphasised by human capital theory. Organisations should utilise stringent evaluation criteria during the recruiting and selection process for Community Health Workers (CHWs) to accurately gauge candidates' potential contributions. Assessing candidates' skills, knowledge, and past experiences may involve many methods such as interviews, simulations, role-playing exercises, and reference checks (Armstrong, 2010).

2.4.4.1.3 Retention methods

According to human capital theory, firms should adopt methods to retain skilled personnel and optimise their human capital. When it comes to Community Health Workers (CHWs), the recruiting and selection procedures should be crafted with the aim of not just identifying suitable applicants, but also attracting individuals who are dedicated to long-term involvement in community health work (Odhong *et al*, 2014). Organisations may enhance the retention of experienced CHWs and optimise their long-term contributions by using retention tactics such as offering competitive salary, providing opportunities for career growth, fostering supportive work cultures, and acknowledging their successes (Hoissan, & Roy 2016; Odhong *et al.*, 2014). By incorporating human capital theory into the recruitment and selection process for Community Health Workers (CHWs), organisations can identify, attract, and retain individuals who possess the necessary skills, knowledge, and abilities to effectively serve their communities and enhance health outcomes.

Figure 2.2: Intangible Asset Human Capital



Source: Hilorme 2016

2.4.4.2 Criticism of Human Capital Theory

The theory of HCT depicts the truth in that education will increase knowledge, develop skills, adaptability and mobility of individuals, which in an ideal setting will reduce the level of unemployment (Coffield, 2000). The belief is that HCT will ultimately contribute to the well-being of individuals, the organisation and the society at large. One can critically argue however that the main objective of an economy driven education policies aims to put the burden on people and expects them to self-cater for themselves (Coffield, 2000). Field 2000 criticises this discipline as he depicts that the main objective of HCT reduces the governments' financial burden as individuals are the ones who receive the pressure of making it by themselves which does not correlate with the 'welfare state policy goals'. The neoliberal perspective recognises individuals as economic drivers and objective changers, with an emphasis on empowering citizens to contribute to production rather than relying on the social welfare state (Slaughter & Rhodes, 2004:114). In that regard, the neoliberal approach allots resources from social welfare functions to production functions (Slaughter & Rhodes, 2004:114).

The most efficient way production functions can increase labour productivity is through education. This is the answer which most human capital theorists perceive as acceptable, and it is also well accepted by policy makers. Blair suggested while making a speech in reference to unemployment and the needs of the 21st century. He can be quoted as saying

“so today I set a target of 50% of young adults going into higher education in the next century” (Blair, 1999). This target was, however, not met by the specified timeframe of 2010 (Groot & van den Brink, 2000:88). One thing that is evident, however, it that there is now a considerable number of university graduates who are over educated or overqualified, yet unemployed or working in low paying jobs that are not within their field of qualification (Groot & van den Brink, 2000:88).

Academic degrees have not produced the expected economic effects or outputs, resulting in a situation where overeducated but often inadequately skilled or overqualified but underutilised persons can scarcely find a job comparable to their training or talents. The set target of 50% has played a negative role in that it “has driven down standards and has also devalued the currency of a degree and damaged the quality of the university experience”. According to a report on BBC 2010 by the Association of Graduate Recruiters, as a result of the oversupply of educated workers, there has been a significant increase in the number of graduates taking non-graduate positions (White, 2023; Walker & Zhu, 2005:150).

According to a study conducted by McGuinness in 2006, the issue of over education is still widespread in several nations worldwide, including the United States of America, the United Kingdom, Germany, Spain, Holland, Hong Kong, South Africa, and various African countries (Battu *et al.*, 2000:85). Despite the present circumstances, economists from HCT maintain that educational accomplishments may not yield immediate desired results. However, over time, there will be a convergence between academic qualifications and projected wages (Battu *et al.*, 2000:85). According to the Human Capital Theorist, excessive education is considered a transient issue that would eventually result in long-term benefits. Empirical investigations do not support this sentiment. Battu *et al* (2000:85) investigated whether overeducation may be regarded as a transitional occurrence. Their findings indicate that overeducated graduates do not have a guaranteed ability to improve their situation in the long term.

On the contrary, “over education can have negative outcomes as several studies found that overeducated employees and their productivity skills or academic knowledge being unused affects the output in a negative manner” (Battu *et al.*, 2000). This is because often

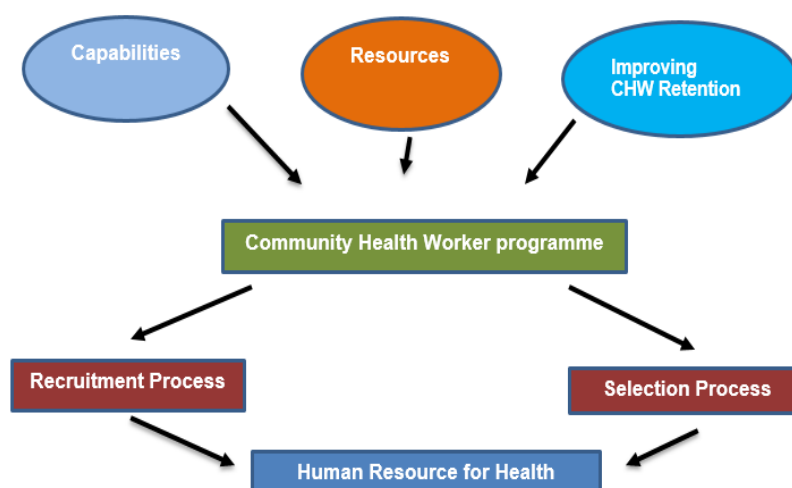
they can find themselves not being stimulated enough in their non-graduate works which may lead them to quit their jobs due to dissatisfaction and non-fulfilment (Quintini, 2011 & Verhofstadt *et al.*, 2007). Therefore, government should view over education as a matter of concern not only for individuals and the organisation because it effects the effective allocation of public money. Despite the several explanations provided above, it is puzzling that the Human Capital strategy remains popular among bureaucrats and politicians, given it has not consistently produced the expected results as anticipated by the theory (Tan, 2014).

Education is highly esteemed because it is anticipated to provide various functions (Tan, 2014). It is perceived as a tool that has the potential to bring about significant change to both individuals and society (Coffield, 1999; Tan, 2014). Education is often perceived as a pathway to fostering innovation, which in turn enhances economic competitiveness and facilitates the development of a knowledge-based economy (Tan, 2014). Education is highly esteemed due to its potential as a social strategy to mitigate social marginalisation among individuals. This is because it is anticipated to enable individuals to enhance their flexibility and adaptability to the constantly evolving and advancing demands of the professional sphere (Coffied, 1999; Tan, 2014).

2.5 CONCEPTUAL FRAMEWORK

This section provides the research context analysis for the conceptual framework of this study. The conceptual framework for this study is presented below. Chapter one provided a brief background for the study, while this chapter defined the concepts relating to this study and the theories for recruitment and selection. From the theories assessed, the researcher came up with the area of concern to achieve the research goals. This study is contextualised within Human resources management. In this regard the study context fits to be analysed within human resource for health to determine how the CHW are recruited and selected. The remaining part of the document is divided around the following headings: the context for community health worker program (in Chapter 3); and the recruitment and selection processes for community health worker program (in Chapter 3). Recruitment and selection are the “indispensable functions of human resource management” (Karim, Bhuiyan, Nath & Latif, 2021).

Figure 2.3: Conceptual framework for the recruitment and selection of CHW



Source: Researchers illustration

Chapter 4 will address the following specific areas to consider for recruiting needs for the CHW programme inspired from the work of Jaskiewicz and Deussom (2013), this includes CHW i) selection criteria, ii) CHW recruitment procedures, iii) resources at disposal influencing CHW recruitment and iv) CHW retention (USAID,2018). These areas pertain to the recruitment and selection of the CHW as the reviewed literature indicates that the appointment of CHW is different to normal recruitment process. Recruitment and selection can significantly impact an organisation's efficacy and performance. When examining the components of the RBT, it is critical to analyse the relationship between recruitment and selection processes and organisational success (Utami & Alamanos, 2022).

2.6 CHAPTER SUMMARY

All three theories discussed above have both a direct and an indirect impact on the field of Community Health Workers. Human Capital underscores the need of investing in education at present, as it will provide benefits in the future. A major critique of HCT is that it has encroached upon various fields and sought to assert dominance over them based on economic imperialism (Tan, 2014). Another significant worry is that it prioritises education based on the requirements of the business world and views education as a means of survival to navigate economic difficulties. This assertion is subject to scrutiny because to the fact that the HCT has generated a perception that education possesses

the ability to independently resolve economic and social issues, a notion that, according to research, fails to materialise as anticipated. This leaves one to question what the role of HCT is, does it create an unrealistic illusion? We recall that the basic assumption of HCT is that education is good and opens better economic doors. However, the real question one can be asked is not whether education or training is good, but whether more education is always better (Wolf, 2002). Does the basis of human capital in supporting and encouraging education and training reap the prescribed benefits of what it stands for? Or is it just a far-fetched theory which displays good intentions but due to current economic and social standing, fails to reach its consensus.

Another significant theory discussed is known as the Equity Based Theory. The most important element of Equity Theory is that it mainly focuses on two sides, which is namely the input and the outcome. Equity Theory is one of the most influential exchange theories socially, and it outlines the conditions which make individuals perceive a situation as being inequitable. Community Health Workers are support staff who have specific roles within their own community which need to be administered to generally increase the goals and objectives towards Primary Health Care. More often their roles may be overlooked as they do not have formal education or training. Based on Equity Theory, a CHW may develop the feeling that their input is not equivalent to the output, it may be in monetary value or other types of rewards, but inequity develops. As a result, inequity causes demotivation and lack of interest amongst individuals. Research suggests that recruitment of CHW's is on the increase due to the high levels of human resource health shortages, more specifically to the low and middle-income countries. The need for CHW's cannot be expressed enough. Although with successful recruitment and selection in place, there is still a great gap which exists for an environment which motivates growth and development with the aim of pursuing retention of the CHW's both on local and national level. The next chapter presents the context for community health workers programme and will highlight the background on the National as well as the District level and will further go into greater detail of the existing guidelines of the CHW' programme.

CHAPTER: THREE

THE CONTEXT FOR COMMUNITY HEALTH WORKERS PROGRAMME

3.1 INTRODUCTION

This chapter provides a context of Community Health Worker Programmes. These programmes serve as a guideline on how CHW's are developed, monitored and evaluated. The chapter will discuss the development, implementation, and challenges of previous CHW's programmes. Folz & Ali (2018) highlight the necessity for further investigation into enhancing Community Health Worker (CHW) programmes to optimise their performance. The chapter will examine the potential areas of deficiency that may hinder their ability to achieve success and sustainability in order to fulfill the objectives of Primary Health Care (PHC). The researcher will observe international methodologies employed in programme management and engage in discussions regarding national initiatives, as well as those at the local level. It is crucial to implement steps to ensure the efficient operation, assessment, and supervision of it.

This chapter provides a concise overview of the particular difficulties encountered by CHW programmes.

3.2 BACKGROUND OF COMMUNITY HEALTH WORKERS PROGRAMME

After the Alma-Ata declaration, there has been a push to implement community health worker (CHW) programmes in low- and middle-income countries (LMICs) in order to enhance comprehensive health activities at the community level (Agarwal, Sripad, Johnson *et al.*, 2019). The use of CHWs has varied since various governments authorised their deployment in the 1960s to enhance healthcare access and improve community health for marginalised populations (Nemcek & Sabatier, 2003). The Alma Ata Declaration of 1978, and its underlying vision, highlighted the importance of involving communities in healthcare and stimulated the expansion of Community Health Worker (CHW) programmes.

Several countries have made major commitments to establish CHW programmes (Perry, 2020). Brown, Celia, Lilford *et al.*, (2019) indicated that the CHW programs are also “growing in size”, CHW programmes are also “increasing the number of CHWs and the proportion of the population with access to a CHW as part of the push for universal health

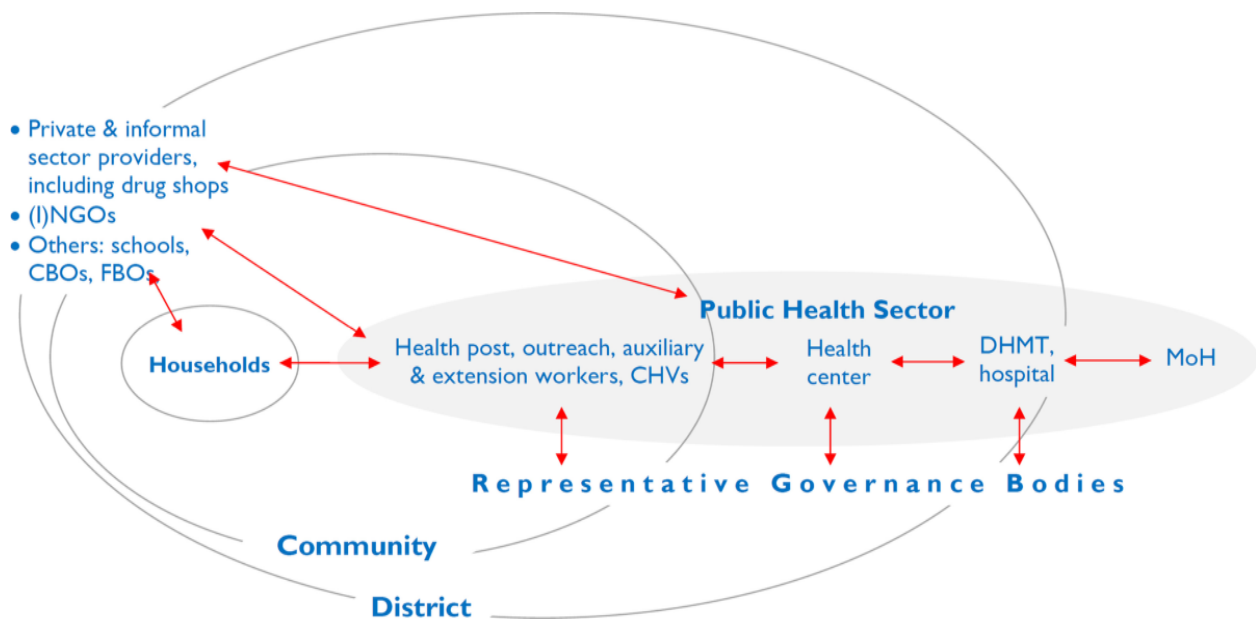
care” (Brown, Celia, Lilford *et al.*, 2019). China and Central America launched the first national programs (Perry, 2020). CHW programmes in China dates to 1930s, while in Central America began in the 1960s (Bari, Sadruddin, Khan *et al.*, 2011). Certain programs are established at the neighborhood level, while others are implemented through collaboration with governmental, private, and non-profit organisations. The Rockefeller Foundation and the Peking Medical College were notable institutions in Ding Xian, China (Bari, Sadruddin, Khan *et al.*, 2011). These changes may be seen dating back to the beginning decade of the century (2000-2009) in “Afghanistan, Ethiopia, India (the Accredited Social Health Activist, or ASHA, program), Kenya, Niger, and Uganda” (Perry, 2020). Perry (2020) mentioned that some initiatives were implemented in “Madagascar, Myanmar, Liberia, Sierra Leone, South Africa, Tanzania, and Zambia” during the second decade.

3.3 CHW PROGRAMME SUB-SYSTEMS AND THEIR INTERACTIONS

Hodgins, Kok, Musoke *et al.*, (2021) indicated that the CHW is “one of many actors in a complex, dynamic primary healthcare system, each with their own agency, interests, views, and values”. According to Schneider and Lehmann (2016), “community health systems” encompass both official and informal entities, including community-based organisations, government actors, and service providers (Hodgins, Kok, Musoke *et al.*, 2021). These players “operate within distinct circumstances molded by local histories”, “economic and political systems, and social norms” (Hodgins, Kok, Musoke *et al.*, 2021; Schneider and Lehmann, 2016). At the site, the community became an active participant in the new healthcare delivery model (Shahidi, Sickora, Clancy, and Nagurka, 2015). The relationship of the respective actors is presented in Figure 3.1 below.

The actors' relationships are shown in red. When taken as a whole, these “components and their interactions can be understood as making up a distinct sub-circuit of the sizeable health system”, which others have named the community health system (Schneider & Lehmann, 2016; Shahidi *et al.*, 2015). In addition to their various responsibilities, these people serve as intermediaries for health promotion in the settings in which they offer medical care (Shakerian & Gharanjik, 2023). The next part provides an explanation of the stakeholders in brief.

Fig. 3.1 Elements and relationships in the work of the peripheral health system



Source: Hodgins, Kok, Musoke *et al.*, 2021

3.3.1 National and Provincial Level

National policy provides the strategic direction for putting health policies into action. Furthermore, the federal level works with provincial health departments to monitor and evaluate the implementation of the WBPHCOT policy framework and strategy (Department of Health, South Africa, 2018:19). The delivery of health care services is carried out at the municipal and provincial levels. Provincial health departments must have specialised human resources tasked with ensuring the formation and operation of WBPHCOTs within the districts in order to realise the health provision (Department of Health, South Africa, 2018:19). Gray, Govender Gengiah, & Singh (2005) state that a CHW Program Director or Manager oversees the management of the provincial program in each province. In order to guarantee that all "programme priorities are included in the CHW program," the CHW Program Director or Manager also performs "an administrator role to control the budget and liaising with other vertical program managers (e.g., HIV, TB, and nutrition)" (Gray, Govender Gengiah, Singh, 2005; Department of Health, South Africa, 2018:19). Given the intricacy of community health systems as previously mentioned, the Provincial CHW Program Manager ought to be in charge of overseeing cross-sectoral cooperation with other departments, local governments, the commercial sector, and other stakeholders at the provincial level (Gray, Govender Gengiah, Singh, 2005; Friedman, 2005:184).

3.3.2 District Health Level

The District Health System (DHS) incorporates the main healthcare system (Vawda and Gray, 2018). In South Africa, there are "fifty-two health districts" (Vawda and Gray, 2018), and the boundaries of each district match those of the municipalities. All citizens are given access to a comprehensive range of services by each health district (Department of Health, South Africa, 2018:9). According to Gray et al. (2005) and Friedman (2005:184), "the District Health Manager (DHM) or a CHW Program Coordinator oversees the direct line management of CHW programmes at the district level." The availability of funding for the necessary equipment, human resources, and process implementation is a responsibility of district health management (Department of Health, South Africa, 2018:19). Overseeing the district's CHW program should fall within the purview of the District Health Manager (Friedman, 2005:184). Each district must:

- Develop a comprehensive strategy and implementation plan for the Community Health Worker (CHW) policy framework.
- Ensure that the district health plans include the policy framework and implementation plan for Community Health Workers (CHWs).
- Ensure that the distribution of WBPHCOTs is equitable among the district's catchment population.
- Enhance the existing referral, transportation, and communication networks.
- Supervise the implementation of the CHW strategy and policy framework and provide quarterly reports to the provincial level (South African Department of Health, 2018:19).

Another important actor at the district level, is the Community Health Forum (CHF) who are employees within the district health establishment. CHFs plays an important role in providing "technical support and detailed oversight of various groups of CHWs" (Gray, et al., 2005). The CHFs is accountable to the DHM. The CHFs office is required to "support, quality assure and supervise generic CHWs" (Gray *et al.*, 2005; Friedman, 2005:184).

3.3.3 PHC Facility Level

Enhancing primary healthcare (PHC) is vital for attaining these objectives, and in order to accomplish this, well-funded community health workers (CHWs) are essential (Hodgins, Kok, Musoke *et al.*, 2021). To improve the delivery of primary healthcare services to

vulnerable people, efforts are being made to revive community health worker (CHW) programs (Malatji, Griffiths & Goudge, 2024). The programme's governance should be overseen by local Community Health Centers (CHCs) or equivalent local participation organisations, such as local Community-Based Organisations (CBOs) (UNAIDS, 2017; Gray, et al., 2005). This is for “ensuring that local priorities and needs are addressed by the programme” (Gray *et al.*, 2005; Friedman, 2005:184). The role of the outreach is essential in this level. The OTL must:

- Make sure that the statistical data generated by the activities of WBPHCOTs is incorporated into provision statistics and released on a monthly basis at the district, provincial, and national levels, in line with the District Health Information Systems Policy.
- Arrange for the distribution of WBPHCOTs to houses in the catchment population in coordination with the PHC facility manager.
- Encourage community dialogues to get input on the WBPHCOTs' work and to rally support for and collaboration with the organization (Department of Health, South Africa, 2018:19).

The Community Advisory Board (CAB) functions at a local level. As stated by Shahidi et al. (2015), the nurse-managed health center, also known as the "health house," caters to the three housing projects that were established. The CAB was established as an autonomous organisation (Shahidi, et al., 2015). The community, having gained authority, enthusiastically engaged in the implementation of the new healthcare delivery model in the specified location (Shahidi, Sickora, Clancy, and Nagurka, 2015).

3.3.4 Small-scale and large-scale CHW programmes

There are numerous CHW programs that vary in their characteristics and approaches (Hodgins, Crigler and Perry, 2013:7). The health care system is implemented through both small-scale and large-scale Community Health Worker (CHW) programs. The inception of small-scale Community Health Worker (CHW) programs may be traced back to the 1960s and 1970s, when they began to emerge in several nations (Perry, 2020). Based on (Perry, 2020) “small scale programmes were regarded as highly influential”, “as they were either associated with academic institutions or non-governmental organisations (NGOs)” (Perry, Crigler, & Hodgins, 2013) and “provided the impetus for significant

international community health projects” (Perry, 2020). The recognition of the efficacy of Community Health Worker (CHW) programs in improving population-level health has increased among decision-makers at both national and international levels. This is why these localised experiences hold significant value (Perry, Crigler, and Hodgins, 2013). NGOs generally undertake CHW initiatives with a disproportionate amount of involvement and with different CHW roles, responsibilities, and timetables in nations without centralised coordination (Agarwal, Sripad, and Johnson, et al., 2019: 3). In the 1980s, several low-income nations developed substantially larger CHW programs as a result of these and other experiences (Perry, 2020). According to Hodgins, Crigler, & Perry (2013), the “majority of these initiatives have close ties to the public health services that are provided in the periphery, such as those that are managed and assisted by health centers or health posts.”

3.4 CHW PROGRAMMES COMPONENT

There is an increased focus on strategies for maximising and expanding the reach of these programmes (Tangcharaoensathien, Limwatthananon, Suphanchaimat *et al.*, 2013). Perry, Crigler & Hodgins (2013) suggest that there are multiple tactics or approaches that can be employed to guarantee the sufficient provision of services to a population. The primary emphasis of CHW programme strategies is on the Sustainable Development Goals (SDGs) and the objective of attaining Universal Health Coverage (UHC) by 2030 (Tangcharaoensathien, Limwatthananon, Suphanchaimat *et al.*, 2013). These tactics are made up of several actions that are subsequently converted into a number of procedures that enable an organisation to make greater use of its input. Such activities and practices require a clear identification to guide decision-making and policy implementation. Each programme consists of components that are scaled to priority levels to produce desired outcomes. In terms of priority, some component elements are core as they define the effectiveness of a programme.

Nemcek & Sebatier (2003) presented a review of community health worker evaluation, in which they “argued that programme goals are often based on increasing service utilisation”. This is by “means of reducing health risks and establishing therapeutic alliances between lay” and “professional actors. In their review they listed programme components as well as the duties of CHWs” (Nemcek and Sebatier, 2003). According to

Nemcek & Sabatier (2003), there are eight components that make up the CHW program: home visits, health education/ counselling, advocacy, public relations, culturally sensitive care, prenatal care, health promotion/ lifestyle modification, and transportation/homemaking. The respective components are presented in Table 3.1 below. The details presented in Table 3.1 below, also list the functions of the CHW. Systems are dynamic, self-organising, nonlinear, and interconnected by nature (Hodgins, Crigler & Perry, 2013:2). The initial shared element of the programme is outreach. Nemcek & Sebatier (2003) state that the purpose of outreach activities is to increase communication with marginalised populations.

TABLE 3.1 Programme Component Descriptions with Community Health Workers' Duties

Programme Component	Description	Community Health Workers Duty (Examples)
Outreach	Engaging individuals and collectives that are not often reached or surpassed in terms of outreach.	-Identify and locate cases -Perform health screening -Coordinate appointments -Conduct follow-up calls -Issue reminder cards -Please consult as necessary. -Mobile units operated by the staff -Engage in networking activities with fellow community members
Culturally sensitive care	Utilise one's understanding of the language, cultural practices, beliefs, and other relevant factors to develop a suitable care plan and enhance the therapy relationship.	-Translate different languages -- - Connect colleagues and professional events -Create or choose health products that are tailored to a given culture in order to establish them among peers.

		-Begin new services/programs Train health professionals on culture
Health education/ counselling	Facilitate the acquisition of knowledge and foster the development of analytical thinking to empower individuals in making informed health decisions and providing guidance, suggestions, and recommendations.	-Educate/counsel: groups or one-on-one -Mass media campaigns -Develop and distribute resource guide
Health Advocacy	Promote and encourage positive health behaviours among peers.	Role model Mentor Crisis Intervention Lobby
Home visit	Meet peers in their homes, thus reducing barriers to access.	Sojourn evaluates home environment social support
Health promotion/ lifestyle change	Employ behaviour change strategies in group or individual meetings.	Leader Coach
Prenatal care	Support prenatal health of mother and child during prenatal, delivery, and postpartum period.	Outreach/early prenatal care Nutrition Parenting and childcare
Transportation/ homemaking	Provide health-related transportation for home chores.	Drive/arrange for travel Cleaning/food preparation

Source: Nemcek & Sabatier, 2003

The outreach team leader (OTL) at the medical institution has the responsibility of supervising the day-to-day activities of the WBPHCOT and ensuring that they have the

required equipment, uniform, and logistical support (Department of Health, South Africa, 2018:19). It is essential to follow ethical standards when conducting outreach programs to ensure that culturally appropriate care is provided. Healthcare experts argue that a successful intervention necessitates the consideration of cultural competency, the improvement of health literacy, and the possession of skills to connect, understand, educate, and involve patients (Keller & Carroll, 1994). These endeavors seek to educate populations about the current condition of health. The COVID-19 pandemic originated globally in 2020, whereas a cholera outbreak was identified in Hamanskraal, Pretoria in 2023. During these disease outbreaks, the Community Health Workers (CHWs) will conduct case investigations to ascertain the root causes of the reported health issues. Through the implementation of this strategy, the community develops a heightened awareness and attentiveness towards underlying health issues, resulting in a more health-conscious mindset.

According to Nemcek & Sabatier (2003), another duty of CHWs is to offer instruction and guidance in cultural matters and language interpretation. CHWs must have a comprehensive awareness of the cultural diversity within the community they serve, as they deal with a wide range of individuals. CHWs' share cultural knowledge with all individuals involved in the alliance, such as patients, family members, and healthcare practitioners (Nemcek & Sabatier, 2003).

Health education and counselling are essential components of all program elements. Health education can be delivered through formal or informal methods. Regarding maternal mortality, Community Health Workers (CHWs) can do diverse tasks, including instructing moms, physically accompanying them on lengthy journeys to birthing centers, and administering emergency drugs such as misoprostol and gentamycin during home deliveries (Palazuelos, 2013). Home visiting is a program designed to overcome barriers that hinder individuals from utilising services (Nemcek & Sebatier, 2003). These workshops are advantageous for persons across all age demographics. From a geographical standpoint, certain sections within the country contain remote villages that are geographically detached from cities and other villages, whereas in other regions, cities and villages are interconnected. Consequently, individuals residing in various regions of the nation may have varying degrees of accessibility to amenities (Shakerian

& Gharanjik, 2023). This is due to the fact that a health service has a global influence on every individual. Specific members of the community have a lack of availability to public establishments, namely in the field of healthcare. Some individuals travel a significant distance to reach the medical facility. While some regions may have restricted transportation choices, the majority of transportation services adhere to a predetermined timetable. Home visits performed by Community Health Workers (CHWs) are seen as an essential component of initiatives designed to address barriers to contacting healthcare professionals (Nemcek & Sabatier, 2003).

Kumar & Preetha (2012) highlighted that health is profoundly influenced by factors that extend outside the boundaries of the health sector, encompassing social, economic, and political impacts. A Community Health Worker (CHW) is responsible for promoting health. Health promotion is extremely relevant in the contemporary day (Kumar & Preetha, 2012). The World Health Organisation (2024) delineates three key strategies for health promotion: "enabling," "mediating," and "advocating." Community Health Workers (CHWs) are strategically positioned to enhance patient education and promote individual responsibility for healthcare (Callaghan, Washburn, Schmit, 2019). This duty can be fulfilled either directly or indirectly (Nemcek & Sabatier, 2003). The approach also utilises a strategy focused on settings to promote health in specific locations such as schools, hospitals, workplaces, residential communities, and through social media (Kumar & Preetha, 2012). Literacy is often essential (Palazuelos, 2016). Social media, by means of extensive mass media campaigns employing radio, television, and newspapers, have made a substantial contribution to educating the community about health difficulties and their underlying determinants (Nemcek & Sabatier, 2003). Nemcek & Sabatier (2003) contend that providing education to community members regarding "prevention," "early diagnosis," and "treatment" results in a decrease in risks. The three objectives are mutually reliant for best performance. Program architects must consistently stay in close proximity to and actively connect with the populations they are helping (Palazuelos, 2016).

3.5 THREE INTERRELATED CHWS GOALS

The need to meet the SDGs—especially 4 and 5 on reducing child and maternal mortality—and the mounting body of research on the potential benefits of CHW programs

to population health have spurred a resurgence of interest in CHW programs (Hodgins, Crigler & Perry, 2013:6). Global CHW programs have developed from grassroots initiatives run by various organisations, such as faith-based groups, public health services, and local and international NGOs (Walker, Downey, Crigler, LeBan, 2013:3). The goals of various CHW programs vary, and they work in a variety of environments (Hodgins, Crigler, and Perry, 2013:5). Agarwal, Sripad, Johnson, et al. (2019: 7) state that Community Health Worker (CHW) programs can focus on a range of health interventions that are suitable for the specific environment, as well as assessing the impact of the program on health outcomes. Community Health Workers (CHWs) address the specific requirements of the community. The programmes utilise Community Health Workers (CHWs) to promote three interconnected objectives: "therapeutic alliance," "health care utilisation," and "risk reduction" (Nemcek & Sabatier, 2003). The Community Health Worker (CHW) operates within the framework of a programme, a community, and a healthcare system (Hodgins, Crigler, and Perry, 2013:2). Moreover, these programs have an impact on health indicators and adhere to standardised coverage that is mandated at the national or international level (Agarwal, Sripad, Johnson *et al.*, 2019: 7).

The primary objective of utilising a CHW is to actively involve patients in order to establish a connection between the general public and essential services (Callaghan, Washburn, Schmit, 2019). The therapeutic relationship involves frequent presence, on-site visits, and regular talks with local leaders and program recipients (Palazuelos, 2016). An effective therapeutic alliance between a patient and provider enhances access to healthcare by promoting appointment attendance and adherence to preventive measures or treatment plans (Nemcek & Sabatier, 2003). Nemcek & Sabatier (2003) refer to the second objective as the desire to enhance the appropriate utilisation of healthcare services. The purpose of these objectives is to offer clients with necessary materials. The health industry requires resources such as job aids, tools, medications, and supplies to effectively deliver services and ensure the provision of excellent care (Kok, Dieleman, Taegtmeyer *et al.*, 2015). Establishing a strong level of engagement in their client's ability to obtain services necessitates the development of trust in order to facilitate efficient information sharing between CHWs and their clients (Callaghan, Washburn & Schmit, 2019). The third objective is to mitigate the health hazards faced by patients, as CHW programmes mostly concentrate on specific diseases (Nemcek & Sabatier, 2003).

Ensuring the reduction of health hazards in health care delivery allows Community Health Workers (CHWs) to enhance preventive, promotive, and curative services. The primary objective of the third goal is to reduce expenses in the healthcare industry and ensure that patients have the opportunity to receive medical care.

Multiple factors contribute to the success of Community Health Worker (CHW) programs (Agarwal, Sripad, Johnson, et al., 2019: 7). According to the 'United Nations' High-level Meeting on Universal Health Coverage, a minimum of 50% of the global population lacks access to fundamental medical care (Perry, 2020:5). Many lives are lost because community members lack information on treatment options and ailments. Throughout the late 1970s and 1980s, numerous countries were found to have deficiencies in certain CHW programmes, which resulted in high attrition rates and inconsistent quality (Walker, Downey, Crigler, LeBan, 2013:3). For maximum efficacy, the three objectives are dependent upon one another (Nemcek & Sabatier, 2003). Additionally, the following indicators—which are listed in Table 3..2 below—may be used to evaluate best practices in relation to the aforementioned CHW Programme aims.

Table 3.2. CHW Programme goal indicators

CHW Goals	Indicators
Healthcare Utilisation	• Decreased emergency room visits • Enhanced adherence to pre-natal sessions • Increased frequency of primary care provider visits
Risk Reduction	• Morbidity: Decrease in the number of births of infants with low and extremely low birth weight • Biochemical: HbA1C, Blood pressure measurements, TB skin test/x-ray • Knowledge acquisition • Adherence to medication • Vaccination rates • Adoption of healthy lifestyle: Participation in fitness activities, Self-management of diabetes
Therapeutic Alliance	• Assessment of contentment on the healthcare services provided by community health workers

Source: Nemcek & Sabatier, 2003

The Assembly adopted a resolution at large declaring that a “measurable acceleration is urgently needed” to reach the health-related targets of the SDGs by 2030 (Perry, 2020:5).

These developments for measuring the progress were to prioritise bolstering the country's CHW programme (Perry, 2020:5). These metrics center on elements that are essential and conducive to measuring the performance of CHWs (Agarwal, Sripad, Johnson *et al.*, 2019: 7). Through indicators, organisations can pinpoint important areas to gauge how well CHW programmes are performing inside their community health systems (UNAIDS, 2018).

According to Hodgins, Crigler & Perry (2013), CHW programmes must be flexible and resilient, able to change to new policies and evidence and better able to carry out recently authorized recommendations. Four determinants of the viability of a CHW programme were proposed by Haines and colleagues:

- community characteristics like geography, infrastructure, and health beliefs;
- national socioeconomic and political factors including political will and corruption;
- health system elements like oversight and compensation; and
- external influences, such as the movement of people and the availability of technical support (Haines, Sanders, Lehmann *et al.*, 2007).

Various committees are established to monitor the progress of the programme. The National District Health Systems Committee (NDHSC) meets to monitor progress, and reports are sent to the National Health Council's Technical Advisory Committee for additional guidance and direction (Department of Health, South Africa, 2018:19). The National Department of Health (NDoH), together with provinces, will do and report on an outcome and impact analysis of the WBPHCOT programme every five years (Department of Health, South Africa, 2018:19). The provincial health departments report the progress in the NDHSC on a quarterly basis (Department of Health, South Africa, 2018:19).

3.6 DIMENSIONS OF CHW PROGRAMMES

The function of the CHW is distributed across various demographic groups and health programs, especially in areas where health disparities are common (Nemcek and Sebatier, 2003). In resource-poor contexts, communities rely on CHWs in a variety of capacities to offer a variety of community-based care and support, which are not adequately addressed by formal services (Friedman, 2005:177). The following four dimensions of CHW programmes were identified by South, Meah, Bagnall, & Jones

(2013) and Lewin, Dick, Pond (2005): "intervention, role, professional support/service, and the community." The dimensions offer specifically to the connections among three groups: the program's developers and leaders; the programme's recipients in the broader community; and the lay health workers they engage, train, and assist (South, Meah, Bagnall, & Jones, 2013). The following sections provide an explanation of the four critical dimensions of the community health worker programme.

3.6.1 Intervention Dimension

A well-known component of programme classification is the intervention dimension (South, Meah, Bagnall & Jones, 2013). When determining the program, classification is utilised. Programmes for CHWs can be tailored to fit a variety of current health concerns, environments, and demographics. The programme's focus on a particular health concern or on general health promotion is classified using intervention dimension processes (Lewin, Dick & Pond: 2005; Andrews *et al.*, 2008). Additionally, it shows whether the application for the software will be horizontal or vertical (South, Meah, Bagnall, & Jones, 2013). According to Lewin, Dick, & Pond (2005) and Andrews *et al.*, (2008), this dimension also indicates whether the program is focused on working with an individual or the community as a whole.

3.6.2 Role Dimension

The roles may evolve over time (South, Meah, Bagnall & Jones, 2013). The role dimension encompasses more than just the kinds and extent of tasks performed by lay health workers (South, Meah, Bagnall, & Jones, 2013). According to Green and Tonnes (2010), the principal role that serves as the foundation for the intervention is the role that is being defined here which describes the functional role that CHWs play. Community health professionals in North America are referred to as "connectors" with underprivileged communities (Andrews *et al.*, 2008). This can be described as the need for communication of health information between peers. As the roles evolve, it is imperative to not view them as mutually exclusive categories (South, Meah, Bagnall & Jones, 2013). Most programmes aim to create hybrid interventions by combining different responsibilities. Role dimensions show that a program can be implemented with a singular perspective, ignoring other health-related difficulties. This is primarily done to persons who share a social standing or have had common experiences, however other

concerns may also be essential. The objective of enhancing knowledge and awareness can also encompass the goal of promoting behavioral modification (Delisle, Global Health Promotion, 2013).

3.6.3 Service Dimension

CHWs role is linked to health services (South, Meah, Bagnall & Jones, 2013). The service dimension outlines how CHWs roles are applied to the health sector for delivery of services. In Table 3.1 and Table 3.2 above, the components and duties of the CHWs were identified to outline their roles. Service dimension provides a description of services provided by CHWs. It includes categories where professional support is applied with the different variations; this occurs even between programmes which share similar intervention methods (South, Meah, Bagnall & Jones, 2013). It also outlines issues of how CHWs are paid. Some work on a voluntarily basis. Over the years, there has been evidence of a gradual shift in sessional payments including stipends and other types of incentives (Jackson & Parks, 1997; Andrews *et al.*, 2008). In Iran, Community Health Workers (CHWs) are hired by the government and get monthly salaries, which serves as a significant incentive for individuals to pursue this profession and excel in their performance (Shakerian & Gharanjik, 2023).

The service dimension makes a distinction between the emphasis on knowledge derived from a professional background and the delivery of training aimed at the lay health worker's personal growth. Shiner also distinguished between peer development, which emphasises empowerment, developing ownership, and facilitation, and peer education, which can be seen of as a delivery technique. One important aspect is the focus on professional control (Shiner, 1999). Therefore, it is important to assess whether the balance of power is in favour of community health workers, who are partially trained and hired by a health system, or natural helpers, who often operate unofficially and are largely responsible to the community (South, Meah, Bagnall & Jones 2013).

3.6.4 Community Dimension

Nunes & Lotta (2019) and Perry *et al.*, (2014) emphasise that Community Health Workers (CHWs) play a crucial role as frontline workers, acting as direct intermediaries between the community and specialist healthcare practitioners. As a result, they are entrusted with

a wide range of broad responsibilities (Hartzler *et al.*, 2018). Consequently, they are integral to the efforts of health systems to provide primary health care, particularly in poor and middle income nations. South, Meah, Bagnall, & Jones (2013) argue that the community component focuses on the specific traits that define the relationship between the lay health practitioner and the community they work with. According to Bishop *et al.* (2002), the framework described above includes definitions that appear to be wide and are based on the main characteristics that are desired, as well as if these features may be compared to the larger community in any way. This dimension specifies the intended receiver of the health service provided by Community Health Workers (CHWs). A Peer: CHW is matched to programme recipients in terms of categories (age, social, status, gender, shared experience) (Lewin, Dick & Pond, 2005). As demonstrated by CHW tactics, programs frequently rely on CHW to reach out to preexisting organizations and disseminate messages through known or unknown networks (South *et al.* 2008). Programs typically seek to establish new networks, which can be accomplished by establishing peer support networks within a familiar community. Planning and evaluation may be aided by the program's structure (South, Woodward & Lowcock, 2007). More program definitions will make it possible to gather enough data from comparable strategies, which may include the benefit of employing sessional payment to encourage community health professionals' involvement.

3.7 INTERNATIONAL ANALYSIS OF CHW PROGRAMMES

CHW programs were documented in a 1975 World Health Organisation (WHO) monograph. At that point, it was confirmed that CHWs were crucial in providing underprivileged communities with basic healthcare services. The initial experience creating and executing national CHW programs yielded contradictory outcomes, prompting inquiries into the applicability of CHWs in enhancing the well-being of individuals residing in resource-constrained environments (Perry, 2020). A number of nations have made an effort to implement PHC models (Nxumalo, 2013). These nations include those that were part of the Accredited Social Health Activist (ASHA) program in “Afghanistan, Ethiopia, India, Kenya, Niger, and Uganda” in the first decade of the century (2000–2009); and “Madagascar, Burma, Liberia, Sierra Leone, South Africa, Tanzania, and Zambia” in the second decade (2010–2019).

As briefly mentioned in Chapter 1, CHW programmes dates to China in what was called the ‘barefoot doctors’ programmes, in the 1920’s (Perry *et al.*, 2014). CHW programs were initiated in China and Central America in their early stages (Perry, 2020). The programs in China were associated with the decolonisation and democracy movements (Campbell & Scott, 2011). China's programmes can be viewed as the prevailing health practices that exert control on the structures in the Western world. However, these programmes have failed to adequately meet the increasing requirements of the most vulnerable populations in low-middle-income countries (Perry *et al.*, 2014). The widespread adoption of national Community Health Worker (CHW) programs has been found to be constrained by many variables, including economic downturns and the influence of neoliberal policies (Perry *et al.*, 2014; Campbell & Scott, 2011:30). Fast forward to the 21st century, there has been a significant growth in interest in the CHW’s, this is motivated by the *“recognition that service needs, particularly in remote and underprivileged communities, are not met by existing health services”* (Lehmann & Sanders, 2007:6).

Another driving force behind the development of CHWs is their association with the Millennium Development Goals (MDGs). This association has led to a positive change by shifting the focus from community-based activities to clinical activities, hence prioritising health issues (Ballard *et al.*, 2018). According to Kok *et al.*, (2017), the effectiveness of CHWs hinges on their capacity to serve as a bridge between formal health centers and the community. CHWs occupy a position that lies between two extremes. The authors above also emphasise the dynamics that lead to the establishment of trusting or distrusting relationships among CHWs, the community as a whole, and the health system. The writers mentioned above, including Lotta & Marques 2020, have identified eight mechanisms that can enhance the relationship between CHWs and the community. These mechanisms include recruiting and selection as well as community support. Another component that exists is the relationship between the CHW and the health system, which encompasses monitoring and training. Table 3.3 below, presented by WHO in 2018 and Kok *et al.*, in 2017, will illustrate the remaining mechanisms.

Table 3.3: Mechanisms that optimise the work of CHW

WHO 2018	Kok <i>et al.</i> , 2017	Kok <i>et al.</i> , 2017	WHO 2018
Selection (1)	Recruitment & Selection	Professional support	Contracting agreements (8) Career ladder (9)
Target population size (10)	Community support		Incentive and Training
Community engagement (13)		Length of pre-service training (2)	
Mobilization of community resources (14)		Curriculum competencies for pre-service training (3)	
Data collection and use (11)		Community health worker tasks	
Types of CHW's (12)	Certification based on competency (5)		
Availability of supplies (15)	Resources		Remuneration (7)
		CHW's connection with health facilities	

Source: Researchers compilation

3.7.1 Brazil

Johnson *et al.*, (2013) and Schneider (2017) both suggest that Brazil has been able to set a type of model or benchmark for other countries as it is archetypal CHW case. This is based on the fact that since its institutionalisation onset in 1991, CHW's have managed to reach a great level of professionalism and legitimacy which is a result of a strong and a firm national mobilisation through the 'CHW National Confederation (Nogueira,

2019:215). This can also prove important for other countries who may be beginning such a process.

To strengthen the above notion, it is important to investigate legislation from the Brazilian Federal government. Brazil began their CHW's programmes in the 1970's locally in Minas Gerais and Ceara (Nogueira, 2019). The Federal Constitution was approved in 1988, this is when Brazil proposed the creation of a Public Health System. This health system became a universal system which aims to provide free health care to Brazil citizens. These services which ideally be provided by federal, state and municipal governments in government system which was decentralised and coordinated. Therefore, a National Community Health Workers Programmes was officially launched in 1991, which was again followed in 1994 by the Family Health Strategy (Brazil Health Ministry 1994). The Family Health Strategy (FHS) reoriented the Public Health System towards an effective primary care model which saw an integration of the CHW programme (Lotta 2015 in Morgana *et al*, 2021). The programme is regulated by the Primary Care National Policies directives. The Family Health Strategy mainly takes place inside primary health clinics and mainly provides primary health care service despite significant disparities. The FHS is also responsible for organising healthcare workers into different teams, one being the Family Health Teams which includes one doctor, a few nurses and CHW's; and CHW teams which includes a few CHW's and a nurse. According to a study by Gomes *et al*, 2020, in 2019 Brazil had 42 605 Family Health Teams (FHT) and 3272 Community Health Worker teams. CHWs mainly had the responsibility of caring for 200 families within an area specified to them, which included visiting them once a month, and offered support roles in communities and local clinics (Morgana *et al.*, 2021).

Seven bills were presented between 1991 and 1999 to regulate CHWs profession. These bills advocated different proposals which included minimum education level, established parameters for professional qualification as well as terms of reference (Nogueira, 2019; Brazil Decree No.3.189; 1999). There was a long period of negotiations between the federal government, the Brazilian Congress and CHW's, but eventually in 1999 the President introduced a national legislation which was meant to address employment rights for CHWs and to set a benchmark for their remunerations. This legislation also described main functions for CHWs and emphasised that they needed to reside within

the area of the communities which they represent. This decree also included competencies such as leadership and spirit of solidarity.

In 2002, an Act #10.507 was adopted which formally created the profession of CHW, this Act established that CHW's needed to complete basic training, should have completed middle school, reside in that area in which they perform their roles, and needed to be contracted directly by governmental institutions or alternatively by civil society organisations. Concerns regarding the uncertainty of CHW's working conditions and meritocracy which guided civil service selection led to the government approving the CA 51, which mainly prohibited indirect hiring process, everything needed to fall into the adopted Act to protect the rights of CHW's (Brazil. Constitutional Amendment No. 51, 2006).

The requirement that a CHW needed to live in the same area as where they work, as per Decree #3189/1999, began to open space for legal conflict as it was somehow contrary to the constitutional principle of equality which meant candidates could not be discriminated solemnly based on where they reside. This saw another amendment being done through CA #51, which determined that CHW selection processes would be done according to the territory (#11.350/2006). This caused them to change the institutionalised selection processes which meant that the community was not going to be involved in the CHW recruitment. In other words, those previously selected based on their position within their communities, going forward they would be selected through public tender (Lotta, 2015). The above changes however fail to align with the recommendations set out by WHO 2018, as the process lacks community involvement.

Legislation of 2002 (#10507) and 2006 (#11350) required only middle school education for community health worker, but as time and demands increased, in 2018 (#13.595) the legislation was amended that high school graduation was a basic requirement for a CHW. As a result of this amendment to the legislation, a change in profile of the CHW was established. In 2002, about 18.2% had completed higher education, in 2015 there was a substantial increase to 70.97% who had completed their higher education (Morosini & Fonseca, 2018). This was a positive shift and the competences of the CHW was established by the hiring institutions, more stringent approach was used in the recruitment

and selection process as interviews also became part of the process (Simas & Pinto, 2017; Lotta 2015). This allowed for growth and a diverse approach.

Studies conducted in Kenya, Bangladesh, Nigeria, India and Indonesia have confirmed that CHW's significantly contributed to the reduction of neonatal, maternal and child mortality through the uptake of antenatal care, vaccination coverage done during pregnancy and also the increase of deliveries within the health facilities (Nkonki, Cliff & Sanders 2011). According to the Community Health Workers, there was an increase in the quantity of new moms breastfeeding throughout the first 24 hours, and new mothers were generally being taught more information. The study demonstrating the effectiveness of CHW presence made many countries in sub-Saharan Africa and Southeast Asia understand the necessity for stronger national planning, implementation, and growth of CHW programs. However, there are still issues with the programs, such as low motivation and interest for new CHWs, inadequate supervision, inadequate training, a shortage of supplies and resources, and insufficient community communication channels (Islam *et al.*, 2002).

Another factor which may seem frustrating with the different CHW programmes is the high attrition rates which often derails the process. On a global scale, an annual report of the attrition rates for CHW's are between 3.2% and 77% which is a high percentage which is likely due to the lack of appropriate remuneration, as in other states, CHW's are often seen to be volunteering their time. Relationships between CHWs, the community they serve, and the health systems are inconsistent as a result of the high attrition rates.

As a result, there is instability in the programs, ongoing costs associated with replacing CHWs, and the process of finding, selecting, and training new CHWs must be restarted, resulting in the loss of experience gained by previous CHWs (Ngilangwa & Mgomella, 2018). The capacity of CHWs to stick with the program determines how effective it is, but it's also important to figure out how volunteer-based programs can attract new participants and provide a friendly environment. There is interest in investigating additional connections, such as rewards, inspiration, and the most effective ways to increase CHW retention in developing nations (Ngilangwa & Mgomella, 2018). The

factors that inspire CHWs in their jobs and help them stay CHWs need to be better understood.

3.7.2 India

According to UNICEF (2015), India is one of just two countries responsible for one third of all maternal deaths globally. In 2015, India had an estimated 45,000 (range 36,000 to 56,000) deaths of mothers connected to pregnancy. The maternal mortality ratio, measured as the number of deaths due to pregnancy per 100,000 live births, declined by 77% from 1990 to 2016 (WHO UNICEF, 2015). The Millennium Development Goals target of lowering maternal mortality by two-thirds was partially accomplished, although the target was not fully attained, and the level of accomplishment varied significantly from state to state (UNDP, 2015). In order to promote primary healthcare as part of the Millennium Development Goals (MDGs), India introduced a version of Community Health Workers (CHWs) known as Accredited Social Health Activists (ASHAs). This program has a well-established history at both the national and state levels. ASHA is recognised as one of the most extensive community health worker efforts worldwide (Gopalan, Mohanty, & Das 2012). The initiative has successfully taught close to 1 million Community Health Workers (CHWs) (Argawal, Curtis, Angeles *et al.*, 2019). The ASHA's, also known as Accredited socioeconomic Health Activists, are community health workers who primarily focus on raising awareness about health and socioeconomic determinants. They also play a crucial role in mobilising the community for local health planning (Liu, Sullivan, Khan *et al.*, 2011).

In April 2005, the Government of India (GOI) created the National Rural Health Mission (NRHM) as a reaction to the limited advancements made in enhancing the health of mothers and children. The National Rural Health Mission (NRHM) is a substantial endeavor aimed at enhancing the provision of healthcare and the overall health services of the country, with a particular focus on the most economically disadvantaged populations (Bajpai & Dholakia, 2011). According to the Ministry of Health and Family Welfare in 2013, the ASHA programme is considered crucial for the success of the NRHM. Its main goals are to improve the availability of public health services and promote greater community engagement with the healthcare system. There were a total of 18 states that participated in the ASHA programme's first launch in 2006. These states

included 10 high-focus states (Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Himachal Pradesh, Jammu and Kashmir, Uttar Pradesh, Uttarakhand, Orissa, and Rajasthan), as well as 8 northeastern high-focus states. The states included in the list are Arunachal Pradesh, Manipur, Assam, Nagaland, Meghalaya, Tripura, Mizoram, and Sikkim. One ASHA was trained and deployed for every 1000 individuals in rural areas over a span of two years. The initiative was extended nationwide in 2009 (National Rural Health Mission, 2011).

Considering the scale and scope of the ASHA programme, it is crucial to conduct an evaluation of the programme for the Government of India and other countries implementing similar CHW initiatives. The ASHA program has expanded nationwide in the last decade, with each state receiving funding allocations ranging from 80 million rupees (\$1.2 million) to 1.05 billion rupees (\$15.5 million) between 2005 and 2010. Although these programmes are important, there is little data to substantiate their effectiveness, especially on a large scale (The Ministry of Health and Family Welfare 2013).

Scott & Shanker (2010) observed that although the ASHA program does not expressly address HIV/AIDS, CHW programs have been identified as a critical strategy for tackling the lack of health resources in developing nations, particularly regarding HIV/AIDS. This analysis of the ASHA programme sheds light on how to best assist CHW initiatives generally, particularly those that address HIV/AIDS (Scott & Shanker, 2010). Previous analyses of the effects of the ASHA program on maternity care have been descriptive in nature (Fathima, Raju, Varadharajan, 2015), limited to a small number of states, or restricted to evaluating the effectiveness of the ASHAs rather than the results of the ASHA program on health outcomes (Bajpai & Dholakia, 2011; Gopalan, Mohanty & Das, 2012). Below we look at the Training, Roles/ Responsibilities assigned, and Incentives received by the CHW in the ASHA programme

- *Training*

ASHAs complete 23 days of training based on five training manuals throughout their first year of employment. Following that, they will be granted an additional 12 training days annually (Perry, Zulliger, Scott, Javadi & Gergen, 2013: 30; Vora, Mavalankar, Ramani et al., 2009).

- *Roles /Responsibilities*

ASHAs often participate in weekly meetings at their local primary health center and conduct essential home visits for community members, however the specific service delivery may differ from state to state. With the exception of training and mobilisation tasks, they typically labor for approximately 2.3 hours each day, four days a week (Zulliger et al, 2013). ASHA's should hold a minimum of eight years of formal education, fall within the age range of 25 to 45, and demonstrate robust leadership skills. The ASHA program, established in 2006, now encompasses a workforce of 820,000 women who have received training and are currently employed throughout the country (Gopalan, Mohanty & Das, 2012). Their responsibilities cover a wide range of tasks, including diagnosing medical conditions, delivering health education, and conducting surveys on health and related events. The figure below illustrates additional tasks. The program is overseen by each state, ensuring compliance with the standards of the National Rural Health Mission (NRHM).

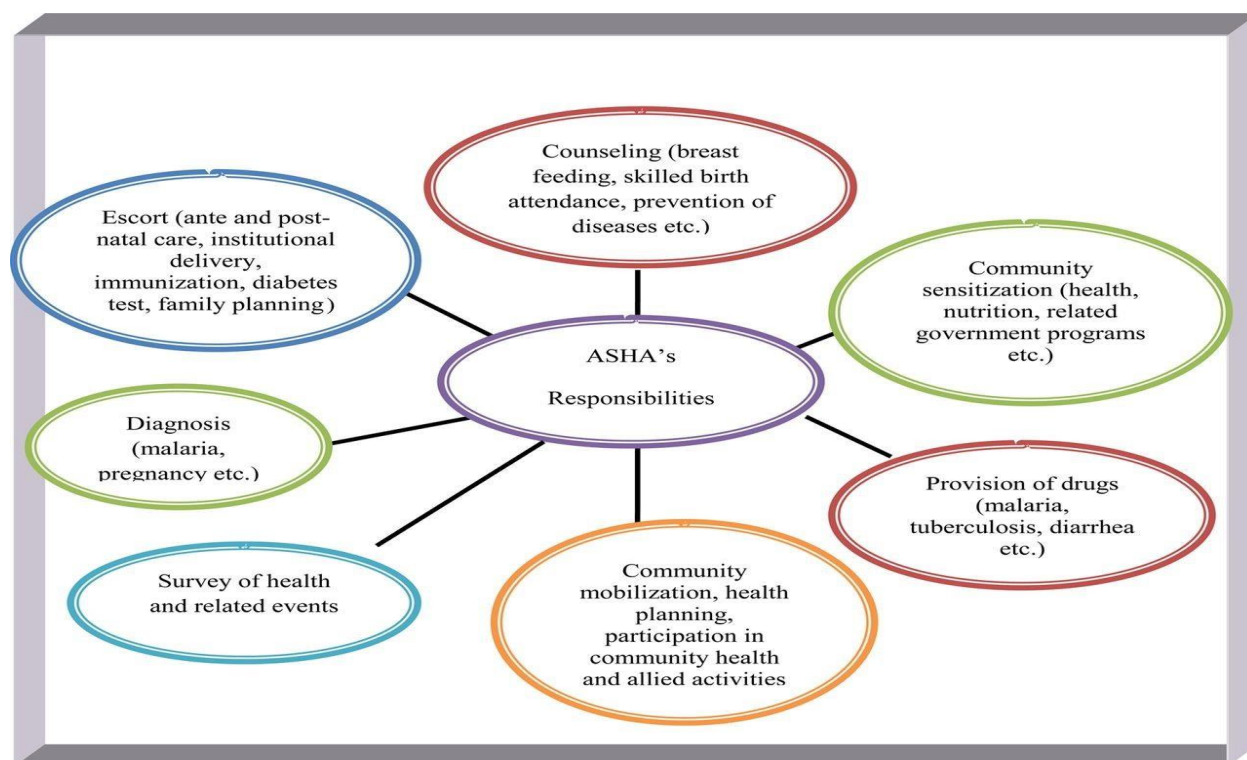
- *Incentives*

ASHAs are paid for enabling institutional deliveries, vaccinations, FP (surgical sterilisation), and toilet construction (Perry, Zulliger, Scott, Javadi & Gergen, 2013: 30; Gopalan, Mohanty, & Das, 2012). They get set activity-based rewards but do not receive a salary, making them part of the voluntary cadre of health personnel (Gopalan, Mohanty & Das, 2012). The rural women view working as a CHW as a wonderful opportunity to advance their social, financial, and personal lives (Willis-Shattuck, Bidwell & Thomas, 2008). Providing rural women with CHW positions when they have no other employment options can be a viable and reproducible approach for community health management. Self-motivation plays an intrinsic role in the operations of the CHW's. This suggests that lay women can be organised for community health initiatives with the right selection, orientation, and training. The programme demonstrates a great dedication to empowering women because women are often more open to suggestions. The level social network among women may be justified by the higher levels of health consciousness and adherence to healthy activities among women than among males (Battacharya, Winch & LeBan *et al.*, 2001).

ASHAs faced institutional constraints including: (1) a remuneration structure based on outcomes; (2) insufficient institutional support; (3) a rigid hierarchical structure within the

health system; and (4) limited community involvement. In order for progressive policy on Community Health Worker (CHW) programmes to receive institutional support, it is essential that CHWs are able to effectively carry out their duties (Gopalan, Mohanty & Das, 2012).

Figure 3.2: Responsibilities of the Accredited Social Health Activist



Source: Author's own

3.7.3 Tanzania

Studies show that Tanzania has the highest concentration of primary healthcare facilities in Africa; nevertheless, getting access to high-quality medical treatment continues to be a significant difficulty. Tanzania has been a leader in developing health care services at the community level throughout the nation, but there are still obstacles standing in the way of the system's development into a state where it is equipped with sufficient human resource methods (Greenspan *et al.*, 2013). The Tanzania government has indicated the great need to involve the community to improve the general coverage for PHC. To reach these goal of more coverage, CHW programmes were implemented mainly by nongovernmental organisations, known as NGO's and have been assisting the government from as early as the 1970's, which resulted in CHW's members who have

different backgrounds and differ in length and type of serve, training; sources and capabilities (Ramsey *et al.*, 2013).

Although Tanzania has a long history of utilising CHWs, they have not yet officially incorporated these health workers into the healthcare system (Mgawe & Maluka, 2020). Furthermore, as stated by Ramsey *et al.*, (2013), CHWs in Tanzania are still perceived as volunteers and are not recognised as public officials inside the healthcare system. One possible factor that discourages individuals from working as CHWs is the lack of formalisation in their role. However, in recent years, the country has made substantial endeavors to provide a formal framework for CHW work, shown by the introduction and approval of the Community Health Based Programme (CHBP) policy in 2014. The policy aimed to consolidate the diverse Community Health Worker (CHW) efforts around the country. The primary objective was to understand the factors that attract and motivate CHWs and determine strategies to retain them.

The Tanzanian government, supported by Armref Health Africa, sought to improve the delivery of healthcare services to women and children in five regions situated in Northwestern Tanzania. For this reason, the Uzazi Uzima program was created and ran from 2011 to 2014. The programme offered CHW's the tool they needed to provide services better which included gumboots, torches, bags, umbrellas and notebooks.

The Uzazi Uzima programme recruited 3924 as well as provided the necessary training for the recruits, this included 2000 men and 1924 women. This number alone exceeded the national target (Mpembeni *et al.*, 2015). The programme had a target set to reach 108 353 pregnant women, 21 010 neonates as well as 114 575 children who were below the age of 5 years. Training was offered to each CHW for one week and the curriculum used was one which was created by the Ministry of Health and Social Welfare. The curriculum encompasses a range of topics, such as prenatal and postnatal counseling, pregnancy detection, identification of potential danger indicators during pregnancy, the process of childbirth, and postnatal care. Each Community Health Worker (CHW) was required to provide services to a minimum of 60-120 homes. However, the number of households served also depended on the size of the specific community (Ngilangwa & Mgomella, 2018).

CHW's were provided support in having the back up of facility managers which included nurse midwives and clinical officers. The supervisors were available to provide mentorship and necessary technical support as the need arises more especially on areas which include Integrated Management Childhood Illness (IMCI). The supervisors were also available to help mobilise and create sensitisation (Mpembeni *et al*, 2015). Data was collected monthly and was submitted to the health facilities and averaged. Once the data was aggregated, it was then submitted to district and regional levels. Reimbursement for transport and lunch was offered which was about 100 TZS, which was equivalent to almost \$5US. This specific programme began with high expectation and suggested to have covered all the main elements required for it to gain momentum and become sustainable, however in the third year after initial implementation, about 500 CHW's were no longer active and were no longer within the programme. (Ngilangwa & Mgomella, 2018). Another different strategy which was introduced include the National Community Based Health Programme Policy Guidelines and its strategic plan between 2015 to 2020. This main policy had the main goal for the formalisation of the CHW cadre (Mgawe & Maluka, 2021).

Other countries which have integrated the Community Health Workers into their national health system are “Zambia, Pakistan, Ethiopia and Ghana: (Mgawe & Maluka 2021). The integration of Community Health Workers (CHWs) in the country in question was influenced by several factors. One factor was the previous experience of health crises, which highlighted the need for additional human resources for health. Another factor was the successful performance of the national Community Based Health Worker Programmes, which played a dominant role in delivering health services. These programmes demonstrated effective health system characteristics and were influenced by social and cultural factors (Maluka, Chitama, Dungumaro, et al., 2018). Several other countries, such as Nepal, Ethiopia, India, Ghana, and Pakistan, have experienced significant improvements in their national health systems by integrating Community Health Workers (CHWs). This integration has led to enhanced access to essential primary healthcare services for local communities, resulting in a notable reduction in malaria cases, as well as maternal and childhood mortality and morbidity (Urassa & Chaya, 2018). The positive outcome of the CHW's programme resulted in its recognition in the national

health care planning legislation, monitoring process, implementation phase, and financial support of the framework (Urassa & Chaya, 2018).

The incorporation of CHW's into the National Health Service (NHS) became a development plan, which unfortunately faced several challenges. In Tanzania, there were two different procedures which supported the selection and training of CHW's. The initial step involved a 1-year training program for Community Health Workers (CHWs). However, this program deviated from the guidelines set by the Ministry of Health and instead followed the guidelines provided by the National Council for Technical Education (NACTE). According to these guidelines, individuals aspiring to become CHWs were required to have completed secondary education, with biology being one of the subjects passed (Maluka et al., 2018). Interviews were conducted using the curriculum that has been officially recognised and approved by NACTE. The duration of the short courses ranged from one to three months. The selection procedure adhered to the Ministry of Health criteria, which required Community Health Workers (CHWs) to be integrated into the local community and reside in the hamlet where they would be deployed following training. Due to a lack of alignment between the teaching staff's competences and the required skills for supporting Community Health Workers (CHWs) in their certified curriculum, the training and tutoring process was often challenging. Several deficiencies were discovered, particularly in the areas of social work and entrepreneurship. In certain instances, the institution had to rely on external social worker officers who were already employed by municipal agencies to teach modules related to social work. It would be a formidable task since the social workers possess expertise in their profession but lack teaching experience (Mgawe & Maluka, 2021).

Tanzania, as a result, was caught in the middle as the initial plan was to integrate the CHW's in the health system, but it proved to be a challenge because of several different factors which clashed (Maluka et al, 2018). Initially, the policy requirements regarding recruitment became a significant factor. This was because the national guidelines mandated that potential Community Health Workers (CHWs) must live in the communities they serve. However, this requirement was not met because the recruitment process followed the standards set by NACTE, which stated that candidates must have at least four passing grades in their secondary education exams, with biology being one of the

subjects (Ngilangwa & Mgomella, 2018). Consequently, adhering to the selection criteria established by NACTE, the implication of identifying a CHW based on these guidelines is that the chosen CHWs are unable to return to the community, since they would not technically be the group selected by the villagers (Ngilangwe & Nomella, 2018).

Despite the extensive preparation of training multiple Community Health Workers (CHWs), they had not yet been officially incorporated into the health system. Consequently, the trained and equipped CHWs continued to function as community volunteers and engaged in tasks unrelated to delivering healthcare services. Based on the information provided, it can be concluded that the theoretical idea of incorporating Community Health Workers (CHWs) into the healthcare system in Tanzania was not well planned. The Ministry of Health developed guidelines and policy documents, which were officially distributed to the districts and regions for implementation. However, it appears that there was a lack of clear understanding among the stakeholders regarding the most effective way to carry out this integration (Maluka et al, 2018; Hudson, Hunter & Peckham, 2019).

3.7.4 North Carolina

North Carolina has prioritised a growing and trusted competent CHW workforce which has seen great success in reaching marginalised communities. North Carolina actively implemented measures to mitigate the impact of the COVID-19 epidemic and prevent it from being the most severely affected state in the United States. As reported by The New York Times in 2021, in March of that year, the state was rated 36th in terms of the highest number of cases per person, and 40th in terms of the highest number of deaths per person. NC was pro-active in developing a COVID 19 programme response which included *prevention*, by means of mask wearing; *testing*, by means of expanding their testing infrastructure; *contract tracing*, this was made to be more effective by means of Carolina Community Tracing Collaborative (CCTC), which was in partnership with North Carolina Area Health Education Centres and lastly *supported quarantine*, this was achieved by supporting people to stay at home as much as it is possible (North Carolina Department of Health and Human Services) NC has been creating a nationwide Community Health Worker imitative and has also provided means to build a sustainable infrastructure which will see CHW's being supported.

In 2018, a report was issued which provided recommendations for an infrastructure to support CHW's at the North Carolina Office of Rural Health (ORH). This report piloted a curriculum for CHW's at six colleges across the community which would commence in early 2020. Covid-19 had an adverse impact, and as a result ORH, saw the benefit CHW's would have as trusted members of the communities. The Office of Rural Health (ORH) developed a program called the North Carolina Community Health Worker (CHW) Covid-19 Program. This program aims to facilitate the connection between CHWs and residents who have been impacted by the epidemic, ensuring they receive the necessary assistance and services. The Covid-19 Support Services initiative (SSP) enhances the NC CHW Covid-19 initiative by offering tangible, direct financial assistance and other essential support in numerous nations. Community health workers (CHWs) frequently serve as intermediaries who recognize emerging needs and refer impacted individuals to social support services. The Support Services Program provides funding and essential assistance for the isolation and quarantine of sick individuals (NC Department of Health and Services 2021).

3.7.5 Nepal

CHWs have become an essential part of Primary Health Care (PHC) initiatives in low-income countries with limited resources. They are considered to have a substantial impact on the Millennium Development Goals (MDGs) related to maternal and child health. In order to advance the objectives of the Sustainable Development Goals (SDGs), which aim to guarantee universal access to reproductive healthcare, policymakers at both national and international levels are increasingly relying on Community Health Workers (CHWs) (Maru et al, 2018). Back in the 1980's, the Ministry of Health began by making an introduction of full-time 'village health workers' (VHW). The VHW's received six weeks of training on primary health care and the focus was on increasing immunisation amongst the community (Nepal *et al*, 2020). After the VHW program was firmly established, community health leaders were recruited to promote community engagement in enhancing the nation's health, providing support to the VHWS, and advocating for the health messages they were disseminating. Community health leaders set up convenient times and places for individuals to meet them elsewhere in the community, as opposed to doing house visits like VHWS did. After just one month of training, community health leaders became unpaid volunteers (Nepal et al., 2020).

While some CHW initiatives are modest, independent programmes, others—like the Nepalese Female Community Health Volunteers (FCHV) programme—are sizable, national initiatives run by government organisations. The first contact or lowest level PHC provider in the public healthcare system is an FCHV (Panday, Bissell, Van Teijlingen & Simkhada, 2017). Even though poverty, political unrest, and the restricted availability of universal healthcare services have persisted for the past 25 years in Nepal, maternal mortality has significantly decreased. Nepal successfully decreased its Maternal Mortality Ratio (MMR) by 80% from 850 to approximately 170 deaths per 100,000 live births between 1991 and 2011. This achievement allowed Nepal to meet MDG Five, in contrast to the global decline of 47%. It is worth noting that Nepal had a high percentage of home deliveries (72%) and a low percentage of skilled attendants at birth (36%). The lowering in maternal mortality ratio (MMR) has been significantly influenced by advancements in women's education, higher adoption of contraception, and a decrease in birth rates (Panday *et al.*, 2017).

The FCHV initiative was acknowledged as a crucial part of Nepal's 2010 recognition as one of the most advanced nations in terms of attaining the Millennium Development Goals (MDG). Despite Nepal's noteworthy accomplishments in community health, especially with regard to the FCHV program, there is still space for growth for community-based cadres (Panday *et al.*, 2017). These include establishing minimal requirements for schooling, expanding to full-time paid employment, and addressing supply chain management difficulties in a way that is similar to the majority of the other health care system components. Having stronger training and administrative systems is one of the other considerations. Shahi, Tamang, Bhatta & Rawal (2021) also add that together with the accomplishments in 2019–2020, evidence from numerous research suggests that FCHVs have played significant roles in delivering and increasing the delivery of community-based primary health care services, facilitating patient referrals when necessary, and creating connections between the local community and health centres.

FCHVs are acknowledged and commended for having contributed significantly towards the accomplishment of the Millennium Development Goals, notably MDGs 4 and 5a, which focused on lowering maternal and infant mortality rates and enhancing the general health of women, children, and newborns. To improve women's health, children, and

newborns in communities with limited access to services, FCHVs have been extremely important in making door-to-door visits and offering promotional and preventive services (Panday *et al.*, 2017).

Despite these successes, studies have identified several crucial areas that need significant attention and additional programme improvement, such as: FCHVs must be paid for the time and services they provide; they must regularly receive training and capacity building; they must have effective support, supervision, and monitoring; they must adhere to pertinent guidelines in order to deliver a variety of health programs and raise the standard of care; Create a polite retirement or departure packet for anyone who would not be able to volunteer as previously done (Shahi, Tamang, Bhatta & Rawal, 2021). Nepal *et al.*, (2020) acknowledge that the existing obstacles faced by the FCHV program hinder its ability to contribute significantly towards achieving the Sustainable Development Goals (SDGs). The introduction of the new FCHV Strategy 2076 will mandate that new FCHVs must meet a minimum educational qualification. In addition, FCHVs are involved in various local initiatives where they advocate for enhancements in the structure, oversight, and remuneration.

It became clear that new concepts and further investments in the CHW systems were required to close the gaps in Nepal's SDG targets, which will contribute to the overall development of the country's health care systems (Glenton, Sheel, Pradhan *et al.*, 2010). Guidelines provided by WHO, and other recommendations for design established for an effective CHW programme offers a helpful framework which highlights that CHW's need the following (1) to receive compensation financially, (2) potential CHW's need to meet the minimum education requirements, (3) supervision must be in place, (4) training needs to be offered on a continuous basis, (5) CHW's need to be incorporated into the local primary health care system, (6) The use of a mobile health tool is required, (7) supply chain needs to be in place and consistent and (8) as with all CHW's, they need to reside in the communities which they offer service to (Glenton *et al.*, 2010).

In order to meet the requirements of the CHW programme Nyaya Health Nepal NGO collaborated with the Ministry of Health and Population and the Department of Health Services, Family Welfare Division. Together, they developed and executed a pilot program for CHWs that followed the guidelines set by the World Health Organisation

(Nepal et al, 2020). The pilot programme developed has shown promising results between 2014 and 2016 which includes the improvement of antenatal care, birth rate which has been institutional as well as postpartum contraception (Government of Nepal, 2019). Although CHW are seen as a cost-effective strategy for strengthening health care systems, data is also limited in Nepal which refers to the costs or operational details involved with such programmes which incorporate the WHO guidelines (Nepal et al., 2020). Below is a table which depicts the Nepal Pilot Programme which highlights the incorporation of World Health Organisation Guidelines.

The Nyaya Health Nepal began their CHW programme in 2014 in a small district of Achham which is situated in Province 7 and had an approximate population of 36 000. The programme was developed and implemented in 2017. The program gained momentum and was now in both Achham and Dolakha districts. Dolakha district is situated in Province 3, where the population is much larger, and consisted of more than 250 000 people. The program was implemented across two municipalities, which are referred to as Kamalbazaar municipality and Senfebagar municipality 30 Community Health Workers were employed for both municipalities during 2017 and 2018 (Nepal et al., 2020:242). The district of Achham is among the poorest and has some of the worst national results in the health sector. There is one main hospital in Achham, which has a shared investment between a private sector and the Ministry of Health and Population (Perry, Akin-Olugbade, Lailari & Son, 2016). The hospital is funded by federal, provincial and municipal spheres.

Through the local Health District Office, Nyaya Health Nepal is accountable to the Ministry for reporting purposes and is in charge of managing the daily management and operations of the surrounding healthcare services. According to Perry et al., (2016), Bayalpata Hospital is the primary referral hospital for emergency obstetrics, management of services needed for infants, and non-communicable diseases (NCD).

The program integrated several fundamental procedures and established partnerships with local government, the Ministry of Health and Population, the Family Welfare Division, and the Department of Health Services (Nepal et al., 2020).

Table 3.4: Nepal Pilot Programme

Recommendations for CHW Programme by WHO	CHW Pilot Programme Descriptive Characteristics	Programme Alignment with WHO Recommendations
Selection	CHWs:	☒
Training	- Have minimum education of 10th level - Locally selected women who live in the community - Includes both preservice and continues training - Training combines theory and practice based in community	☒
Certification	Formal program certification in process	☒
Supportive supervision	The behavior of supervisors - Regular in person supervision - Dedicated supervision, data-driven feedback, and performance review	☒
Incentives	CHWs are paid salaries, full time employees, at competitive rate, paired with other non-financial incentives	☒
Career ladder	Pending further government approval	☒
CHW: population ratio Data collection/utilization	Ratio based upon epidemiology, geography, topography, security and expected responsibilities	☒
Community integration	CHW's mobilise resources and promote health and social needs	☒
Supply chain	CHW's have reliable and consistent supply of medicines and supplies closely linked to primary health centres	☒

Source: www.ghspjournal.orgs.

The following items were mandatory for CHW to incorporate in the pilot: (1) Regular financial compensation is mandatory. (2) A secondary education is the minimum

requirement for their level of education. (3) CHWs must be closely supervised. (4) All CHWs must receive continuous training. (5) CHWs need to be closely integrated into the community's primary healthcare system. (6) The use of a mobile health tool is necessary. (7) A consistent supply chain must be available. (8) It is crucial for CHWs to reside within the communities they serve. (9) Services should be provided to point-of-care users without any charges. Community Health Workers (CHWs) were regarded as full-time, salaried staff members of Nyaya Health Nepal. Each health worker was allocated to a certain village or ward, in accordance with the political divisions of the federal system now in effect (Citrin *et al.*, 2018; Maru *et al.*, 2018). A Community Health Worker (CHW) in Nepal typically earns a monthly basic wage of 19,930 Nepalese rupees (NPR).

The procurement department of Nyaya Health Nepal is in charge of giving the CHWs the tools they need to carry out their daily duties, including mobile phones, blood pressure monitors, home pregnancy tests, measuring tapes for circumference of the upper arm, and other necessities (Citrin *et al.*, 2018). Every CHW is designated to house two thousand people. There are certain places with dispersed populations and difficult environment; in those areas, more CHWs are assigned to work that particular ward. Supervision is provided for each CHW, there is one Community Health Nurse (CHN), who provides supervision, training, and is responsible for the monitoring and evaluation for five CHW's (Perry *et al.*, 2016). Community health program associates are responsible for providing supervision to 2-3 CHN's and are mainly responsible for program planning as well as the administration part of it.

CHW's receive preservice training which lasts a month, which is followed by a two-week training module every month over the next 3 months after the registration has been completed. Ongoing training on a continuous basis are conducted monthly when they have their meetings (Nepal 2020). Additionally, Android-based smartphones are provided to CHWs. These smartphones are used with the CommCare platform, which offers clinical service documentation and content, including counseling and support referrals (CommCare, 2020). The smartphone data is electronically connected to the Nyaya Health Nepal hospital, facilitating continuous care across facility-based and community-based services (Acheampong, Asenso-Boadi, Beaulieu *et al.*, 2014; Özalın & Cashin, 2014).

The programme design of the Nepal Ministry of Health and Population, Nyaya Health Nepal, and Family Welfare Division CHW Pilot Programme is conceptualised in the table below with respect to the number of participants and the duties assigned to each job.

Table 3.5: Nepal programme design

RATIO	RESPONSIBILITIES
1 CHPA: 2-3 CHNs	• Programme planning: derive programme calendars, lead preservice training as well programme implementation, monitor CHN performance • General administration: which includes logistics and procurement, recruitment, budget planning and financial management, and stakeholder engagement
1 CHN: 5 CHWs	• Supervision, monitoring and evaluation: conduct regular in-person monitoring and quality assurance, coaching for continuous improvement, and review patient data for high-risk condition and referrals. • Training: hosting bi-weekly trainings aimed to foster group learning when CHW's for improved capacity to cater to health care needs • Services: provide prenatal labs and US for group antenatal care sessions
1 CHW: 2000 population	• Continuous surveillance: use proactive system to identify patients, record vital events and track demographic changes • Pregnancy surveillance system: conduct proactive visits to married women of reproductive age, households visit every 3 months • Antenatal care: conduct monthly home visits for birth planning, counselling, referral of high-risk pregnancies, and bi-monthly facilitation of group antenatal care sessions • Postnatal care: conduct monthly home visits for counselling on danger signs, breastfeeding and nutrition, and postpartum contraception • Child health management for children under 2: conduct monthly home visits for age-appropriate counselling, and basic treatment and referral of sick children • Non-communicable diseases: follow up for medication adherence and referral based on symptom screening

Cost Effectiveness and Analysis

Vaughan, Kok, Witter, Dieleman, 2015 states the term "cost-effectiveness" refers to a type of study where "both the costs and implications of health programs or treatments are assessed" (Vaughan *et al.*, 2015). When comparing two programmes or scenarios, intervention A is said to be "cost-effective" when its program cost per effective unit is

lower than that of intervention B. The term "cost-effective" can also be used to compare anything to a standard or benchmark. The change in desired outcome brought about by the intervention or program is referred to as effectiveness or benefits (Vaughan *et al*, 2015). To assess a program's cost-effectiveness, realistic, comprehensive estimations of the expenses of CHW programmes are now required. Given the full spectrum of program costs vs available resources, costs analyses can give decision-makers the knowledge they need to decide which programs under consideration are feasible to introduce and which ongoing programs are feasible to retain (Mirambeau, Wang, Ruggles & Dunnet, 2013). Costs remain an important factor in the administration and facilitation of any programme. The below table depicts the costs analysis, which includes advantages and disadvantages based on 3 possible scenarios for Alternative CHW Programme Implementation (Mirambeau, Wang, Ruggles & Dunet, 2013).

Table 3.6: CHW (Community Health Worker); PHC (Primary Health Care)

Scenario 1: Adjusted salary	Pros: Lowering the wage provided to CHW's may avoid perceptions of salary inequity between cadres in the health sector and improve integration of a new cadre Cons: Wages in the current pilot programme are competitive for local market and ensure dignified, equitable, and rights-based labour practices. Decreasing the salaries may have adverse effects upon socioeconomic status and empowerment	\$2.39
Scenario 2: Municipality governance	Pros: Municipal administration may enhance integration with local PHC and ownership by local governance. Cons: In new federal system, oversight of health governance between local government and district health office is not fully clear. This could cause challenges with oversight. Additionally, this could lead to challenges with supportive supervision, training, M & E, or supply chain and other support for CHW's	\$1.69
Scenario 3: PHC facility integration	Pros: PHC administration could further integrate CHW's to local facilities, fostering improved coordination and linkages between community based and facility-based services Cons: PHC staff already experience challenges with bandwidth, capacity, training, and absenteeism, and may not be capacitated to provide necessary supportive supervision, training and other programmatic support to CHW's	\$1.07

Program implementation would see an average of US\$3.05 per capita, and this high cost was mainly due to the human resource and transportation. Based on the above figure which displays 3 possible scenarios, we see a significant decrease in the per capita costs. The first scenario shows where CHW's would receive an adjusted annual salary, which equated to US\$1,829.36, which is regarded a minimum wage according to Nepal Labour Act, this scenario would allow for the decrease in the overall program costs of about 21% from US\$3.05, to move it to a per capita of US\$2.39. The merger of primary healthcare facilities and local governance institutions results in lower per capita expenses in scenarios two and three. It is anticipated that public sector staffing will partially offset the administrative costs associated with the management of the CHW program.

These would not be included in the projected per capita cost because they would be unanticipated implementation costs. In the second scenario, we discover that the program is administered by the municipal health care units, and that expenditures have decreased by about 30%, with US\$1.69 being the per capita cost.

In the third case, CHW integration into neighborhood basic healthcare institutions results in a 36% reduction in costs per person, or US\$1.07 (Nepal, 2020).

3.8 SOUTH AFRICAN CONTEXT

The Community Health Worker (CHW) programme in South Africa has played a crucial role in the provision of healthcare services for many years. Community-based health workers have played a significant role in enhancing the health and socioeconomic results of communities for a considerable period of time. (Department of Health, South Africa, 2018:10). The initiative exhibits diverse modes of implementation, but it adheres to a robust national framework that has been in place since 2011 and was recently updated in 2018 (Murphy, Moola, Kgowedi *et al.*, 2021).

A total of 84% of the population in middle-income South Africa has access to healthcare thanks to a tax-funded public health system. The other sixteen percent receives care in a separate private system that is subsidised by pricey private health insurance and contributes to notable disparities in health care costs. Nurse-based PHC access is a reasonable alternative for South Africans, though, as 90% of them reside within 7

kilometers of the nearest public clinic (McLaren, Ardington & Leibbrandt, 2014). In spite of this, South Africa continues to have extremely high rates of avoidable mortality due to the burdens of injury, violence, and non-communicable and communicable diseases. Since much of this load may be prevented, the preventative and promotional measures of the PHC system need to be strengthened right away.

CHWs should play a larger position in primary healthcare, according to recent public health suggestions, especially in sub-Saharan Africa (Singh & Sachs, 2001; World Health Organisation 2012). As previously stated, global health experts view community health workers (CHWs), who are unlicensed laypeople with some training in health care delivery, as crucial to providing comprehensive primary health care globally. (Commeto & Witter 2013). Boerma & Siyam 2013 points out that middle- and low-income nations striving to adhere to international health policy frameworks place a high focus on finding affordable ways to enhance CHW effectiveness.

According to Singh & Sachs (2001), plans for growing CHW programmes place a strong emphasis on the cost-effectiveness of hiring and training CHWs as well as the potential for quickly scaling up CHW operations. There is a dearth of research defining the elements of these programmes' effective implementation, which restricts the body of evidence supporting their effectiveness (Kangovi, Grande & Trinh-Shevrin, 2015).

Naimoli, Frymus, Wuliji, Franco & Newsome (2014); van der Ruit (2019:3) define CHWs as individuals who provide health services and are tasked with providing "a defined role within the community system and larger health system, and who receive standardised training outside the formal nursing or medical curricula to deliver a range of basic health, promotional, educational, and outreach services."

Many low- and middle-income countries (LMICs) have increased their investments in CHW programming in the hope of developing more open, just, and people-centred health systems as a result of the push to meet the MDG's by 2015 (Frenk, Chen, Bhutta, Cohen, Crips *et al*, 2010), current discussions surrounding the post-2015 deadline, and the introduction of Universal Health Coverage. How to maintain this vital cadre of the health workforce's optimal performance at scale is a key concern for CHW programming. Yet,

the strength of the study evidence on the best and most productive methods to guarantee such performance is limited (Naimoli, Frymus, Quain & Roseman, 2012).

CHW programmes increase access to resources, which promote equity, providing health treatment in rural locations and serving as a bridge between marginalised communities and the official health system (Schneider, Hlophe & van Rensburg, 2008). National CHW programs need careful consideration, planning, and considerable support if they are to make a significant impact on health improvements and reach their full potential (Lehmann & Sanders 2007; Pallas, Minhas, Peraz-Escamilla, Taylor, Curry, Bradley 2013; Naimoli, Frymus, Wuliji, Franco, & Newsome 2014; Meyer 2020). They must be incorporated into PHC systems while also becoming part of and receiving support from the communities. What strategy then should be used to strengthen national CHW programs? McCord et al. (2013) suggested that Community Health Worker (CHW) programs should be considered as a component of the broader health system, employing the World Health Organisation's (WHO) "building blocks" framework. Their strategy encompasses several elements such as service provision, personnel planning, information technology, supply chains, financing, leadership, and governance, with the aim of enhancing CHW programs. One strategy to addressing the issue of governance in CHW programmes is to define the architecture, links, decision-making, and participation structures of the programs, as suggested by Lewin & Lehmann. This encompasses the extent of decentralised decision-making, mechanisms for community involvement, and the question of whether Community Health Workers (CHWs) should be seen as a distinct entity or integrated into the official health system (Lewin & Lehmann 2014). According to Lewin & Lehmann, "because CHW programs are located between the formal health system and communities and involve a wide range of stakeholders at local, national, and international levels, their governance is complex and relational." Governance and management overlap as well, with management being "more concerned with running or implementing programs" (Lewin & Lehmann, 2014).

When taken as a whole, these diverse theories regarding the governance of CHW programs and related concepts such as strategic management, leadership, and implementation suggest a set of decentralised activities encompassing policy and system development, participation and coordination structures and mechanisms, and program

execution. They are interested in the "how" of implementation and scaling up as well as the "what" of CHW programme policy. Particularly, CHW programmes necessitate involving a more diverse and complicated group of participants than is typically the case with other health sector sub-systems, reaching into communities. Nevertheless, CHW initiatives keep growing and changing, frequently including a range of promising but unproven support measures (Crigler, Hill, Furth & Bjerregaard, 2011). Further research is needed to find the optimum strategy for ensuring optimal CHW performance at scale, as LMIC governments are increasing domestic health spending and donor financing for the health sector is changing (Dieleman, Murray, Haakenstad, Leach-Kemon, Baral, Graves *et al.*, 2014).

A programme theory is defined as, "*an explicit theory or model of how an intervention, such as a project, a program, a strategy, an initiative, or a policy contributes to a chain of intermediate results and finally to the intended or observed outcomes*" (Funnel & Rogers, 2011:10). A logic model depicts the intended causal linkages and interconnections between the actions and outcomes of a program (WK Foundation, 2004).

Logic models usually contain contextual elements that could have a positive or negative impact on how a program is implemented and how well results are achieved. Although the logic model's conceptual foundations can be found in program evaluation research, its application today is much more widespread (Rogers, Petrosino, Huebner & Hacsí, 2000). It can direct operational research, assessment, monitoring, and program design. Academics, governmental organisations, non-governmental organisations, and evaluation professionals have become increasingly interested in using causal models during the past two decades, especially in industrialized nations (Rogers, Petrosino, Huebner & Hacsí, 2000).

A variety of Community Health Worker (CHW) programmes were implemented in low- and middle-income nations during the 1970s, as documented by Gilson (1990). Nevertheless, interest waned in the late 1980s and early 1990s due to several factors, such as the ineffectiveness of governments lack countries with major programmes, structural adjustment programs, and changes in ideology (Gilson 1990). South Africa has a significant historical background of Community Health Worker (CHW) programs that

flourished under the repressive apartheid period. In this politically and racially divided system, healthcare was not allocated adequately (WHO, 1983). One of the earliest Community Health Workers (CHWs) were individuals known as malaria assistants. They received training in the late 1920s from G.A. Park Ross, who was a top health officer in Zululand and Natal (MacKinnon, 2001). "Health center" activists emerged in the 1940s, opposing the early Smuts government's promotion of racial segregation. Henry Gluckman, the ex-minister of health, was one of the politicians who had the greatest direct involvement. The Beveridge Report, published in 1942 in the United Kingdom, had a significant influence on him. The Gluckman Report of 1945 and the National Health Service Commission of 1942 aimed to deliver comprehensive healthcare to all segments of the South African population, establishing ambitious benchmarks for their objectives. The concerns over the potential impact of poor health on the efficiency of Black migrant laborers and miners prompted them to tackle both the social and biological factors contributing to illness (Phillips, 1993).

3.8.1 The inception of CHW programmes

NGO's or rural health projects were frequently motivated by people's desire to improve the health of the underserved black majority. While blacks found it difficult to develop such infrastructures due to oppression and poverty, most of these projects were led by white doctors or nurses. One exception to this was Mamphela Ramphele's Ithuseng health centre initiative (Wilson & Ramphele, 1990). Religious conviction or remorse over their luxury in comparison to their racially oppressed black counterparts served as motivation for involvement at times. Many programs' founders have stated that their initiatives came up at a time when protests and uprisings against apartheid were becoming increasingly common. Black people's access to healthcare was not expanded as promised by the 1977 Public Health Act.

The Second Carnegie Investigation into Poverty and Development in South Africa (1984) found that the health and social problems faced by the black majority deteriorated. The increasing frustration ultimately resulted in the initiation of several projects (Wilson & Ramphele 1990). In order to prioritise the most urgent requirement at the time, CHW programs often commenced as individual interventions (Table 7). The Elim Care Groups addressed the issue of trachoma, a condition that leads to blindness, under the guidance

of Erika Sutter, a Swiss ophthalmologist. Under the guidance of doctor Trudy Thomas, the Newlands and Chalumna initiatives implemented a nutrition program to specifically target kwashiorkor, a form of protein-energy malnutrition. As a result of the effectiveness of these isolated initiatives, the broader health issues faced by communities were subsequently tackled.

Katzenellenbogen, Hoffman & Miller (1990) state that the Alma-Ata declaration (1977) and subsequent global community health programs were influenced by the Community Oriented Primary Care (COPC) model pioneered by the Karks in South Africa. Furthermore, it had an impact on subsequent South African initiatives. The Karks' visits to Johannesburg and Durban in the 1980s and 1990s were essential in revitalising COPC-based monitoring and research programs among researchers. The University of Witwatersrand Health Systems Development Unit conducted participatory research at the Mamre site in the Western Cape and the Agincourt site in Gazankulu, which is currently located in Limpopo Province. This research resulted in the generation of a significant amount of information regarding community health needs (Tollman 1999). The Karks model has a diminished impact on project managers involved in non-academic civic initiatives. Despite being subject to international sanctions, South Africa's founders of the initiative recognised and supported the concepts discussed and endorsed at the Alma Ata summit.

In South Africa, there is an ongoing effort to reposition a community care system that is very diverse and loosely structured, with a focus on HIV/AIDS and tuberculosis (TB), in order to build a systematic, complete, and integrated CHW program. Most community-based groups that acted as intermediaries in the community care system received funding from the government through dedicated budget allocations for HIV/TB. In 2010, the Minister of Health formed a "PHC Re-engineering" Task Team with the aim of developing recommendations for the reorganisation of community-based services. This initiative was motivated by the achievements of the Brazilian Family Health Programme (Schneider & Nxumalo, 2017).

Table 3.7 below depicts the timeline of the CHW projects/ programmes historically in South Africa

Table 3.7: Timeline of CHW projects and historical landmarks in South Africa.

Date	Event
1913	Natives Land Act (7.3% of South African land dedicated for Africans' habitation)
1930s	Park Ross: Malaria assistants
1940s	Revival of African nationalism. African National Congress (ANC) rebuilt
1940	Pholela Health Unit founded by the Karks (KwaZulu)
1942–1944	National Health Services Commission
1945	Gluckman Report: intersectoral recommendations for comprehensive health service. Only health centres and IFCH established.
1948	Nationalist Party comes to power
1951	Bantu Authorities Act: forcible relocation of blacks to 'homelands'
1951	Valley Trust established
1958	Karks' exodus
1960	Sharpsville massacre; ANC and Pan African Congress (PAC) banned.
1970	Chalumna/Newlands project started
1976	Soweto uprising: sparks nationwide uprisings
1976	Elim Care Groups started
1977	Steve Biko (leader of Black Consciousness Movement) tortured/dies in detention
1977	Public Health Act: dual/segregated healthcare
1979	Health Care Trust–VHW project started
1980	Valley Trust establishes CHW programme; SACLA clinic
1982	National Medical and Dental Association founded to address human rights
1985–1986	3 states of emergency: detentions/repression/assassinations
1986	SACLA clinic taken over by army
1986	Mamre Community Health Project and Rural Foundation Health Project started
1987	National Progressive Primary Health Care Network founded
1989	Relaxing of emergency laws
1990	ANC/PAC unbanned; progressive release of imprisoned leaders (including Mandela)
1991	Mamre/Zibonele projects start CHW programmes
1992–1994	Preliminary ANC health plan; national CHW workshops/conferences

Date	Event
1992	HCT– Brown's Farm and Agincourt started (CHWs until mid-1990s)
1994	First democratic elections (Mandela elected); final health plan
1994–2003	Social/health policies promoting development and intersectoral collaboration (e.g. 1994: Reconstruction and Development Programme); Many late-apartheid CHW programmes close
2004	Community Health Policy Framework

Source: Author's own

In 1948, the government withdrew its funding for these institutions as the Afrikaner National Party grew. There were several founders, including the Karks, who fled into exile because of the closure of numerous centres (Marks 1997). Medical care for black people who are displaced by force was the duty of the "homeland" government from the 1960s until the 1980s, when the Bantustans (or "homelands") became "independent" (Van Rensburg & Harrison 1995).

As a result of their poor financial situation and corruption, the majority of these administrations failed to support health care. The establishment of a second phase of CHW initiatives, largely by individuals or modest civic or religious organisations, started in the 1970s and lasted into the 1990s (Tollman & Pick 2002). Beginning in the late 1980s, there was a rising belief that apartheid would shortly come to an end, especially after African nationalist organisations were allowed to operate and their leaders were freed. This inspired academics and progressive thinkers to create community projects and offer recommendations that they thought would influence a future government's health policies (Price 1993; Baldwin-Ragaven, London & de Gruchy, 1999)

South Africa's first democratic administration was inaugurated in 1994. Despite the 'District health system' (DHS) being the foundation of the government's national health plan, CHWs were left out. As a result, many CHW projects failed when foreign funders stopped supporting them or diverted their money through government agencies. An unorganised array of CHW programs has re-emerged in recent years, mostly in the context of healthcare for HIV/AIDS patients (Friedman, 2005). The early history of the CHW projects from the 1930s and 1940s has already been examined elsewhere (Jeeves, 2000).

Table 3.8: PERI-URBAN INITIATIVES AND RURAL INITIATIVES

Project	Comments	CHW characteristics	Current Status
(PERI-)URBAN INITIATIVES			
South African Christian Leadership Assembly Health Project	CHW programme in several peri-urban townships in Cape Town	Paid; generic and specialist (rehabilitation)	Running
Mamre Community Health Project	Coloured community. 3 components: research, CHW project, student teaching (academic)	Paid; specialist (youth, chronic illnesses, hypertension)	Closed
Health Care Trust – Brown's Farm Project	Peri-urban township in Cape Town	Paid; generic	Closed
Zibonele	Peri-urban township in Cape Town (academic)	Paid; specialist (women, children)	Closed
RURAL INITIATIVES			
The Elim Care Group Project	Originally focussed on trachoma, then expanded to general health (Northern-Province)	Most volunteers; generic: (care-group volunteers, motivators, CHWs)	Running
Chalumna and Newlands Village Health Worker Project	In the former Ciskei (Eastern Cape) Focus on nutrition, immunisation, TB	Stipend; generic	Closed
Health Care Trust – Village Health Worker Project	Xalanga district in the former Transkei (Eastern Cape)	Volunteers; generic	Closed
The Valley Trust Community Care Project	CHW project: part of Valley Trust – a large influential organisation, Kwazulu-Natal. Focus on health and ecology.	Volunteers then paid; generic	Running
The Rural Foundation Health Programme	Nationwide CHW programme for farm workers (started in Transvaal)	Paid by farmers; generic	CHW programme closed
National Progressive Primary Health Care Network	Umbrella organisation for progressive community health projects. Set up a CHW National Training Centre.		Closed
Agincourt	Community health project with a focus on surveillance in Gazankulu (academic)	Paid research assistants	Running
The Elim Care Group Project	Originally focussed on trachoma, then expanded to general health (Northern-Province)	Most volunteers; generic: (care-group volunteers, motivators, CHWs)	Running

Source: Author's own

Late in the 1980s, the environment improved for information interchange. Anti-apartheid activism and health activism both grew. PPHCN, or the Progressive Primary Health Care Network, is an alliance of local community health organisations. With assistance from the National Medical and Dental Association and the Kaiser Foundation, it expanded project cross-fertilisation and collaboration in order to create a future primary healthcare plan (Kaiser Foundation, 1988).

3.9 CHAPTER SUMMARY

Naturally, increasing the population served by CHW programmes entails scaling them up, but it can also mean enhancing their quality and introducing new elements to ones that already exist. A pilot programme's or a more widely implemented programme's experience is frequently built upon during a scale-up.

Therefore, it's crucial to take into account the identities of all the stakeholders, how their roles will develop or alter in the new programme, and any training requirements that may arise while planning the adaption or expansion of a CHW programme. Furthermore, it is crucial to take into account who the most suitable mentors and trainers are for each stakeholder. In addition, it is crucial to take into account international best practices that are pertinent to the updated programme as well as the policy, regulatory standards, and expectations for a specific setting.

Given the necessity for stakeholders to adapt their roles as programs expand, it is evident that training requirements extend beyond CHWs alone. Indeed, a significant aspect of training pertaining to the expansion of CHW programmes frequently involves the instruction of various other primary healthcare personnel, including nurses, physicians, as well as supervisors and administrators operating within health systems at the district, regional, and national levels. Providing training to these additional cadres can facilitate their comprehension of successful collaboration and support for CHWs, while also mitigating apprehensions over potential competition, confusion, or compromised quality of service within the current healthcare system. The scale-up of CHWs at both national and mid-levels necessitates the provision of training and assistance to managers and supervisors responsible for managing these programs across many tiers. The

comprehensive primary healthcare (PHC) system necessitates adaptation in response to the introduction and expansion of CHW programmes.

The relationship a CHW has with the community is what determines how effective they are. Programmes must take all possible measures to bolster and nurture this relationship. The social complexity of communities and the fact that no two communities are exactly alike must first be acknowledged by programme planners. Depending on alternative job options, prior experience with CHWs, the local economy, and other variables, various communities will require different kinds of incentives. Regrettably, there isn't much knowledge or advice available about how to distinguish communities. In other words, programme planners are often left to implement a programme and to monitor its effectiveness based on how it achieves the desired objectives. It is a trial and error which needs to be constantly improved for optimum results.

It is completely appropriate to provide an update on national CHW programmes from a global viewpoint, given the potential that these programmes now have to accelerate progress toward reaching global health goals.

The next chapter outlines the recruitment and selection process of CHW.

CHAPTER: FOUR
RECRUITMENT AND SELECTION PRACTICES FOR COMMUNITY HEALTH
WORKER PROGRAMMES

4.1 INTRODUCTION

This chapter describes the overview of the practices related to the recruitment and selection for CHWs. Recruitment is a crucial process for any organisation, and it often involves various steps and phases before an actual appointment has been made. The chapter begins with understanding regulatory frameworks that promote and ensure responsible recruitment and selection for CHWs. The needs and objectives of an institution need to be considered as well as the vision. The line manager is usually up front and centre in the appointment of a new candidate and it is important to make the correct fit regarding long-time appointments. The chapter will begin by providing a clear definition of what recruitment is. It is important to highlight it to give the reader a clear view of what the chapter entails.

The chapter further discusses the selection process, which is fundamental and is what mainly sets companies apart from each other. If human resource planning of an institution is effective, appointments made will prove to be the best. HR mainly has four phases, each phase will be explained in detail as it plays a significant role in the recruitment and selection process. Both the processes of recruiting and selection can incur significant costs. Consequently, in situations where financial resources are constrained, careful deliberation is required to determine the allocation of the human resources budget. One could posit that in a situation where there is a scarcity of applicants, human resource management should prioritise recruitment efforts. Conversely, in a scenario where there is an ample pool of applicants but worries over their quality exist, the focus of human resource management should shift towards selection processes (Brown, McManus, Davison, Gill & Lilford, 2019).

As with any research dimension, there is often law and legislation which governs and sets guidelines of how recruitment should be to be fair and observe human rights. Therefore, the legislative surrounding recruitment will be discussed. The chapter further discusses in details recruitment of the CHWs and what the selection criteria is used to maintain

retention. The chapter ends by giving a conclusion and highlights of the chapter and briefly outlines what the reader can expect in Chapter 5.

4.2 LEGAL AND REGULATORY FRAMEWORK

This section examines the legal and regulatory framework that influences the recruitment process. Each nation will employ distinct methodologies. Engaging recruiting officers at an institution may appear to be a straightforward process in the construction of a CHW programme. Recruitment results differ among countries due to the absence of consistent rules for the selection process (Shakerian & Gharanjik, 2023). The process of recruiting and selecting CHWs to assist and occasionally take charge of health programs is a well-established method in health promotion practice (South, Meah, Bagnall & Jones, 2013). Practices play a crucial role in all administrative operations, particularly when it comes to appointing the community. Institutions function within a framework of legal norms and regulations to protect the interests of both candidates and employers.

The recruitment sector has two legally defined types of service, the person who will attract prospective employees and the person who will engage staff under his or her supervision. Having such functionaries is important to ensure that specific rules and procedures are followed to fill the posts. Workplace practices are not static, and this requires HR managers to keep up to date with the latest legal and regulatory changes in their market. In this regard, planning is essential for recruitment and selection process. An inadequately implemented recruitment procedure might incur significant expenses - the failure to fill vacant posts leads to a decrease in productivity (ILO, 2023:1). The procedure should adhere to the principles of good governance (ILO, 2023:1). The recruiting process must adhere to principles of fairness, transparency, and consistency in order to ensure the selection of the most suitable candidate for each position (ILO, 2023:1).

In order to maintain consistency, it is necessary for the HRM to possess an authorised recruiting policy that incorporates an official declaration of the goal, values, and principles of staff recruitment within the organisation. The International Labour Organisation (2023:1) states that the recruitment policy may encompass the following:

- an introduction, and policy statement;
- qualifying criteria;

- the organisation's position on internal applicants;
- legal information;
- a recruitment process description;
- criteria that govern the utilisation of temporary and contractual personnel, and
- certain criteria (ILO, 2023:1).

An institutional recruitment policy needs to have a policy statement. A policy statement should be a concise and clear declaration that outlines the criteria for recruitment, typically based on merit (ILO, 2023:1). It is crucial to consider this aspect while hiring new staff members. The policy should include specific criteria for qualification, such as measures against discrimination and ensuring equal opportunities (ILO, 2023:1). Candidates may express dissatisfaction with the outcome of the selection process. The recruitment policy shall delineate the procedures that must be adhered to in the event of uncertainties or grievances. It is crucial to verify that the text of all documents adheres to employment legislation, specifically with discrimination and employment contracts (ILO, 2023:1).

4.2.1 Key Legislation

The following pieces of legislation are key in this regard:

- Constitution of the Republic of South Africa, 1996 (Act 108 of 1996);
- The Public Service Act, 1994 (Act 103 of 1994);
- Basic Conditions of Employment Act, 1997 (Act 75 of 1997);
- National Health Act, 2003 (Act 61 of 2003);
- Intergovernmental Relations Act, 2005 (Act 13 of 2005);
- Occupational Health and Safety Act, 1993 (Act 85 of 1993 as amended);
- Non-profit Organisations Act, 1997 (Act 71 of 1997);
- The Skills Development Act, 1998 (Act 97 of 1998);
- Promotion of Access to Information Act, 2000 (Act 2 of 2000);
- The Children's Act, 2005 (Act 38 of 2005), and the
- Division of Revenue Act.

Chapter 2 of the Constitution of the Republic of South Africa includes the Bill of Rights, which mandates the State/Department of Health to implement appropriate laws and actions to guarantee that all citizens have access to healthcare services. Section 27 of

the law guarantees the entitlement to healthcare services, food, water, and social security. On the other hand, Section 24 ensures that all South Africans have the right to an environment that does not pose any harm to their health or well-being.

The main purpose of the legislative framework in recruiting and employment practices is to prevent bias or discrimination and to ensure that equitable job opportunities and appointments are based solely on merit. The Public Service Act is a regulatory framework that governs the terms and conditions of employment in the public service of South Africa. The Skills Development Act is pertinent to the career trajectory of Community Health Workers (CHWs), particularly in relation to learnerships and skills programmes. Several significant difficulties have arisen in relation to the recruitment process in South Africa (Warnech *et al.*, 2015).

- *The Employment Equity Act, 55 of 1998*

The Employment Equity Act (EEA) regulates unjust discrimination in the working environment. Under the Employment Equity Act, employers are prohibited from publishing job advertisements that discriminate against candidates based on any of the grounds specified in section (61) of the Act. This legislation is broken into two primary components. The first piece primarily addresses affirmative action, while the second section addresses unjust discrimination that may occur in a workplace setting. When combined, it may be stated that the two elements are interconnected, as an employer would not be able to effectively enforce affirmative action if there is widespread unjust discrimination within the company.

Hence, the European Economic Area (EEA) imposes a duty on employers to actively identify and eradicate any form of unjust discrimination in the workplace, and to clearly outline this commitment in their policies and procedures. The recruitment process commences with the implementation of the EEA, which safeguards job seekers against unjust discrimination and biased medical and psychometric evaluations. In the context of the European Economic Area (EEA), a job applicant refers to an individual who has submitted an application for a position with an employer. The Promotion of Equality and Prevention of Unfair Discrimination Act, 4 of 2000, should address unfair discrimination that occurs outside of job relationships.

- *The Human Rights Act 1993*

The Human Rights Act of 1993 safeguards individuals from many forms of discrimination throughout all aspects of life. Discrimination is the act of treating someone in an unjust or less advantageous manner compared to another person who is in the same or comparable situation. Each employer is legally responsible under the Act to provide an explanation for its actions.

4.2.2 Key Policies and Strategies

The emphasis on community support makes assessing the functionality of CHW programs increasingly important (Peynetti, 2016). The creation of community health workers was encouraged by the Alma Ata Declaration of 1978, which emphasised the need of community involvement in health. The following are key policies and strategies influencing the recruitment and selection processes:

- World Health Organisation: Health in all policies (HiAP) framework.
- National Policy on Community Health Workers, 2004.
- National Development Plan (NDP) 2030.
- National Health Insurance (NHI) in South Africa White Paper.
- National Department of Health Human Resource for Health (HRH) Strategy: 2012/2013 – 2016/2017.
- National Department of Health Strategic Plan 2014/2015 – 2018/2019.
- Provincial guidelines for the implementation of the three streams of PHC re-engineering.
- Ten Point Plan of the National Department of Health.
- Whitepaper for the Transformation of the Health System, 1997.
- District Health Management Information System (DHMIS) Policy.
- National Environmental Health Policy of 2013.
- HRH Strategy for the Health Sector.

The task of visualising and implementing improvements in the health workforce is influenced by the health, policy, legislative, and economic settings. The ‘1978 Alma-Ata Declaration’ represented a worldwide acknowledgment of the capacity of Community Health Workers (CHWs) to establish a solid basis for primary health care (PHC). Many countries initiated national Community Health Worker (CHW) programmes in the early 1980s, motivated by this goal (Perry, 2020).

4.2.2.1 National Policy on Community Health Workers, 2004

The National Policy on Community Health Workers (NDoH, 2004) was introduced in 2004 and its concept is based on the following five imperatives:

- The President's declaration of a people's agreement to combat poverty and generate jobs.
- The government's resolve to enhance the provision of services.
- The national plans for skill development and human resources.
- The growing complexity of the problems associated with poverty and the burden of diseases.
- The growing demand for community-based, home-based, and health promotion programs (NDoH, 2004).

The framework was created by the national Department of Health (DoH) in collaboration with other government departments, provinces, municipalities, non-governmental organisations (NGOs), academic institutions, other civil society organisations, the Health and Welfare Sector Education Training Authority (HWSETA), and the South African Qualification Authority (SAQA) (Friedman, 2005).

Zembe (2009) proposed a strategy that involved the extensive utilisation of Community Health Workers (CHWs) and emphasised that their function should extend beyond simply improving and expanding South Africa's healthcare system. The government's significant departure from conventional CHW concepts, which previously confined CHWs to delivering fundamental primary health care services aimed at disease prevention, health promotion, and in-home hospice care for the ill, is evident in the national policy on CHWs (NDoH, 2004). The initiative (NDoH, 2004) has brought about a considerable transformation in transitioning from single-purpose to generalist CHWs. The strategy enabled improved professional advancement prospects for Community Health Workers (CHWs). In addition, it presents new criteria for selecting Community Health Workers (CHWs) based on established norms (Zembe, 2009).

4.2.2.2 Logistics of the CHW programme

The National South African Community Health Workers Policy (NDoH, 2004) provides a clear definition of the roles and responsibilities of CHWs, outlines the criteria and process

for their selection and recruitment, specifies their remuneration and training, and establishes the recommended approach for managing them. The policy addresses two concerns regarding the selection and recruitment of CHWs: the process of selecting them and the criteria used for selection (Zembe, 2009).

The policy framework also provides how CHWs are allocated to respective programmes. These are outlined below as follows:

- Fully trained generalist CHWs would receive a minimum stipend of R1 000.
- In rural areas each CHW would cover from 80 to 100 households, the corresponding number being 100 to 150 households in urban areas.
- The maximum number would be 250 households to ensure that quality is not compromised.
- A geographic information system (GIS) would be developed together with a directory and operational monitoring and evaluation system (Department of Health, South Africa, 2004).

The health sector as an essential service providers is also affected (Department of Health, South Africa, 2011:10). In order to improve the implementation of community-based health professionals, this policy framework and strategy provide the vision, mission, goals, and objectives. The priorities set out by South Africa for the burden of disease align with the work that CHWs do. One thing to bear in mind is that the organisation's mission and values should be carefully reflected in the recruitment policy.

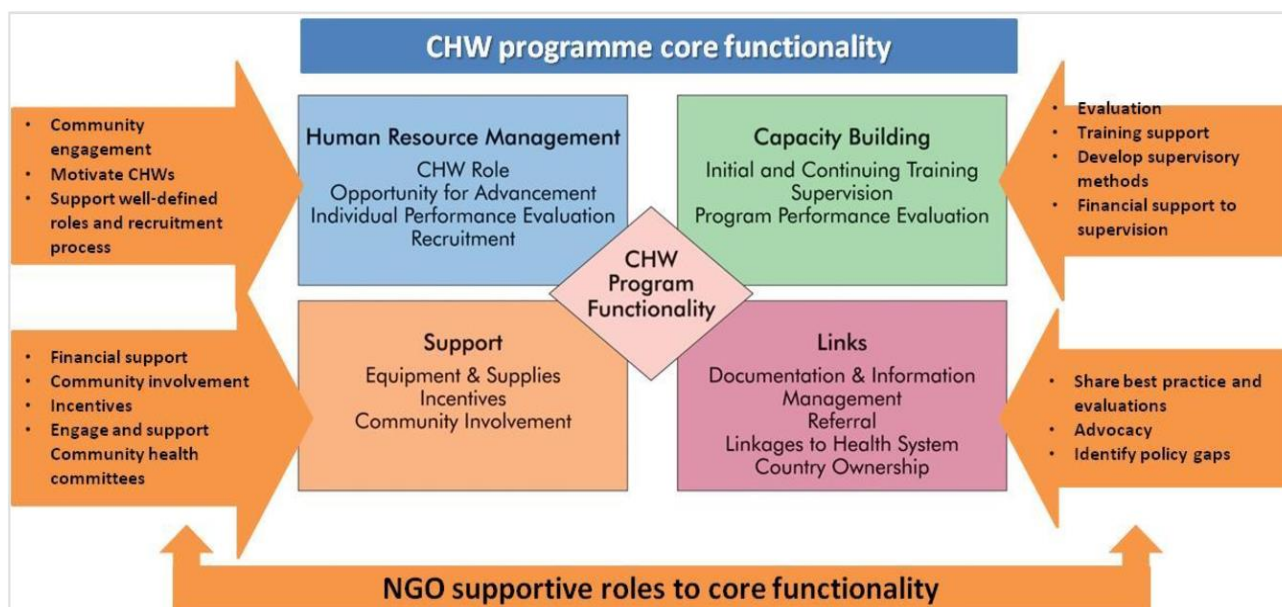
Fair processes are also essential to avoid discrimination and to be legally compliant (ILO, 2023:1).

4.3 HUMAN RESOURCES FOR HEALTH

Human resources for health are recognised as one of the fundamental components of a health system, according to the World Health Organisation (WHO, 2006). The individuals encompassed in this group consist of physicians, nursing professionals, pharmacists, midwives, dentists, allied health professions, community health workers, and other social service and health care providers. Health human resources consist of health management and support staff, as stated by the World Health Organisation in 2006.

Figure 4.1 below displays the CHW capabilities matrix and the NGO support mechanism. The figure illustrates the importance of hiring Community Health Workers (CHWs) in the healthcare industry. The figure illustrates the functions, incentives, and selection process of Community Health Workers (CHWs).

Figure 4.1: CHW AIM functionality matrix and NGO support mechanism



Source: Hodgins, Crigler and Perry, 2013:7

When one talks about human resource management, it is important to understand the role that managers have. The key role of the leadership of the health sector at all levels is to ensure a health care environment where the health workforce is valued and supported and could develop while providing high quality care (Department of Health, South Africa, 2011:56). HR managers need to consider the internal and external factors when they plan to obtain new staff. These factors comprise of:

- Internal Factors: Cost of hiring, size of the company, human resource planning, growth, and expansion; recruitment policy
- The following are examples of external factors: labor market, supply and demand, political, social, and legal aspects, environment, unemployment rate, and competitors (Al-Harerat & Halaseh, 2019).

HHR, or Human Resources for Health, encompasses various areas including workforce planning, policy evaluation, recruitment and retention, training and development of skilled

personnel, performance management, health workforce information systems, and research on health workforce strengthening (Gupta, Balcom, Gulliver & Witherspoon, 2021).

The delivery of service is accomplished by the utilisation of knowledge, training, education, skills, and the experience of the company's employees, which can be effectively applied (Dessler, 2013; Molley & Ployhart, 2012). On the other hand, the HRM is challenged with the increasing rate of global shortage of certain skills for highly qualified, knowledgeable workers which is on the increase (Gratton, 2011; Meister & Willyeard, 2010). Shortages of skilled health workers are also reported in many specific care areas (Gupta, Balcom, Gulliver & Witherspoon, 2021). On this regard, HR managers are required to undertake the following to strive by:

- ensuring that the goals in the strategic plan are achieved;
- coping with future staff requirements which could be a result of external or internal change, and by
- ensuring the correct supply and mix of qualified staff (Coetzee & Schreuder, 2016).

Based on the above points, institutions need to have staff that will work together to achieve the organisation's goals. Institutional goals are realised through five basic functions, which include planning, organising, staffing, leading as well as controlling. All these functions are imperative as they represent the management process.

4.3.1 Planning and Leading

Workforce planning in many institutions is challenging and complex (ILO, 2023:1). The strategic planning process consists of several key elements, it is important that it adds to the organisations ability to add value to the marketplace (Coetzee & Schreuder, 2016:73). The tool offers health managers a structured approach to make staffing decisions in order to effectively manage their workforce. It utilises activity criteria for each workload component at a specific health facility, taking into account a health worker's workload. (WHO, 2006). Setting objectives and benchmarks, which involves creating precise regulations and protocols, as well as formulating strategies and predictions. Human resource planning must align and maintain consistency with the overarching strategies of an organisation's human resource department.

The human resource planner is typically responsible for anticipating the skills and abilities that the employer will require in order to fulfill the relevant criteria (Coetzee & Schreuder, 2016:73). The function of a manager is crucial in upholding morale and inspiring subordinates (Dessler, 2014:39).

4.3.2 Organising, Staffing and Controlling

HRM establishes channels of authority and how communication is expected to be like (Dessler, 2014:39). In terms of staffing, managers determine what type of people need to be hired and trained (Dessler, 2014:39). Recruitment and training of clinical and community volunteers is one of the HRM role in the health sector (Gupta, Balcom, Gulliver & Witherspoon, 2021). Controlling puts pressure on the manager to monitor the actual performance based on set standards (Dessler, 2014:39).

The following sections outline the recruitment and selection process for CHWs.

4.4 RECRUITMENT PROCESS

Recruitment is the process of “identifying and attracting a pool of candidates who will be selected to receive employment offers” (Coetzee & Schreuder, 2016:87). Recruitment in institutions is a lengthy process which requires orderliness. Thebe and Van der Walddt, (2014) identified eleven common sequential steps to be considered in the recruitment process:

- Determine the need to recruit or ascertain whether a vacancy exists;
- Determine recruitment needs and vacancies;
- Remodel job descriptions, specifications, and profiles;
- Establish the important performance areas for job/recruitment planning;
- Refer to the recruitment policy and procedure;
- Research potential sources of recruitment;
- Select the right recruitment method;
- Create the recruitment advertisement and plan;
- Place the campaign in the most acceptable and suitable communication medium/enact a decision;
- Considering the availability of application blanks/ensuring a pool of prospective qualified applications/allowing adequate time for responses;
- Filter responses/screening, and

- Controlling and evaluating recruitment (Thebe & Van der Waldt, 2014).

The above mentioned steps are discussed in detail below.

4.4.1 Job analysis and Job specifications

The two processes are explained below.

4.4.1.1 Job analysis

Job analysis is typically the initial stage in the process of recruiting and selection. This is crucial for both organisations and applicants. This task involves determining the rationale behind a job position. The recruitment process begins with an assessment of the number of job vacancies and the distribution of a promotional message. The firm effectively recruits people who are highly qualified for its specific requirements. Through the process of identifying, examining, and effectively utilising the most appropriate sources of candidates. Recruitment contributes to the enhancement of both individual and organisational performance (Fathmath, Azam & Ahmad, 2021). Health Resources for Health (HRH) has been demonstrated to enhance health outcomes and functions as a means to accomplish the Sustainable Development Goals. There is much data to show that numerous countries worldwide continue to have challenges in training, distributing, and retaining healthcare professionals. According to the World Health Organisation (WHO) report from 2006, there is a significant global shortage of workers, estimated to be over 4.3 million. This shortfall is particularly urgent in approximately 67 countries. The scarcity of healthcare workers is exacerbated by evident disparities both within and within nations. Across several nations worldwide, there is a prevailing pattern of the health workforce being concentrated in prosperous metropolitan regions and significantly lacking in rural and impoverished areas. Hongoro and McPake (2004) found that high income countries have approximately three to four times as many doctors and nurses compared to lower income countries.

Regrettably, the uneven distribution of healthcare professionals poses a persistent obstacle to the attainment of national development objectives, particularly in the pursuit of universal health coverage. The scarcity of healthcare professionals in rural or remote places is primarily due to employee retention issues rather than a lack of recruitment

efforts (Dussault & Fransceschini, 2010). Managers must diligently focus on job analysis and strive for efficiency at this point.

4.4.1.2 Job specifications

A job specification is a “written description of the human characteristics necessary for the successful performance of a job” and is derived by performing a job analysis (Ellington, Brannick & Levine, 2015). If the job specifications are clear and realistic, it is often easier to match the skills and competencies of the applicants with the job requirements. In addition to its definition as the process of acquiring an adequate number of qualified individuals in a lawful manner, recruiting encompasses a range of activities and procedures aimed at ensuring that these individuals are positioned appropriately, at the appropriate time, and in the appropriate role. A job specification provides a “statement about the personal characteristics needed to perform the job successfully and achieve the necessary output” (Amos *et al.*, 2008). For job specification, the HRM will look for the following element on the characteristics of job specification. The element will include experience, ability, strengths, technical and assembly skills and behaviours, presented in Figure 4.2 below.

Figure 4.2: Recruitment and selection framework



Source: Author's own

The above elements all form part of a strategy in ensuring the correct skills are matched up with the correct job specification. It is important to be able to identify ones strengths and how their strengths can be utilised effectively. Experience gives confidence because of the knowledge gained through the exposure one may have been exposed to. Ability is an important element because there is a certain standard which is set which needs to be adhered to. If you cannot live up to that standard, one cannot be described as being an asset to the institution. The technical aspect includes the skills to perform the tasks, this is in a professional setting and involves knowledge and educational qualifications to perform the task at hand. Another important element in the recruitment and selection framework involves the assembly skills and behaviours. These behaviours may be learnt, but the actions people do result in effective performance in a job. This facilitates a mutual selection process between the individuals and the institution, ones' personal short-term and long-term interests (Warnich, Carrell, Elbert & Hatfield, 2015).

The objective of the recruitment process is to gather a pool of eligible and competent individuals. By implementing cost minimisation strategies, organisations can effectively meet their operational requirements while optimising resource allocation. In addition, the recruitment process encompasses an authoritative job specification which is required for a currently available post, outlining the primary duties and responsibilities, as well as the essential skills and qualifications necessary for the role.

4.4.2 Determining key performance areas and recruitment policy

HR planning, labour turnover and retention can sometimes be overlooked, especially when institution need to hire employees on an urgent basis.

It is important to note that without proper understanding of job analysis and HR planning, seen as one of the best channels to use for attracting candidates, selection decisions may be useless (Marchington & Wilkinson, 2012).

Before an organisation can start with its recruitment plan, it is imperative to have a recruitment policy in place. This policy will normally outline the governance mechanism of how the company aims to carry out the recruitment and usually provides guidelines for the selection process. Usually, a recruitment policy will include information pertaining the following aspects:

- Legal guidelines which will ensure that the employees are all treated in a fair manner and that there is no discrimination against anyone.
- A policy will also outline the urgency or time frame which the post needs to be filled.
- Whether the post will be for internal members or if external sources will be consulted.
- If family members or friends of employees who are already working in the organisation may be appointed.
- The policy will also outline which department or person will be responsible for the recruitment and selection process within the organisation (Nel, Werner, Botha *et al.*, 2012).

4.4.3 Recruitment methods

There are different methods of recruiting, since the jobs do not have the same requirements. Recruitment techniques are the instruments that a company uses to attract candidates. This can be accomplished by luring interns as an external source, with the possibility of transforming internships into full-time work. It is crucial for an organisation to know that it not only has people with the proper skills and expertise to meet its current goals and strategies, but that it also has human capital resources for the company's future growth (Robinson, 2006). The following are typical recruitment methods used by institutions:

- Direct advertising.
- Social media recruiting.
- Talent pool databases.
- Employee referrals.
- Boomerang employees.
- Promotions and transfers.
- Employment exchanges.
- Recruitment agencies.
- Professional organisations.
- Internships and apprenticeships.
- Recruitment events.
- Word of mouth.

These platforms are drawing the attention of organisations in addition to traditional means of sourcing new staff (ILO, 2023: 6). These are applied irrespective of the size, structure or sector. Industrial psychologists have discovered ways to improve the quality, including the reliability, validity, fairness and utility for decisions. Correct recruitment and selection as well as placement of employees promote the overall job satisfaction, morale and productivity. Industrial psychologists have employed a scientific approach in developing and applying employee selection and placement methods which ensure that the suitable applicants are hired for specific jobs and that their talents match the jobs offered to them. They create and choose tests which will guide the interview process to ensure that job applicants should be hired and correctly placed within the organisation (Kuther, 2005). When new recruits are hired, they provide managers with an opportunity to acquire new skills, and they may be a need to amend the existing organisational cultures. It does sometimes happen that vacancies are filled in an ad hoc or reactive manner without a systematic analysis of whether those specific jobs are needed to be filled. Organisations can make use of either internal and/or external recruitment methods.

4.4.3.1 Internal recruitment

Internal recruiting involves filling vacancies with existing employees from within an organisation. This simply means an employer would advertise the post internally with a list of open positions where existing employees can apply for a better position. These positions are often placed on noticeboards, information bulletins, others can be placed in company newsletters or on the company website or intranet (Swanepoel, Erasmus, Schenk & Tshilongamulenzhe, 2014). It invites deserving employees to engage in the recruitment process. Al-Harerat and Halaseh, (2019) mentioned three advantages of Internal recruiting as:

- First, “individuals recruited from within are already familiar with the organisation and its members, and this knowledge increases the likelihood that they will succeed”.
- Secondly, “a promotion from within policy fosters loyalty and inspires greater effort among organisation members”
- Finally, “it is usually less expensive to recruit or promote from within than to hire from outside the organization” (Al-Harerat and Halaseh, 2019).

Internal recruiting is good, but it has its disadvantages. The process has drawbacks because it limits the institution from getting new skills and talent from the outside.

4.4.3.2 External recruitment

Most employers have a policy of first recruiting internally, this is to offer current employers an opportunity for a promotion within the institution. If no internal candidate is found, only then will the position be advertised externally. Many vacancies are filled from outsiders (Al-Harerat and Halaseh, 2019). External recruitment methods may include advertising, walk ins, applications done directly to the organisations via email or hand delivery, it can be through employee referrals, social media platforms, internet recruitment, internships, recruitment agencies or professional associations (Van Aswegen, 2012, Warnich *et al.*, 2015). External recruitment has proven to be very useful and effective for finding the right number of people who are able (Al-Harerat and Halaseh, 2019). External recruitment brings opportunities to the institution because the new staff will bring a renewed energy to the team in the workplace.

4.4.4 Advertisement

One of the most popular methods of attracting potential employees is through advertisements. The number one method of filling vacant positions within an organisation is to 'job post'. The organisation uses advertisements to communicate its needs to the public and uses different platforms which includes newspapers, professional magazines, radio, television, credible websites, jobsites (such as Pnet/Career Junction and so forth). It is important that an advertisement reaches suitable candidates, and that enough information is included in the advertisement, to help narrow the search to only suitable candidates. A successful advertisement is seen as consisting of the AIDA formula which emphasise on: (A=attract attention, I=develop interest, D=create desire as well as A=encourage action (Swanepoel *et al.*, 2014; Warnich *et al.*, 2015).

The aim of adverts is to attract prospective qualified candidates who are available to fill vacant positions within the organisation. This is usually done to attract several prospective candidates widely. In short, we can say that recruitment is the link or the process which connects the organisation with potential employees (Warnich, Carrell, Elbert & Hatfield, 2015).

4.5 OVERVIEW OF THE SELECTION PROCESS

Once an appropriate number of candidates has been recruited, the next phase is usually the selection process. A selection process can be defined as “the process of screening and hiring the best qualified applicants with the greatest performance potential” (Wild, Wild, Han & Ramman, 2009). A good selection process is fundamental in finding talent and we can say this forms the backbone of effective performance management. The selection process has a funnel structure. Finding the right candidate for a job is a complex, time-consuming, and costly process that does not occur overnight. A poor decision has the ability to not only cause the organisation to lose money, but also to cause a lack of productivity in individuals and the overall performance of the organisation. The better personnel perform, the more successful the corporation will be in meeting its strategic goals and producing a competitive edge. It remains the manager's responsibility to precisely estimate which applicants will become productive and loyal employees. Selection is thus the process of determining which persons will best fit a specific job by considering all of the potential candidates' differences (Robinson 2006; Coetzer, 2016).

Below is the selection process which consists of a sequence of steps that an organisation follows to ensure that the individual best suited for a position with the best qualities and qualifications is appointed. Van Aswegen (2012) points out that there are many determining factors and there are all imperative to ensure the success of an organisation. It is important to note that each step from the preliminary interview is as important as the final step which involves the final selection and the rejection of the unsuitable candidates. For selection to be a success, every single step has to be done accordingly (Van Aswegen, 2012).

4.5.1 Step 1: Initial screening

Human Resource office receive many applications, some are suitable to the post advertised, but others immediately do not match the criteria. These individuals are immediately disqualified. The initial screening determines if the applicants have the correct job requirements and minimum qualifications as outlined in the job profile as well as the job specification. To comply with South African employment legislation, a specific criterion for determining whether an applicant is unqualified must be carefully defined (Robinson, 2006).

4.5.2 Step 2: Application forms

Application forms are used to gather personal information from the applicant, this information can include biographical information, age, qualifications obtained, work experience acquired over the years and other general information which may include the applicants' health status. Certain details may be unfair, such as relationship status and sexual orientation, and should be avoided. To encourage affirmative action, it is permitted to request information on race, gender, and handicap in order to create a representative organisation.

4.5.3 Step 3: Interviews

The previous section emphasised the role of planning in HR. Interview process should be well structured. There is an interaction which takes place during an interview, and it can occur in several different ways. Interviews may be formal or informal. The selection interview is between the interviewer which is the employer, and the interviewee, which is the applicant regarding a particular position. The different type of interviews includes: "the one-on-one interview", "the group interview", "the stress interview" and "the panel interview" (Van Aswegan, 2012). The one-on-one interview has only two people who are present in the interview room, namely the interviewee and the candidate. The group interview involves several applicants interacting together and the interviewer usually observes them while they interact. The stress interview is essential in institution that deals with essential services like the health department. Stress interviews are conducted to evaluate how a candidate behaves in stressful conditions (Van Aswegan, 2012). In terms of the *panel interview*, a group of people are involved to conduct interviews. The panel members are normally between three or five members or may be more depending on the needs of the institution. The panel will question one applicant at a time. This type of interview is often not bias, as the applicant is scored by more than one interviewer. This becomes an advantage to the candidate.

The primary goal of the interview is to assess whether the candidate is qualified for the advertised position. The interviewee is mainly there to convince the interviewer that he or she is capable and motivated to occupy the position. Another goal of the interview is for the applicant to learn more about the position and the firm in order to determine whether

their professional and personal goals can be realised in that environment. A job interview, like anything else, has its advantages and disadvantages, presented in Table 4.2 below.

Table 4.2 Advantages and disadvantages of a job interview

Advantages	Disadvantages
Useful in determining how well applicants communicate and interact with other people	The information obtained in the interview is not always reliable
Used to evaluate the applicant's language skills, and expression of thoughts and emotions	An interview is subjective
Additional information is gathered during the interview	The procedure is not standardised
The applicant's knowledge of the job and organisation is assessed	An interview cannot be used if there are many applicants
The interviewer can determine if the applicant will fit into the organization or not	An impression of the applicant is made in the first few minutes of the interview
Interviews are practical when there are only a few applicants	Candidates who are good communicators perform better during interviews (while they are not necessarily better on the job)
Interviews give applicants a chance to ask questions about the position and the organization	Other selection methods such as assessments are more reliable and valid as scientific methods in making sound decisions

Source: Meyer & Kruger-Pretorius, 2018

Group interviews are good for saving time, especially when the health sector require many applications for a few job vacancies.

4.5.4 Step 4: Employment tests

This step comes after applicants have been interviewed, this can include applicants undergoing some form of psychological assessment, which can also be referred to as psychometric testing and other types of employment tests. An employment test can be defined as an instrument used to obtain information including the applicant's personality, aptitude, their skills and abilities as well as things which interest them. An employment test is often used to predict job success and to determine if the applicant fits into the culture of the organization. These tests do however need to be interpreted in a way which will avoid discrimination.

According to Net *et al.*, (2014), the use of psychometric tests in South Africa is regulated by government, the Professional Board for Psychology and the Test Commission of South Africa. Psychometric testing as well as other similar employment tests or assessment of an employee are prohibited according to Employment Equity Act 55 of 1998, unless the tests used comply with the following criteria:

- Has been scientifically shown to be reliable and valid.
- Can be used and applied fairly to all employees.
- Is not biased against any group or employee.

As a result, tests used in the selection process must verify that they do not prejudice against any individual or group of individuals. All candidates should be considered on all levels before tests are approved and given for testing.

4.5.5 Steps 5: Reference checks

Following the interview, reference or criminal record checks are typically conducted to learn more about the applicant's overall behavior and previous connections with coworkers. Reference checks are also usually done to verify the information provided on the CV (for example, employment record, education and training. There are several ways background checks can be done, but the most popular way is by telephone which offers immediate information found immediately from the referee. Reference checks are essential since information can be explained and elaborated on the candidate. It is a cost-effective way of verifying information. A structured form can be utilised, which is send to the referee to provide details about the candidate.

4.5.6 Step 6: Medical Testing

In certain types of industries, such as mining and nursing, applicants must go for medical of physical assessment. The main purpose of the medical testing is to determine if the applicant is physically fit for the position which is being filled. This test is important as a job offer will not be made if the applicant does not pass the medical test. It is equally important to note that according to the Employment Equity Act 55 of 1998, medical testing of an employee is prohibited, unless:

- Legislation permits or requires the testing, and

- It is also found justifiable considering medical facts, employment conditions, social policy and fair distribution of employee benefits or the inherent requirements of the job.

Even with the above clause, an employer is not permitted to test an employee or a job applicant for HIV, unless the employer can prove that being HIV positive would affect the employee's performance or personal well-being. Therefore, testing of employees to determine their HIV status is prohibited unless such testing is justifiable by the Labour Court (Meyer & Kruger Pretorius, 2018:17).

4.5.7 Step 7: Selection Decision

After completing all of the steps, such as interviews, employment exams, background/reference checks, and medical examinations, a selection decision must be made. This choice is normally made after the line manager and the HR representative have reviewed the most suitable candidate's information. It is important to note that the position is not always offered to the candidate with the highest or best qualifications or employment record, but the person who on observation is the best match with the specific job and who will best fit into the organisations culture. Throughout the process from beginning to end, the decision maker needs to be objective and fair to all the applicants.

4.5.8 Step 8: Offer of employment

A candidate with a strong likelihood of getting a job offer is one who completes all of the aforementioned processes. Typically, a verbal employment offer is given over the phone, followed by a written one. A candidate is required to accept or reject an offer after it has been made to them. An official letter of appointment is given to the candidate if they accept it. The job description, responsibilities, pay scale, and other details relevant to the new appointment are typically included in the letter provided to the new hire. The other candidates who made the short list are then notified via email that their applications were not accepted (Meyer & Kruger Pretorius, 2018:17).

4.6 BACKGROUND DETAILS OF EMPLOYED CHWs

As discussed in previous chapters, CHWs are essential public health personnel that operate at the forefront and possess a high level of trust and familiarity with the community in which they serve (APHA, 2009 in Shahidi, Sickhora, Clancy & Nagurka, 2015). A wide

variety of healthcare professionals are included in the CHW categorisation, such as village health workers, community resource persons, traditional birth attendants, and people known by local monikers. Although these providers undergo training, they generally lack professional certification (Haines, Sanders, Lehmann *et al*, 2007). St John, Fox, Rosenthal & Lee (2022) emphasise how the current moment has witnessed a significant increase in attention towards the function of CHWs, mostly due to their ability to directly address community-centred health. The COVID-19 pandemic has brought significant attention to the disparities in health equity, particularly in relation to racial and social justice concerns. This heightened focus has underscored the valuable contributions of CHWs in enhancing overall population health outcomes (Goldfield, Crittenden, Fox, *et al.*, 2020). Nevertheless, the focus on CHWs as a potential remedy for many difficulties has been observed in the past. For instance, CHWs played an active role in mitigating the infant mortality rate in the United States by participating in initiatives such as Healthy Start during the early 1990s. Furthermore, CHWs were invaluable in helping communities in the wake of devastating disasters like Hurricane Katrina in 2005. Additionally, CHWs were acknowledged in numerous portions of the Patient Protection and Affordable Care Act (2010), including the National Health Care Workforce Commission and the Public Health and Prevention Fund. An increasing number of state Medicaid programmes are actively engaged in the process of incorporating CHWs into their reimbursable services to tackle the social determinants of health (St John, Fox, Rosenthal & Lee, 2022).

Despite substantial financial allocations, CHWs positions frequently exhibit characteristics such as part-time employment, absence of benefits, and inadequate provision of workspaces and equipment, including desks and computers. There is a lack of adequate investment in CHWs, and they often face isolation, preventing their full integration into the health and human services systems.

However, CHWs can integrate several components and address multiple deficiencies (St John, Fox, Rosenthal & Lee, 2022). During the 1960s, several countries, like Indonesia, India, Tanzania, and Venezuela, witnessed the emergence of community health worker programs (Perry, Zulliger & Rogers, 2014). CHWs are known to possess the capacity to provide a diverse range of health care services within the community setting, making them

especially significant in regions where the utilisation of facility-based treatments is limited. In addition to their other duties, Shahidi *et al*, (2015) states that CHW's have emerged as a novel group of workers who possess a deep understanding of the community they serve, either by being members of the community themselves or by having extensive familiarity with it. The primary objective of CHWs is to address various obstacles in healthcare delivery. This is achieved through enhancing communication, bridging cultural gaps, mitigating disparities, enhancing health literacy, advocating for wellness, and promoting compliance with medical instructions (Shahidi *et al.*, 2015). The efficacy of their abilities to attain these objectives has been demonstrated (Corrigan, 2005; Kreiger, 1999). The Institute of Medicine Report emphasises that in order to guarantee quality, supervision, and safety, CHW training must take place within a cooperative relationship between the community and a local healthcare delivery unit (Corrigan, 2005).

The need of enabling a community to assume a prominent position in enhancing the health and overall welfare of its constituents is of utmost importance, particularly in communities who face marginalisation, encounter cultural disparities with their healthcare providers, and/or harbour distrust towards the healthcare system (Krieger 1999; O'Brien, Squires, Bixby, Larson 2009; Wallerstein & Duran, 2010). The identification of evidence gaps in CHWs recruitment strategies was conducted by the Community Preventative Services Task Force, a division of the Centres for Disease Control (CDC). Many recruitment efforts initiated by the healthcare workers would unfortunately begin without the participation of the community (Balcazar *et al.*, 2011).

The procedure of recruiting and selecting the most suitable candidate for the position of a CHWs is a critical component that significantly contributes to the effectiveness of a community health strategy. It is important to note that effective CHWs-integrated initiatives commence with the appropriate recruitment of CHWs (St John, Fox, Rosenthal & Lee, 2022). Prior to the recruitment of CHWs for a community-based program, it is essential to establish predetermined criteria or qualifications that each prospective CHW must fulfil to be eligible for participation in the program. A variety of demographic parameters, such as gender, age, marital status, and customary place of residence, may be included in the selection process for CHWs. Crucial factors to take into account are also education level and the ability to successfully finish training on required

competencies. These requirements depend on the particular duties and responsibilities that the CHWs will take on as well as the community-based health plan that they will support (Jaskiewicz, Deussom, Perry & Crigler; 2014).

This encompasses the establishment of selection criteria and the implementation of appropriate procedures (Jaskiewicz, Deussom, Perry & Crigler; 2014). According to a declaration made by the World Health Organisation in 1989, it was recommended that CHWs should ideally be individuals who are integrated within the communities they serve. The selection of CHWs should be carried out by the communities themselves, and these workers need to be accountable to the communities for their actions. While they should receive support from the health system, it is not mandatory for them to be formally affiliated with its organisational structure. Additionally, it was suggested that CHWs should undergo a shorter duration of training compared to professional healthcare workers (WHO 1989).

The selection of community health workers who possess the necessary qualifications and are culturally sensitive is crucial in effectively conveying health messages to the target audience. After the completion of recruitment preparation processes, the recruitment process commences, encompassing the establishment of criteria, identification of potential applicants, initiation of contact and interviews with candidates, and ultimately, the selection and hiring of community health workers (CDC, 2022).

4.6.1 Desired qualities and skills of Community Health Workers

The recruitment strategy employed to identify and engage workers has a direct impact on their subsequent efficacy within the community. For instance, endeavours to enhance the professionalism of CHWs have the potential to undermine their established community connections and generate discord between community health professionals and their constituents (Krieger, 1999). The implementation of sensitive recruitment tactics not only facilitates the efficient identification and utilisation of community health workers, but also serves to safeguard their standing within the community after the initiation of health programs. Below is a list of qualities which encompass an efficient CHW as well as the general skills which are desired to complete their tasks at hand.

Desired qualities of Community Health Workers include the following:

- Commitment to serving the community;
- Caring about others;
- Warmth;
- Respect by peers in the community;
- Shared values and experiences of the people being served;
- Membership in the community being served;
- Good health practices, attitudes, and self-esteem;
- Ability to take a stand for what they believe;
- Ability to grow, change, and learn; and
- Leadership in the community (Krieger, 1999).

Skills refer to the acquired abilities and competencies that individuals have developed through learning and practice. Skills have the potential to be acquired or improved through instructional interventions and additional training (O'Brien *et al.*, 2009).

Desired skills of Community Health Workers include the following:

- Good communication (speaking, listening, writing, teaching, being bilingual);
- Being constructive in interpersonal relationships;
- Being friendly, outgoing, sociable, culturally competent, patient, open-minded, and non-judgmental;
- Knowing about health issues and the health care system;
- Understanding the importance of sharing that knowledge with family and friends; Being able to identify and use resources (e.g., having initiative, being self-directed, having the capacity to work independently);
- Facilitating empowerment and leadership skills;
- Resolving conflicts, and
- Being respectful.

There are various reasons why community health professionals frequently fail to acknowledge their complete range of abilities and attributes. These include the following, among others:

- Typically, individuals have not been remunerated, provided with formal instruction, or acknowledged for their proficiency in these abilities.
- Individuals may possess self-awareness regarding their own abilities, although they may not necessarily perceive these attributes as being skilful in nature.
- Community health workers are often perceived as lacking in skills by many other professionals in the health and social services field, leading to a self-perception of inadequacy among community health workers themselves.

The current responsibilities of CHWs encompass a broader scope that extends to various areas, including infant care, subpopulations affected by infectious diseases, non-communicable diseases (NCDs), mental health, and other services such as vital event registration, disease surveillance, and response to humanitarian crises and pandemics, this includes Covid-19 pandemic (Freeman, Schleiff, Sacks, Rassekh, Gupta & Perry, 2017; Mishra, Neupane, Preen, Kallestrup & Perry, 2015). This is due to the fact that prevalence of non-communicable diseases (NCDs) on a worldwide scale presents significant obstacles for health systems in nations with lower and intermediate levels of wealth (Horton 2013).

According to macroeconomic models, it is projected that the burden of non-communicable diseases (NCDs) will result in a cumulative output loss of US\$ 47 trillion over the course of the next two decades. This amount is equivalent to 75% of the world gross domestic product (GDP) in 2010, which was valued at US\$ 63 trillion (Bloom, Cafiero, Jane-Llopis *et al.*, 2012).

Perry, Zulliger & Rogers (2014) also emphasises how the responsibilities of CHWs have undergone significant transformations in recent decades, paralleling the expansion of their service offerings and the broadening of their target populations (Perry *et al.*, 2014). Traditionally, CHWs primarily concentrated on providing care to children and women of reproductive age. In recent years, there has been a notable expansion in the expectations placed on CHWs. These expectations now involve a broader range of services aimed at serving various subpopulations. Additionally, CHWs are expected to actively engage communities, fostering collaboration and assisting health systems in effectively responding to intricate and occasionally demanding situations (Perry *et al.*, 2014).

Community Health Worker programmes have seen a progressive transformation, transitioning from predominantly employing non-professional individuals who primarily engage in health promotion and education activities and facilitate connections between communities and other healthcare providers, to assuming the role of primary service providers for various healthcare interventions (Kim, Choi, Choi, *et al.*, 2016). Immunisations, hormonal contraceptives, vitamin A supplementation, and deworming drugs are all included in this group of therapies. Furthermore, they encompass the identification and handling of pediatric pneumonia, diarrhea, and malnourishment via integrated community case management (iCCM) techniques (Kim *et al.*, 2016). Included is the distribution of necessary goods like bed nets coated with pesticide and contraception. In addition, measures are taken to detect and manage tuberculosis (TB) cases, and at the same time, several targeted programs are implemented to manage HIV and malaria (Gross, Pfeiffer, Obrist, 2012).

Numerous CHWs programmes have demonstrated enhancements in mother and child health outcomes by helping in various areas, including antenatal care, safe delivery, postnatal care, and home-based care for newborns (Callaghan-Koru, Gilroy, Hyder, *et al.*, 2013; Lewin, Munabi-Babigumira, Glenton, *et al.*, 2010). In recent times, health systems have been confronted with a growing number of epidemiological and demographic shifts, as well as other crises including climate change, conflict, and outbreaks such as the COVID-19 pandemic. The current situation is placing significant pressure on leaders within the health system to seek out effective ways for addressing the intricate and frequently enduring care requirements of their respective populations (Haines, de Barros, Berlin, *et al.*, 2020). Although community and CHWs functions are not clearly identified in a significant portion of the health systems strengthening literature, they nonetheless play a crucial part in the overall framework (Sacks, Swanson, Schenoul, *et al.*, 2017). CHWs are progressively delivering a broader spectrum of healthcare services, effectively addressing more intricate health conditions, fostering enhanced collaboration with fellow healthcare professionals, and facilitating improved connections between communities and healthcare systems within the framework of a more comprehensive and integrated healthcare system (Kok, Kane, Tullock, *et al.*, 2015; Huicho, Dieleman, Campbell, *et al.*, 2010).

The various changes mentioned above have a significant impact on the factors considered when selecting CHWs, as well as the length, substance, and methods employed in both pre-service and in-service training programs for these individuals. The significance of training in the success of CHWs programs has been recognised, while insufficient provision of training has been cited as a hindrance. The comprehensive body of literature about the training of health workers in low- and middle-income countries holds significant importance. According to Crigler *et al.*, 2006, the training of CHWs in isolation from their working setting is unlikely to result in improved performance (Crigler, Alredo, de Diez, *et al.*, 2006). The influence on the level of care given by CHWs might not be as great as expected, even in conjunction with group problem-solving techniques and supervision (Rowe, Rowe, Peters *et al.*, 2018). The most recent guideline from the WHO focuses on health policy and system support for CHWs programs. This guideline offers thorough suggestions for a number of CHW program components, including as certification requirements, pre-service training duration, curriculum-required competencies, and training modalities. It is clear from the guideline that judgments about the type and extent of CHWs' training should be in keeping with the tasks and responsibilities they are expected to carry out, even though the recommendations are dependent on the program's context and goals.

These positions and duties are growing and becoming more intricately entwined with the health system in a variety of circumstances (Cometto, Ford, Pfaffman-Zambruni *et al.*, 2018).

4.7 RECRUITMENT AND SELECTION PRACTICES FOR CHWs

The process of selecting and recruiting CHWs seems intricate, involving multiple mechanisms that are employed even in similar settings. HR uses methodical process for the recruitment of CHWs. CHW recruitment begins by means of formulating and executing a recruitment strategy accompanied by well-defined recruitment guidelines. These guidelines allow all stakeholders to understand their individual responsibilities within the recruitment process. Jaskiewicz & Deussom (2013) provides the following points to consider developing an effective and actionable recruitment strategy:

- specific recruitment needs for the CHW programme;
- CHW selection criteria;

- CHW recruitment process;
- available resources influence CHW recruitment, and
- improving CHW retention.

The abovementioned points are essential to formulate a proficient and implementable recruitment strategy. The respective areas are discussed in the sections below.

4.7.1 Specific recruitment needs for the CHW Programme

An effective HRM should discover human resource needs in the organisation and the recruitment would determine the potential candidates for actual or anticipated organisational vacancies (Fathmath, Azam and Ahmad, 2021). One of the basic principles of employee selection is to respond to the needs of the community located in that region. The recruitment process should be guided by the extent and goals of the health programme, as well as the specific needs of the community (Rural Assistance Center, 2011). Prior to commencing the recruitment stage of any programme, it is imperative to gain a comprehensive understanding of the distinct requirements and contextual factors associated with the CHWs programme within which the CHWs will be operating. This method pertains to the establishment of a comprehensive delineation of the duties, obligations, and assignments that the CHWs will assume. Additionally, it involves an accurate assessment of the population residing within the catchment area, specifically in terms of the quantity of houses to be attended to, as well as the geographical expanse that the CHW will be required to traverse (Jaskiewicz, Deussom & Perry 2013). This information will provide programme planners with the necessary data to establish the selection criteria, qualifications, and requirements that are tailored to the specific responsibilities and tasks that CHWs will be assigned. Additionally, it furnishes a well-defined scope of responsibilities for the CHWs, enabling prospective CHW applicants to assess their suitability for the position. Some of the factors to consider before recruitment takes place for CHWs include the following:

- the total number of CHWs need to be recruited;
- confirm if the management of recruiting will be centralised at the national level, or if it is decentralised and administered at lower levels such as regional, provincial, district, or other administrative units;
- define the organisational level that will be responsible for providing the resources for recruitment, and

- define the chronological sequence of events for the recruitment process.

Identification of the needs will also require managers to define which primary care services are encompassed within the CHWs strategy. The manager should also indicate what specific duties are CHWs anticipated to undertake and the volume of the tasks to be conducted. This is because the CHWs have varied role in the community. We need to know if the CHWs possess a comprehensive understanding of their duties, including their tasks and other job requirements. This may encompass the fulfilment of fulfilling coverage or service delivery targets, as well as the reporting of programme objectives, tasks, or activity outcomes.

Further, CHW programmes have its peak seasons. The HRM need to define what is the expected time for the commitment for CHWs in terms of days per month or hours per week to fulfil their tasks. In terms of the needs, it is important to define the classification of the individual's commitment including full-time or part-time.

Another point to capture is to define if the programme will provide remuneration to CHW. We need to determine if community health workers will receive compensation for their work or do they engage in voluntary service. This encompasses a form of a salary, an hourly wage, or a stipend. The HR manager should know what categories of incentives will be offered encompassing both monetary and non-monetary forms. Sometime the activity could have been offered before, so the HRM can determine their method of compensation.

In terms of the needs of the programme, the CHWs may be required for the outbreak of an illness or pandemic, such as COVID-19. Most large-scale global health programs during the 1960s and 1970s concentrated on treating specific diseases like smallpox, malaria, and tuberculosis (TB). Local outreach workers were frequently hired, trained, and sent out to perform program-specific community-level work (Perry 2020: V). The intervention will require managers to define what kind of training will the CHWs undergo to ensure their competence in carrying out their assigned duties, such as pre-service training or in-service training. The programme need may have certain criteria or qualifying requirements, such as certification, that CHWs must fulfil to be eligible for employment.

Every programme has a lead person, therefore the HRM must know what kind of supervisory and managerial support is needed, including the management of resources that will be provided to enhance their performance.

4.7.2 CHWs selection criteria

The selection criteria and instructions encompass both broad and specialised elements (Javanparast, Baum, Labonte, Sanders, Heidari, Rezaie, 2011; Perry 2020). The requirements may vary. The Ministry of Health (MOH) establishes the selection criteria for each local district in certain nations. In several nations, national standards and tests are universally employed, irrespective of the location where services are provided (Perry 2020). The criteria for educating community health workers (CHWs) differ between regions within nations like India and Ethiopia. These variations are influenced by the cultural context and specific needs of each region. The training requirements for CHWs are determined based on the location where they would be serving (Shakerian and Gharanjik, 2023).

The National Department of Health (NDoH) in South Africa prioritises the improvement of recruitment, selection, placement, and development of human resources. Below are several criteria utilised for the recruitment and selection of CHWs.

4.7.2.1 Education

The NDoH document indicated that the minimum educational prerequisite for CHWs should be the completion of Grade 12, with the condition that they attend appropriate training programmes (NDoH, 2018). Additionally, it suggests that the principles of recognising prior learning should be implemented for CHWs who form part of the system already and have received relevant training, where feasible (NDoH, 2018). Furthermore, the document asserts the need of guaranteeing proper execution and outlines the specific implementation duties assigned to various tiers within the healthcare system. It is the provinces' duty to ensure that training is provided to both new and current members of the Ward-Based Primary Health Care Outreach Teams (WBPHCOTs). Furthermore, districts must create, implement, and maintain a system of capacity building for every member of the CHW team within the context of a multidisciplinary team (NDoH, 2018).

4.7.2.2 Language proficiency

Language proficiency is an additional crucial factor to consider when selecting CHWs (Cancer NTCftPaEDo 1998). The CHWs work at the forefront of the healthcare system. They have multiple tasks and roles and act as mediators of health promotion where they provide healthcare services (Shakerian and Gharanjik, 2023). They can overcome many obstacles that hinder service delivery to communities, such as cultural, linguistic, and moral gaps, thereby bridging the formal sectors of the community. While it may be presumed that CHWs who originate from or live in the community they serve would possess the ability to communicate in the local language, it is possible that the catchment population exhibits linguistic variety, resulting in the presence of various languages. Language variations have the potential to differentiate between socioeconomic or ethnic collectives, and it is advisable to exert efforts, whenever feasible, to enlist CHWs who possess the ability to effectively interact with various subgroups within the target community. On the other hand, it is advisable to consider the recruitment of multiple CHWs that possess diverse language proficiencies to effectively cater to the needs of the same target group.

The significance of selection lies in its ability to facilitate the identification of CHWs who possess the greatest potential for trainability, as well as those who exhibit superior levels of abilities and qualities that are less amenable to training (Glenton, Colvin, Garlsen, Swartz, Lewin, Noyes *et al.*, 2013). The implementation of a selection process can potentially contribute to the informed decision-making of prospective CHWs regarding their career trajectory. This is achieved by enhancing their understanding of the CHW role through various means, such as providing a comprehensive briefing on the responsibilities and expectations associated with the position, as well as introducing applicants to the nature of the role through the inclusion of relevant scenarios in the selection assessments. Consequently, this is expected to enhance retention rates, as prospective CHWs will possess a more comprehensive understanding of the practical aspects associated with the profession. K'Omudho & Tenambergen propose that the variable performance of CHWs across various programs may be attributed, in part, to the inadequate consideration of selection processes by program providers. The lack of established criteria for the selection of CHWs has a varying impact on program outcomes across different regions globally (K'Omudho & Tenambergen, 2015). Nkonki & colleagues

further emphasised that the significance of CHW selection is underscored by the fact that the criteria used to choose individuals for participation in a Lay Health Worker program directly influence the characteristics and qualifications of the workers who are ultimately employed (Nkonki, Cliff & Sanders, 2011).

4.7.2.3 Local needs

One of the basic principles of employee selection is to respond to the needs of the community located in that particular region (Shakerian and Gharanjik, 2023). One fundamental tenet of staff selection involves addressing the requirements of the local population situated inside a certain geographic area. The World Health Organisation stressed in 1989 that one of the primary criteria for staff selection is often the individual's place of residence in relation to the service location (WHO, 2018). Nevertheless, empirical evidence suggests that this approach to selection may not be optimal or as efficacious as initially anticipated in certain instances (Brown, Lilford, Griffiths, Oppong-Danko *et al.*, 2019; Taylor, Lilford, Wroe, Griffiths & Ngecho 2018).

The qualifications for CHWs differ among regions within nations like India and Ethiopia. These variations are influenced by the cultural context and specific needs of each region. The training requirements for CHWs are determined based on the location where they will be serving. Certain factors, such as age, marital status, and degree of education, may also vary depending on cultural and societal circumstances (Jaskiewicz, Deussom & Perry, 2013).

The selection and hiring of CHWs exhibit variations in criteria and regulations across diverse communities and countries. The selection criteria for several countries are established by the Ministry of Health (MOH) on a district level. In some other nations, irrespective of the location of service provision, national standards and assessments are implemented.

4.7.3 CHW RECRUITMENT PROCESS

The optimal process for recruiting CHWs involves several key steps. Firstly, it is important to establish specific criteria that will guide the selection of CHWs. These criteria should be carefully designed to ensure that candidates possess the necessary qualifications and

skills to effectively fulfil the role of a CHW. Once the criteria have been established, it is crucial to effectively communicate the available CHW opportunities to potential candidates. This can be achieved through various channels such as job postings, community outreach programs, and partnerships with local organisations. By actively promoting the CHW positions, a wider pool of candidates can be identified. After identifying potential candidates, the next step is to conduct interviews to assess their suitability for the CHW role. The interview process should be structured and standardised to ensure fairness and consistency. It is important to ask relevant questions that evaluate the candidates' knowledge, experience, and interpersonal skills. This will help in selecting individuals who are best suited for the CHW position. Finally, once the interview process is completed, a CHW is given an offer of employment. Different countries have utilised different methods to enhance their recruitment strategy (Jaskiewicz, Deussom & Perry, 2013).

The following sections provide examples of practices undertaken in Zambia, Afghanistan and South Africa.

4.7.3.1 Randomised Control Trial (Zambia)

Another method used for recruitment is referred to as 'Randomized Control Trial' (RCT). RCT is used in Zambia to recruit CHW's. The economists responsible for the design of the RCT discovered that by utilising job advertisement posters that highlighted future career opportunities, they were able to attract applicants who demonstrated higher levels of effectiveness as health professionals, as determined by several quantitative metrics. The policy suggestion was duly acknowledged and adopted by the Zambian government, which proceeded to enlist a substantial number of new CHWs through the utilisation of posters that effectively emphasised the potential career trajectory associated with this profession (Wintrup, 2022). Randomised controlled trials (RCTs) are currently advocated as a very effective approach for establishing novel development and global health strategies, with a special emphasis on nations located in the Global South (Webber & Prouse, 2018). The randomised controlled trial (RCT) was developed by economists affiliated with the London School of Economics (LSE) and Harvard University, and its implementation was overseen by Innovations for Poverty Action (IPA). The objective of the study was to evaluate the strategies employed by the Zambian government to identify

and recruit CHWs who would be most proficient in their roles (Ashraf, Bandiera, Davenport & Lee, 2020). Beginning in 2013, the Zambian government utilised the results of this randomised controlled trial (RCT) to enlist a fresh group of CHWs. A significant number of individuals residing in rural areas of Zambia submitted their applications for this position after their exposure to posters shown at health centres and clinics. These posters prominently highlighted the potential career trajectory that would be accessible to them upon achieving success in their applications. In the year 2018, the economists responsible for the design of the Randomised Control Trial (RCT) made a noteworthy observation on the hiring of 1400 more CHWs. It was observed that a recruitment strategy was implemented, which placed significant focus on the career rewards associated with the position (Ashraf, Bandiera & Lee, 2018).

The process for recruitment, which first appeared to have promise, was shown to possess several flaws. Regrettably, the existence of this career ladder has never materialised. Since its implementation in 2013, the Zambian government has neglected to establish a career advancement framework for the CHWs position. Consequently, the recruitment strategy has raised unfounded expectations among the numerous Zambians who were employed with the belief that they could pursue professional growth within the healthcare system and enhance their livelihoods.

4.7.3.2 Afghanistan CHW Selection Criteria

Certain programs, such as the Afghanistan program, purposefully incorporate both male and female CHWs inside a given community. These programs actively promote the selection of male and female CHWs who share familial ties, hence facilitating collaborative efforts between them (Aitken, Arwal, Edward & Rohole, 2020). In the context of Afghanistan, the selection of CHWs is conducted through a consultative procedure involving both NGO personnel and community elders. In accordance with the established protocol, it is customary for each health station to be staffed by both a male and a female CHWs, often consisting of individuals who are spouses or closely related. The familial bond between the individuals enables them to collaborate more effectively within a cultural setting that imposes significant restrictions on interactions between unrelated individuals of different genders. The official prerequisites encompass two criteria: (1) individuals must fall between the age range of 20 to 50 years, and (2) they must command

respect from fellow members of the community. There is not a specified upper age limit. Furthermore, it should be noted that while there is no explicit educational prerequisite, it is worth acknowledging that those possessing a higher level of education may possess an advantageous position if they satisfy the remaining conditions. During the initial period of female CHWs, it was observed that the literacy rate was at a mere 30%. In a study conducted in 2011, a sample of CHWs was examined across 33 provinces. These provinces had an average female literacy rate of 15%. Among the 158 female CHWs included in the sample, it was found that 65% of them were literate. Furthermore, 54% of these literate CHWs had successfully completed at least basic school (Rafiq, Wheatley, Mushi & Baynes, 2019).

Alongside social and cultural factors, the evolving healthcare requirements resulting from continuous demographic and epidemiological transitions are contributing to the changing duties and expectations of CHWs. These transformations are influencing the burden of disease and the necessary measures to maintain and enhance community health (Mokoena, Mokgatlhe-Nthabo, Madiba, Lewis Ngcobo, 2007).

4.7.3.3 South Africa CHW selection Criteria

The difficulties related to human resource for health (HRH) pose a significant threat to the integrity of the South African health system, thereby compromising the effectiveness of initiatives aimed at mitigating the burden of disease. There exists a need for a specific group of healthcare professionals who can effectively address the fundamental health requirements of individuals at the local level, thereby ensuring the provision of accessible and inexpensive healthcare through the utilisation of suitable technologies that are acceptable to those receiving treatment. The primary health care outreach teams that operate within wards are strategically positioned to deliver community-based primary health care services. These services cover a range of activities conducted within communities, families, and referral networks including community-based clinicians (Mhlongo & Lutge, 2019). In 2010, the National Department of Health (NDoH) in South Africa introduced a countrywide primary health care (PHC) initiative aimed at improving health promotion, disease prevention, and early disease detection.

The suggested strategy, referred to as Re-engineering Primary Health Care, aims to strengthen a community-based primary health care (PHC) model that prioritises prevention and health promotion. This is accomplished by employing community-based outreach teams, known as ward-based primary health care outreach teams (WBPHCOTs) in South Africa. The WBPHCOTs, or Ward-working Primary Health Care Outreach Teams, consist of Community Health Workers (CHWs) who work under the supervision and direction of nurses in healthcare facilities. These teams have the responsibility of providing health education, promoting healthy behaviors, assessing community health needs, managing minor health problems, and enabling access to health services and facilities (Austin-Evelyn, Rabkin, Macheke *et al.*, 2017). The proposed strategy involves deploying primary health care outreach teams that are led by a professional nurse and include a health promotion officer, an environmental health officer, and six community health workers (Sodo & Bosman, 2017). Since January 2012, the District Health Information System (DHIS) has been used to document the establishment, registration, and reporting of activities by the WBPHCOTs in South Africa. Nevertheless, there is a prevalent concern regarding the subpar performance of WBPHCOTs (Mhlongo & Lutge, 2019).

It is very encouraging to note that over the past decade, South Africa has experienced a significant rise in the quantity of CHW's. In the Sedibeng District, where the researcher is conducting the study, the implementation of Wireless Body Sensor Networks (WBSNs) was introduced alongside an existing established local outreach approach known as "health posts," which were overseen by a family practitioner trained in Cuba. Health posts are fundamental physical infrastructures that are frequently built using resources gathered from nearby communities. These facilities serve as satellite distribution points for clinics and community health centres. The health posts are manned by a qualified nurse, who is selected from a group of retired nurses, and a team of CHWs. These health posts aim to provide preventive services, as well as follow-up care for chronic diseases and the dispensing of medications, in closer proximity to the community (Schneider & Khumalo, 2017).

4.7.4 Influence of available resources to CHW recruitment

The availability of resources for recruiting CHWs can significantly impact the way the recruitment process is managed. Following the Alma Ata Declaration, there has been a tendency among decision-makers who lack familiarity with the practical aspects of programming to mistakenly perceive community-based health programs as a cost-effective method for delivering primary health care. The endurance of suitable financing for CHWs programs is frequently jeopardised by conflicting goals in the field of health or other sectors (Jaskiewicz, Deussom & Perry, 2013; Standing & Chowdhury, 2008). The emergence of new priorities, such as non-communicable diseases (NCDs), mental health, and infant care, necessitates the establishment of robust primary healthcare (PHC) teams. These teams should incorporate a designated role for CHWs who possess the capacity to deliver essential services directly to communities. Additionally, these CHWs should be equipped with referral mechanisms to effectively address the healthcare needs of the population. To enhance the package of vital services delivered by CHWs at the home level, it will be necessary to incorporate new services and protocols.

Additionally, comprehensive training programmes will be required to ensure the efficient implementation of these additions (Rowe, Brilliant, Cleveland *et al.*, 2010). In light of the expanding range of services offered, it is imperative to enhance the professionalisation and integration of CHWs into the healthcare system.

4.7.5 CHW retention

The evidence-based Guideline on health policy and system support was adopted by the World Health Organisation in 2018 with the aim of optimising community health worker programs (Perry, 2020). For the first time, the Assembly passed a resolution emphasising the role of CHWs. As part of the global plan to achieve Universal Health Coverage and Sustainable Development Goal 3 (Ensure healthy lifestyles and promote well-being for everyone at all ages), the Assembly called upon Member States to "optimise community health worker programs" (Perry, 2020). The Assembly noted the importance of the CHWs in "advancing equitable access to safe, comprehensive health services" (Perry, 2020). Sustainable programmes have the financial, operational, and programmatic infrastructures to continually adapt to changing needs over time (Singh, 2016).

It takes a lot of time, energy, and resources to promote health and avoid disease (Shahidi, Sickora, Clancy & Nagurka, 2015). Haines *et al.*, (2007) mention four factors that contribute to the efficacy of a CHWs initiative: There are several key factors that contribute to the overall state of a nation's socioeconomic and political landscape. These factors include corruption within the government and the level of political will to address pressing issues. Additionally, community-specific factors such as geographical location, infrastructure availability, and prevailing health beliefs also play a significant role in shaping the overall health outcomes within a population (Haines *et al.*, 2007). Furthermore, the effectiveness of a nation's health system is influenced by various factors. These include the adequacy of remuneration and supervision mechanisms in place to support healthcare professionals. Lastly, international factors, such as migration patterns and the provision of technical assistance, can have a substantial impact on a nation's health landscape.

CHWs necessitate the provision of supportive supervision, well-defined roles encompassing particular duties, incentive systems that are locally appropriate and encompass both monetary and non-monetary rewards, recognition, opportunities for training, support from the community and policy frameworks, and effective leadership. Various factors can influence the duration of a worker's tenure as a CHWs (Mathauer & Imhoff, 2006; Haines *et al.*, 2007).

Furthermore, the motivation of individual CHWs has a significant influence on their retention and attrition rates, in addition to the aforementioned considerations. Motivation is influenced by various aspects, encompassing inherent characteristics like as an individual's work-related objectives, as well as their altruistic tendencies, self-efficacy beliefs, and devotion to the organisation. Extrinsic considerations encompass elements such as peer approval, offered incentives, and the anticipation of future remuneration (Walt, Perera & Heggenhougen, 1989; Franco, Bennett & Kanfer, 2002; Meyer, Becker & Vandenberghe, 2004). The characteristics identified in a recent review as influencing motivation and retention of professionally trained health workers in low-income countries have resemblance to the ones discussed here (Willis-Shattuck, Bidwell *et al.*, 2008). High attrition rates provide a substantial challenge to the investment made in CHWs programs, potentially impeding the efficacy of community-based treatments targeting the reduction

of newborn mortality. Volunteers are found to exhibit higher attrition rates (Walt, Perera & Heggenhougen, 1989).

A study conducted in Bangladesh revealed that CHWs expressed several reasons for their departure from their positions. These reasons encompassed constraints related to time management, such as the inability to allocate sufficient time to attend to their own children and fulfil other familial obligations. Additionally, inadequate financial compensation, specifically insufficient profit or salary, emerged as a prominent factor contributing to their decision to leave. Furthermore, the disapproval of their families about their CHW role was identified as another influential aspect in their departure (Khan, Chowdhury & Karim, 1998). A separate study conducted in Nigeria revealed that village health workers ceased their activities due to inadequate remuneration, limited prospects for career progression, a lack of trustworthiness among the local population, and insufficient oversight (Gray & Ciroma, 1988).

Henderson & Tulloch (2008), conducted a study aimed at identifying some crucial recommendations for the purpose of keeping salaried health-workers. Recommendations encompassing various aspects, including enhancements in working and living conditions, improvements in supervision and management practices, the clarification of job descriptions, promotion criteria, and career progression pathways, the augmentation of education, training, and professional development opportunities, as well as the provision of social recognition, are relevant and applicable to both paid employees and individuals engaged in volunteer work (Henderson & Tulloch, 2008). On the contrary, suggestions such as "strategies pertaining to the repatriation of individuals," "establishing strong social connections and obligatory service," and "implementing appropriate remuneration mechanisms" do not hold significance in the context of CHWs. Although the suggestion to raise salary may not be feasible for CHWs, enhancing "benefits and allowances" and implementing "performance-based non-financial incentives" could potentially enhance CHW retention rates (Henderson & Tulloch, 2008). According to other research, CHWs who receive strong community support that affirms their work and role are more likely to stay in that capacity in spite of other potentially detrimental circumstances. Strong social networks and social cohesion are also important factors for CHW retention (Nyanzi & Manneh, 2007).

4.7.5.1 Incentives for Community Health Workers

Incentives for CHWs are often categorised into two main types: financial incentives and non-financial incentives. Both types of incentives can be categorised as "direct" incentives, as they are particular rewards provided directly to individual CHWs as part of a CHW programme. Many programmes provide a certain type of cash incentive. Within bigger government-operated programmes, these salaries may be quite little yet encompass full-time employment. In programmes operated by non-governmental organisations (NGOs) or sponsored by the community, the incentives provided may consist of modest stipends and reimbursements for travel or communication expenses (Colvin, 2014). For instance, Rwanda and India have put in place performance-based incentive programs that pay CHWs for achieving higher levels of productivity. Apart from offering life insurance to specific government CHWs, India also conducts multiple non-governmental organisation (NGO) programs in South Africa, such as scholarships meant to enable further possibilities for professional growth. Widely observed non-monetary incentives on a worldwide scale encompass the provision of official uniforms, T-shirts, and name tags; availability of bicycles and medical equipment; as well as privileged access to health or housing services (Colvin, 2014). Identifying and recruiting the best candidate for the position of Community Health Worker (CHW) is one of the most important components of a successful community health plan. Attrition is a significant problem for many large-scale CHW projects, and an efficient recruitment approach can assist lower it (Jaskiewicz & Deussom, 2013:161). Jaskiewicz, Deussom, Perry and Crigler (2014) also advised that it is "important for managers to show flexibility to upgrade and expand the CHW recruitment strategies."

4.8 CHAPTER SUMMARY

This chapter provided an outlook at what the recruitment process involves. The hiring of a CHW is not something which is done without proper planning and consideration of what the organisation needs and what the employee will benefit also. As discussed above there are many steps which are involved, and these steps all have significance and should be adhered to avoid possible misunderstandings in future. Institutions need to ensure that fair processes are always applied to ensure effective recruitment process.

The next chapter discusses research design and methodology.

CHAPTER: FIVE

RESEARCH DESIGN AND METHODOLOGY

5.1 INTRODUCTION

This chapter explains the study's research design and methodology, which include the population, data collection instrument, and data collection and analysis. The ethical considerations are also addressed. The research technique or design encompasses the systematic approach that researchers must follow to conduct their research (Sileyew 2019). The research design is discussed as it includes the steps used to plan, structure, and conduct a research study.

5.2 RESEARCH DESIGN

In order to conduct research effectively, it is essential for a researcher to possess a well-defined grasp of the topic that needs to be addressed, as well as a comprehension of how the empirical data obtained or gathered through the study design can result in dependable answers (Blair, Coppock & Humphreys, 2023). Choosing the appropriate approach at the beginning of the research is crucial for obtaining accurate and dependable results (Wipulanusat, Panuwatwanich, Stewart & Sunkpho, 2020). The study design generally emphasises the aims, applications, goals, intentions, and methods while considering the practical restrictions of geographical location, temporal constraints, financial resources, and the researcher's accessibility (Hakim, 2000). The research design of the study reflects the researcher's conceptualisation. Implementing a well-organised approach in research helps reduce dissatisfaction by efficiently incorporating different elements of the study, thereby showcasing their combined work in addressing the research questions (Asenahabi, 2019). The study design prioritizes the outcome and the logical reasoning behind the research approach (Mouton, 2001:56).

The main goal of research design is to transform a research problem into data that can be analysed, in order to provide relevant solutions to research questions while reducing costs (Asenahabi 2019). To address the research issues and achieve the research aims, the researcher employed a mixed methods design, which will be elaborated upon.

5.2.1 Research design lifecycle

A research process has lifecycle in which the processes involved in research are categorised. The lifecycle may be divided into three broad categories: planning, realization, and integration (Schoonenboom & Johnson, 2017).

- *Planning*

The reliability and validity of a study's outcome are contingent upon a well-designed study that employs an objective, reliable, and repeatable methodology. This includes appropriate conduct, data collection, and analysis, as well as logical interpretation of the results (Garg, 2016). Planning encompasses all the preparatory actions carried out prior to the commencement of data collecting, such as completing ethical evaluations, acquiring necessary authorisations, establishing collaborations, securing financial resources, conducting preliminary tests, gathering feedback, and formulating analysis strategies (Schoonenboom & Johnson, 2017). A research proposal was formulated and subsequently submitted to the scientific committee for presentation at a colloquium. The inputs provided during the colloquium were integrated to make necessary corrections. Subsequently, the research proposal was presented to the institutional Ethics Committee for review. Authorisation to carry out research was obtained from both the university and the Department of Health in Gauteng.

- *Realisation*

Realisation is the implementation phase for the data strategy planned in a study (Schoonenboom & Johnson, 2017). Several factors may develop at the initial phase of a research project, and the researcher was able to counteract the hindering factors. The study started during Covid-19 pandemic and precautionary measures were taken care off to ensure that the researcher and participants adhere to health regulation. A doctoral student is required to attend an ethics training workshop before the submission of the proposal to the ethics committee, and to this effect two virtual ethics workshops were attended as it is required by the institution.

During this stage a theoretical background and literature review were done to ensure that there are sources related to the study and a framework that guides the study. The collection of data also form part of this phase and due diligence was considered to the realized data.

- *Integration*

Deciding the location of the integration point and the manner of integrating the results is a crucial, if not the most crucial, choice in the design of mixed methods research (Schoonenboom & Johnson, 2017). The researcher opted for a mixed technique approach, using both qualitative and quantitative components in their research. Integration encompasses the ways in which the study will contribute to theories and decision-making, as well as how it will be subjected to future re-analysis, replication, and maybe meta-analysis (Schoonenboom & Johnson, 2017). The following are the primary methods for connecting the components to one another:

- The process involves combining two sets of data,
- transitioning from analyzing one set to collecting another,
- incorporating one type of data into a larger design or procedure,
- and utilizing a framework (either theoretical or program-based) to unify the data sets (Creswell & Clark, 2011, p. 76).

Intentional data integration allows researchers to gain a comprehensive understanding of their research field by examining events from various perspectives and using multiple research approaches (Shorten and Smith, 2017).

5.2.2 The four elements of a research design

Research designs consist of four interconnected elements which includes: Model (M), Inquiry (I), Data strategy (D), and Answer strategy (A), collectively referred to as *MIDA*. (Blair, Coppock & and Humphreys, 2023). *MIDA* has two sides, which are theoretical and empirical half (Blair, Coppock & Humphreys, 2023).

- Theoretical Side (M and I): This refers to the researcher's theoretical framework and the main topic they aim to address. and
- Empirical Side (D and A): This encompasses the methodologies for gathering (Data strategy) and examining or condensing data (Answer strategy) (Blair, Coppock & Humphreys, 2023).

Blair, Coppock & Humphreys (2023) referred to M and I as the theoretical component since it instructs researchers to conceptualise contexts, envision processes, and formulate inquiries. Research designs consist of three essential components: an inquiry

(I), a data strategy (D), and a response strategy (A) (Blair, Coppock, & Humphreys, 2023). Models offer a framework in which a question can be resolved. The Model (M) is the subject of investigation that allows the researcher to choose a model of the world that offers a valuable depiction of the world. I should be accountable for answering the request according to the model. In this study, multiple models were examined in order to provide a comprehensive understanding of the research emphasis, as outlined in chapters 2 and 3.

The researcher of this study also used the *Model (M) as a guideline to determine* what data can be produced. The *Inquiry (I)* element enabled the researcher to develop the main research question as presented in chapter 1. This also allowed the researcher to provide a summary of the problem statement and to develop the outcomes of the study. In this case five research questions and objectives were developed as a guide to determine the results anticipated for this research project. Whereas the Data strategy (*D*), was used to determine data collection methods. The data strategy is the full set of procedures used to gather information from the world (Blair, Coppock & and Humphreys, 2023). There are three basic elements of data strategies parallel the three features of inquiries: whereby *units* are selected, *conditions* are assigned, and *outcomes* are measured (Blair, Coppock & and Humphreys, 2023).

All data strategies require an identification of units. Many involve sampling, gathering data on a subset of units specified by a model or by an inquiry (Blair, Coppock & and Humphreys, 2023). During the proposal development phase, the researcher outlined the sampling procedures whereby a study area and the preferred sample and the sample size were selected. This also involved how the selection of the units will be treated and measurement procedures. A data strategy was followed by an Answer strategy (*A*), which entailed how data will be analysed for disseminating the research results. In this case the researcher of this study made an indication of how data will be cleaned, transformed and interpreted. To summarise the data produced a chapter outline was presented in chapter 1. The researcher read documents and summarised their meanings in chapters and section, the tables and graphs are also developed to depict the results.

5.2.3 Research Design Principles

Design principles are rules that will help guide you and your team while making important decisions throughout your projects (Blair, Coppock & and Humphreys, 2023). The research design principles allowed the researcher of this study to be rightly positioned in conducting research without deviating. Applying design principles fosters a cohesive problem-solving approach, promoting efficiency, consistency and user-centricity (Blair, Coppock & and Humphreys, 2023). Design principles comprise of the following: design holistically; design agnostically; design for purpose; design early design often; and design to share. The preferred broader principles as suggested by Blair, Coppock & Humphreys (2023) are design holistically; design agnostically; design for purpose.

The design of a study defines the study type and sub-type, research problem, hypotheses, independent and dependent variables, experimental design, and, if applicable, data collection methods and a statistical analysis plan (Creswell, 2014). *The holistic design allowed the researcher to use a mixed-method approach for data collection, preventing the isolation of other factors in the research process. This is linked to the design agnostically which enabled the researcher to select a model used as a framework to unpack the research content. In chapter 2, related theories and models were discussed to keep track of the study content and understand the research world undertaken. The design for purpose allowed the researcher to position the study, whereby the purpose of the study is outlined in chapter 1.* This also aligns to the selection of the sample to eliminate unbiased conclusion.

5.2.4 Mixed methods

The incorporation of mixed methods research has gained significant recognition as a distinct methodology within the field of social science (Wipulanusat, Panuwatwanich, Stewart, & Sunkpho, 2020). This strategy utilises a combination of quantitative and qualitative methodologies to effectively address a research problem and reduce biases that may be present in studies that use only one methodology (Creswell, 2013). Mixed methods research encompasses various design categories, such as explanatory, exploratory, parallel, and nested (embedded) designs (Shorten and Smith, 2017). Mixed methods research aims to enhance knowledge and validity (Schoonenboom and Johnson, 2017). It encompasses the gathering, examination, and incorporation of both

numerical and descriptive information within a single investigation or an extended research initiative. Mixed method techniques provide the chance to examine qualitative aspects such as culture, perceptions, and beliefs, while also creating quantitative measures (Shiyanbola, Rao, Bolt, et al., 2021). The objective is to efficiently tackle the research inquiries (Creswell, 2013).

Mixed methods research is a methodology that combines quantitative and qualitative methodologies in a single study to provide a more full and holistic knowledge of a subject. Mixed methodologies are employed when there is a requirement to comprehensively do both comparative analysis and advance many aspects of the study (Almeida, 2018). By employing a combination of different methodologies, researchers are able to overcome the limitations of utilising only quantitative or qualitative approaches. This allows them to get comprehensive information that would otherwise be impossible to obtain using either method alone (Almeida, 2018). The study done by Burke-Johnson et al. (2007) utilised an empirical research design that combined elements of qualitative and quantitative research approaches. This technique was implemented with the primary goals of attaining a thorough and profound understanding of the subject matter, as well as confirming the findings through verification. Qualitative research in a mixed methodologies study design involves gathering open-ended data without relying on predetermined responses. In contrast, quantitative research entails the collection of data that is limited to predetermined response options (Creswell, 2014).

In this study, the researcher has chosen to employ an exploratory sequential design. The exploratory sequential design is a research methodology that combines both qualitative and quantitative approaches. In this design, the qualitative phase of data collecting, and analysis is conducted prior to the quantitative phase.

5.3 TYPES OF MIXED METHODS

Mixed methods research combines the advantages of qualitative and quantitative methods, enabling researchers to examine different viewpoints and discover connections within complex research issues (Shorten & Smith, 2017). Various separate rationales exist for integrating quantitative and qualitative research data, such as triangulation design, embedded design, explanatory design, and exploratory design (Creswell et al.,

2007). This study also employed an exploratory design to direct the utilisation of a mixed methods approach. Below is a concise explanation.

- *Triangulation Design*

Triangulating means using several sources of information or procedure from the field to repeatedly establish identifiable patterns. (Stahl & King, 2020). The triangulation design aims to collect diverse and complementary data on a certain issue, which can then be combined for the purpose of analysis and interpretation (Creswell 2007).

- *Embedded design*

Embedded design involves the utilisation of a certain way of inquiry that serves a supplementary function, facilitating researchers and readers in comprehending the study. The objective is to provide further explanation, bolstering, improvement, exemplification, and clarification of the findings obtained from one approach by utilising the findings obtained from the other approach (Creswell 2007).

- *Explanatory design*

Explanatory research aims to explain the relationships between variables, often addressing 'why' questions (Panke, 2018). In the context of explanatory design theory, a comprehensive design theory can be distilled down to just two fundamental elements: requirements and solution components (Baskerville & Pries-Heje 2010). An explanatory design theory offers a functional rationale for the inclusion of specific components in a solution, based on the needs outlined in the design. It is primarily concerned with identifying cause-and-effect dynamics and is typically quantitative in nature (Panke, 2018). The goal is to test hypotheses derived from theories and to establish patterns that can predict future occurrences (Panke, 2018).

5.3.1 Exploratory research design

According to Swedberg (2020), exploratory research is the foundation of all credible scientific publications. When doing a study that involves both quantitative and qualitative research methods, it is necessary to carry out these approaches either sequentially or concurrently (Wipulanusat, Panuwatwanich, Stewart, & Sunkpho, 2020). According to Edmonds & Kennedy (2017), the exploratory sequential technique is a progressive strategy that is employed whenever quantitative (QUAN) results are enhanced by qualitative (QUAL) data. According to Polit & Beck (2006), exploratory design refers to research that investigates the various aspects of a suggested phenomenon in order to

build or improve a hypothesis about the different links that exist between these phenomena. The strategy of exploring a notion before verifying it provides greater flexibility in identifying new ideas, as demonstrated by the QUAL approach (Gogo & Musonda, 2022).

On this process previously unexplored issue is subjected to an initial study, while an already established topic is examined to generate novel ideas and hypotheses, albeit without the ability to fully validate them (Swedberg 2020). This form of research is inherently precarious, as it is impossible to predict beforehand whether any ground-breaking discoveries would emerge from the entire process.

It is necessary to exercise patience and continue with your investigation before obtaining a definitive solution (Swedberg 2020). In social science, exploratory research encompasses various definitions, but it primarily involves the pursuit of novel and captivating findings by systematically investigating a chosen research subject. As it is descriptive in nature, it then seeks to define a target audience's attitudes, opinions, and behaviours. Sequential mixed methods data is analysed in a particular sequence which strives to explain or expand on the findings of one approach with the other approach (Creswell, 2013).

In the sequential explanatory design, priority is normally given to the quantitative phase. The quantitative phase of data collection and analysis follows the qualitative phase of data collection and analysis (Shiyanbola, Rao, Bolt, et al., 2021). Below we look at the explanation for the choice made of using both the qualitative and quantitative method approach.

5.4 QUANTITATIVE METHODS

Quantitative research aims to measure and analyse data in order to draw conclusions that can be applied to a larger population (Panke, 2018). The quantitative approach involves utilising surveys and usage data to gather information. The researcher chose to use a survey approach to collect data from 254 Community Health Workers (CHWs) in the designated clinics within the study area. Quantitative research places emphasis on the gathering of numerical data (Kabir 2016). It encompasses quantifiable, numerical

information and frequently employs statistical techniques for examination (Panke, 2018). The use of a quantitative technique enabled the researcher to make generalisations that apply to the selected groups as a whole. The study utilised a quantitative methodology, enabling a broader scope of inquiry. The researcher employed a quantitative methodology to collect data from a significant number of participants, hence increasing the possibility of extrapolating the findings to a wider population (Dawadi, Shrestha, & Giri, 2021). The use of this quantitative methodology was appropriate, as it is beneficial for clarifying data from a broader population.

The methodology was used for this study because it enables a comparative comparison of different groups of Community Health Workers (CHWs), which helps the researcher understand their commonalities and differences. This also allowed the researcher to display data on the identified sample. The survey was forwarded to the facility manager and/or Outreach Leader in the designated clinics, and thereafter disseminated to more than 300 CHW's via the Google link.

Firstly, questionnaire information was collected to ensure the survey tool's validity (Gogo and Musonda, 2022). Secondly, surveys were used to gather perspectives on top leadership commitment to recruitment and selection of the CHW's (Gogo and Musonda, 2022). The researcher employed survey questionnaires and conducted a statistical analysis to examine the causal linkages between the recruitment officers' methods and selection processes. This strategy effectively addressed the number of Community Health Workers (CHWs) recruited the rate at which they are retained, and the extent to which the recruiting and selection program contributes to enhancing the recruitment of CHWs in the SDM. This approach is suitable for testing hypotheses or examining relationships between variables (Panke, 2018). However, a quantitative research programme is criticised for not considering specific research contexts, not giving participants a voice, and lacking depth, the qualitative method can be denounced for small sample sizes, possible researcher biases, and lack of generalisability (Wipulanusat, Panuwatwanich, Stewart and Sunkpho, 2020).

5.5 QUALITATIVE METHODS

In this study, the researcher employed a qualitative methodology, focusing on a limited sample size of persons. Qualitative research is uniquely positioned to provide researchers with process-based, narrated, storied, data that is more closely related to the human experience (Stahl & King, 2020). Denzin and Lincoln (2005) describe qualitative research as a multifaceted research method involving an interpretative, naturalistic approach to subject matter. It aims to understand human behaviour, beliefs, feelings, and experiences (Panke, 2018).

It involves collecting non-numerical data, often through interviews, focus groups, or textual analysis (Panke, 2018). The qualitative approach offers a more profound comprehension of the matter under investigation, respecting and valuing the perspectives of its participants (Dawadi, Shrestha & Giri, 2021). This method is ideal for gaining in-depth insights into specific phenomena (Panke, 2018). The qualitative methods enabled the researcher of this study to gain further explanation and interpretation of the quantitative results obtained in the literature (Wipulanusat, Panuwatwanich, Stewart & Sunkpho, 2020). Theories were developed using qualitative research based on the conceptual model and hypothesis. This strategy facilitated the most accurate responses to the meanings, concepts, definitions, and descriptions related to the recruiting and selection process. It was beneficial to examine the provided evidence and provide findings to address the highlighted problems. The researcher employed primary observation methods, such as interviews, document analysis, case studies, and examination of artifacts. The aforementioned approach enhanced this study by facilitating the derivation of both theoretical and practical conclusions. This, in turn, aided in comprehending the underlying concepts, thoughts, and experiences of the CHWs in the Sedibeng District Municipality.

This method provided insights into how the recruitment and selection process can enhance the effectiveness of the Community Health Workers' Programme of SDM. The researcher of this study was able to secure semi-structured interviews with the selected participants at the District Health Service office. Semi-structured interviews were conducted by means of telephone with the key informants wherein one participant agreed to the only platform of Microsoft Teams to conduct the informal interview. The researcher

had already given them a copy of the interview questionnaires which made the process more accommodating as both the researcher and the respondents were comfortable enough to answer the questions posed. The semi structured interview method is preferred as it often allows the researcher to collect the required data by making use of open-ended questions. This allowed the researcher to explore the participant's thoughts on the topic and engage in a constructive manner. The other key informant opted to submit the answers on the questionnaire and did not have sufficient time for a one-on-one interview.

5.6 STUDY AREA

This study examined the recruiting and selection process within the Department of Health in the Sedibeng District Municipality in Gauteng province. The community health centres are recognised as the foundation for examining the study question. The health sector in Gauteng province consists of 5 health regions/districts: Sedibeng Health District (SDM), Ekurhuleni Health District, JHB Health District, West Rand Health District, and Tshwane Health District. These districts offer primary health services. The research will take place in the Sedibeng Health District facilities, which are part of the SDM. The Sedibeng District is situated in the southern region of the Gauteng Province and comprises three local municipalities. The SDM is a category C municipality named after the Sesotho term meaning 'the place of the pool', due to its location near the Vaal River, a significant water source for Gauteng and surrounding areas. The district spans 4,173 square kilometres and is located in Gauteng's Southern Corridor. The region has three local municipalities: Emfuleni Local Municipality (ELM), Midvaal Local Municipality (MLM), and Lesedi Local Municipality (LLM). There are 33 clinics, 4 Community Health centres, 2 district hospitals and one regional hospital in Sedibeng (See table 5.1).

Table 5.1 Number of Primary Health Care Facilities in the Sedibeng District Municipality

Municipality	WBPHCOT	Clinics	Community Day Centre	Community Health Centre	District Hospital	Regional Hospital	Other hospital
ELM	56	20	1	4	1	1	6
LLM	14	8	0	0	1	0	2
MLM	5	5	1	0	0	0	1
Total	74	33	2	4	2	1	9

Source: *WBPHCOT (Ward Based PHC Outreach Teams)

5.6.1 Inclusion and exclusion criteria

Research must be conducted in a methodical manner with careful preparation and on-time execution (Garg, 2016). The population to be examined is one of the key components of research. Research procedures must be reproducible, dependable, and objective (Garg, 2016). Since we generalise from our studies, it is imperative that the study area details be disclosed as well. The researcher must determine whether it is feasible to examine every member of this target population in order to determine a result after this group has been identified (Garg, 2016). It is necessary to choose a certain group of patients who are generally homogeneous (Stanley, 2007). The study's inclusion and exclusion criteria are listed below. The research employed certain criteria to evaluate the suitability of persons belonging to the target population for research participation. Demographic, clinical, and regional factors were taken into account for this investigation.

- *Inclusion*

This included the demographic features and the geographical location region. The inclusion process allowed the researcher to choose the people who will answer the research question. The researcher selected participants who were CHW at the time of the survey. The age factor was considered, whereby the age group identified were over 20 years of age. Both males and females in their respective race and ethnicity were considered. The institutions selected was a public institution offering basic health services to the community.

- *Exclusion*

The age group above 65 were not selected since the category does not fall within formal employed. Specialised health centre was excluded such as the hospitals the Level 1 district hospitals, Level 2 - regional hospitals, Level 3 - academic hospitals which. Prospective participants who refused to give consent were eliminated. Other employees in the District Health Services were not part of this study, only the HR and the CHW District Manager.

5.7 DATA COLLECTION METHODS

The initial phase of the data collection and analysis was the interview stage (Gogo and Musonda, 2022). Data collection requires adequate sample size. Data collecting involves the accumulation of information to solve a research issue (Polit & Beck, 2006: 498). The methodology and analytical approach chosen by the researcher define how information

collected is utilised and the explanations it might provide, making data gathering methods crucial (Wright, O'Brien, Nlmmmon & Mylopolus, 2016). Various methods can be employed to examine qualitative survey data (Wright, O'Brien, Nlmmmon & Mylopolus 2016). For this study a mixed method was used and process collecting data.

5.7.1 Qualitative data collection

There are different methods for collecting qualitative data, and the researcher used non-observation, interviews and document analysis. The respective three are explained below.

5.7.1.1 Non-observation

A researcher may either be a participant observer or non-participant observer. The researcher for this study considered a non-participant observation whereby she observed respondents without participating. This allowed the researcher to understand how the process unfolds. The researcher resides within the jurisdiction of the study area. For this study, the researcher read the books, newspaper articles, articles, government report to understand the content and organisational situations.

5.7.1.2 Interviews

The researcher used interviews as the instrument to support the document analysis to collect the data about the identified research problems. This research started with the development of a topic list to identify the questions to be asked. The list development helped to eliminate repetition and questions that may lead to bias and exclusion. A list also helped to be effective with the collection of data. Interviews are conducted to collect information from persons in a one-on-one setting, utilizing a set of preset questions or topics of interest.

Interviews produce large amounts of data that make it possible to study idea subdomains. Additionally, interviews are the most direct method of gathering data that is ideal for comprehending the complexity and depth of issues (Gogo & Musonda, 2022). In order to get a clear response, the verbal interviews used in this study also included probing approaches. To obtain more detailed information, interviewers must utilise asking strategies and practice active listening.

Interviews are effective for capturing participants' narratives, perspectives, and experiences related to specific circumstances or occurrences. Interviews are frequently documented by recording and transcription. The time for a semi-structured interview was 40 minutes. This time was allocated to allow for the question-and-answer session. The researcher recorded the respondent's answers on the interview answer sheets. Interview data are frequently utilised to develop themes, ideas, and models. Interviews necessitate more time and resources for both conducting and analysing. Interviewers must be trained to acquire consistent data since they are responsible for data collection (Wright, O'Brien, Nlmmmon & Mylopolus 2016; Teherani, Martimianakis, Stenfors-Hayes, Wadhwa & Varpio 2015).

5.7.1.3 Document analysis

Document analysis was achieved by means of the literature review to collect data. Various sources were considered for collecting data on recruitment and selection, and the context of CHW programme. This included but is not limited to books, journals, legislative frameworks, previous database of thesis and dissertations from tertiary institutions as well as reliable internet sources.

5.7.1.4 Questionnaire: Design and administration

Mixed method approaches have been used to develop and adapt questionnaires (Shiyanbola, Rao, Bolt, et al., 2021). The design of the semi-structured interview questionnaire followed the protocols and guidelines (Gogo & Musonda, 2022). The questionnaires used were divided into sections and subsections. Questions added to surveys to gather qualitative data are usually open-ended and allow respondents to provide free-text responses.

Surveys are optimal for recording impressions, attitudes, opinions, or knowledge among a specific, predefined group of people. Effective open-ended questions should be precise to elicit consistent responses from different individuals, while yet being inclusive enough to encourage a variety of answers. Various methods can be employed to examine qualitative survey data (Wright, O'Brien, Nlmmmon & Mylopolus, 2016). For qualitative approach, a questionnaire enquired about the following themes, recruitment process,

communication for CHW position opportunities, criteria of selection for CHWs, opportunity for advancement and programme performance evaluation.

5.7.2 Quantitative data collection: Surveys

Consistency is key to quantitative studies (Gogo and Musonda, 2022). The researcher needs to prove or disprove a hypothesis. Generally, quantitative research requires a large population for responding to the questions prepared. In this regard a survey was used to collect data. The study targeted CHWs for a survey. The questions were structured a survey which consisted of close-ended questions. To prepare the questions for the survey, a Likert Scale questions were developed. The survey required at least 20 minutes for the CHWs to complete the survey. A survey for the CHWs was in a form of self-administered questionnaires which was distributed among identified CHWs. The questions for the CHWs are predetermined to address topic and the order of questions are on different section. It can be said that a survey enabled the researcher to achieve validity in the process. This is because the participants cannot make invalid selections. The responses were anonymous as they eliminate biasness of the interviewer. The request for survey participation was administered via email to $n = 254$ respondents for the study. In the request, a link to the online survey participation was provided.

5.7.3 Secondary and Primary Data

A review consisted of primary and secondary data as explained below.

Secondary Data

The secondary information gathered serves as input for the survey approach used to obtain primary data (Gogo and Musonda, 2022). Secondary data sources offer many advantages and can be quite beneficial. Data can be gathered from huge population samples over long time periods and on various subjects (Kara 2023). Secondary data sets are usually quicker to gather than primary data and are non-invasive, posing little hazards to participants and decreasing the likelihood of study bias. Relevant variables for a project can be obtained from existing data to streamline the data collection process by eliminating unnecessary data. The background knowledge was derived from the literature review's output and synthesised into a hypothesis (Gogo and Musonda, 2022).

Primary Data

Data was primarily collected through a survey. Utilising primary data for analysis has several benefits, since it allows the researcher to exercise full control over topic selection (Kara, 2023). The initial findings, which are gathered on an individual basis, are often relevant to the research aims (Gogo and Musonda, 2022). The researcher manipulates independent variables based on a pre-established design and evaluates their influence on dependent variables, which are the variables that are affected by the independent variables (Kara, 2023). This application provides enhanced data quality compared to paper surveys as it automatically stops respondents from making erroneous selections. Privacy and security concerns provide limits on obtaining data in a primary data environment, which discourages individuals from participating in data collection efforts (Gogo and Musonda, 2022). The researcher ensured inclusion by selecting volunteers from all areas, ensuring a proportional representation in the study.

5.8 SAMPLING

Everyone cannot be included, so a study population is sampled (Garg, 2016). A sample is a smaller group chosen to accurately represent the characteristics of the entire population. Given our inability to research the entire population, we must rely on a sample (Acharya, Prakash, Saxena, P & Nigam, 2013). The sections below explain how participants were selected.

5.8.1 Types of Sampling

Sampling techniques can be classified into two primary categories: 'Probability' and 'Non-probability' samples. Probability sampling allows the researcher to make inferences about the entire target population based on the results obtained from a sample. Probability sampling methods encompass several techniques such as simple random sampling, systematic random sampling, stratified random sampling, cluster sampling, and others (Dudovskiy 2019). A precise and reliable sample frame is crucial for conducting probability sampling. In order to effectively address the study issue, it is crucial to ensure that the sampling frame is accurately chosen from the target population. Random sampling from an improperly selected frame will not yield satisfactory results. Generalisations can only be applied to the particular population that is defined by the sample frame. Non-probability purposive sampling offers a straightforward approach to

specifically select a subject-matter expert (Gogo and Musonda, 2022). Non-probability sampling methods include Convenience/purposive sampling, Quota sampling, Snowball sampling, and other techniques. Every sampling method has its own advantages and disadvantages, but probability sampling is preferred since its results can be extensively generalized (Acharya, Prakash, Saxena, P & Nigam, 2013; Dudovskiy 2019).

5.8.1.2 Purposive Stratified Sampling

One technique that can be used in both qualitative and quantitative research approaches is purposeful sampling. Because the method's efficiency is linked to its inherent bias and to guaranteeing the dependability and competency of the informant, the purposeful sampling methodology is robust and convenient (Tongo 2007).

Purposive sampling procedures ensure that particular types of scenarios that could potentially be included are intentionally chosen to be part of the final sample in the research study, moving away from random sampling methods. Adopting a purposive technique is justified by the belief that individuals with different points of view related to the study's goals and objectives should be included in the sample (Mason, 2017; Robinson, 2014). Below is a sample size distribution for the study.

Table 5.3: Sample Size

Local Municipality	Population Size (CHWs)	Percentage of Sampling Size	Total Sampling size	Sample distribution	
				Number of clinics sampled per municipality	Number of participants per clinic
Emfuleni	572	77%	196	14	14
Lesedi	99	13%	33	3	10
Midvaal	70	10%	25	3	8 (*9)
Total	741	100%	254	20	254

Stratified sampling involved selecting particular types or categories of participants that must be included in the ultimate sample. The sample was divided into strata based on the participant or group's characteristics, with a specific number assigned to each level

(Mason, 2017). Stratified sampling was employed to select CHWs due to their shared characteristics. Community Health Workers are assigned to work in either public health clinics or non-governmental organisations (NGOs). The study's sample population was selected from public health clinics in the SDM to enhance representation. Below is a sample size distribution for the study

- *Community Health Workers (254)*

There are approximately 742 appointed CHWs in the Sedibeng Health District Services. The surveys were distributed to 254 CHWs across 20 selected clinics to understand the recruitment and selection process undertaken upon their appointment. The study was inclusive of gender, ethnicity, and socio-economic level to eliminate biasness and for representativeness. The study area exhibits a varied population. The questionnaire includes a component that asks questions about the participants' demographics. The study examined several gender, ethnic, and socio-economic groups to reduce bias and ensure representativeness. Both males and females of different ethnicities (Black, Coloured, Indian/Asian, and White) were given an equal opportunity to take part in the study. There is an age restriction for participating in CHWs. The study included people aged 20 to 64 years.

The researcher observed the placement of 18 public amenities, which included clinics and Community Health Centres (CHC's). This also facilitated the connection of responses from the participants. The CHW questionnaire/survey included a part that focused on transportation and the distance between the clinic and the residences visited by CHWs. Once the researcher comprehends the field of study, it becomes simpler to craft a narrative detailing the study's findings.

- *District CHW Programme Coordinator & Human Resource Manager (2)*

In selecting the key informants at the Sedibeng District Health Service, the researcher made use of purposeful sampling technique, a single questionnaire was developed which was distributed to both The District CHW Programme Coordinator and the Human Resource Manager. They were required to participate in the questionnaire to answer the questions concerning the recruitment, selection, and administration of the CHW.

5.9 VALIDITY AND RELIABILITY

Various techniques are employed for data collection. These strategies can enhance the credibility of the results. Reliability and validity are crucial elements in research,

representing the anticipated results of a study. Quality and rigour remain central to the methodological process in research (Gogo and Musonda, 2022). Validity guarantees that the measurement accurately reflects what it is intended to measure. Typically, a researcher may replicate a study in other situations to assess the trustworthiness of the research. A dependable and reproducible study outcome will generate new theories. Researchers can apply several strategies in social settings to obtain results that are more trustworthy.

Reliability is challenging to obtain in social sciences because of the complexity of human behaviours, which are hard to replicate even in consistent settings. One method of promoting credibility is through the various processes of triangulation (Stahl & King, 2020). The following sections provide a background about ensuring credibility, by using Research questions, sample size, Data collection methods, and ethical considerations.

- Research questions and sample size

The researcher developed a research question and five questions to comprehend the study context. Research questions were important as they enabled for the selection of appropriate methods and data collection techniques. The questions developed also allowed the researcher to have a set of hypotheses. The study used a mixed method approach. In this regard a sample size was considered to validate the study results. The survey was used to ensure that the population is represented to guide with generalization and validity.

- Data collection methods

The goal is to comprehend how the data as reported "hang together," meaning that the concepts should have some connection to one another (Stahl & King, 2020). Dependability, on the other hand, guarantees consistent results (Kumar 2000). Chapter 1 covered a research design that outlined the methodology for the investigation. Strong research designs produce dependable, accurate, or pertinent responses to research questions, whereas weak designs produce answers that are unreliable, imprecise, or irrelevant (Blair, Coppock, and Humphreys, 2023). The degree to which results are consistent and repeatable at a given time is referred to as reliability. Within a single study, the sequential explanatory design integrated both qualitative and quantitative methods in two successive stages. The researcher was able to guarantee the validity of the study process by employing an exploratory sequential strategy. This was done in order to

harmonise the empirical and theoretical parts. Researchers must comprehend and carefully weigh each of the mixed methods design elements when designing a mixed study, and they must always keep validity in mind (Schoonenboom and Johnson, 2017). Utilising both qualitative (QUAL) and quantitative (QUAN) methodologies in individual research studies provided a greater chance to gain deeper understanding of the subject under investigation, resulting in enhanced validity and accuracy compared to using only one strategy (Gogo and Musonda, 2022). Utilising mixed approaches can enhance and enhance our comprehension of the subjects being investigated (Zhao, 2014). Surveys, interviews, and observations were employed to guarantee that the responses attain significance. A survey was created in collaboration with a statistician to guarantee precision in collecting data.

Reliability: Qualitative and Quantitative approach

Validity in qualitative research required the research to be appropriate with the tools used for processing data. The researcher utilised a qualitative methodology to gather in-depth and comprehensive data in order to gain a better understanding of the phenomenon being studied (Wipulanusat, et al., 2020). The utilisation of qualitative and mixed approaches in research has revealed promising advantages in comprehending the concept of sustainability in individuals' daily lives and their energy consumption patterns. This knowledge provides a solid foundation for advancing towards greater energy efficiency (Zhao, 2014). The data were obtained from many sources, including EBSCO, Google Scholar, and university databases, which had been previously used in study.

The quantitative approach was utilised to identify the pattern and trend of research methodology in the field (Zhao, 2014). The second stage employs the qualitative approach to examine the characteristics of chosen studies that used quantitative, qualitative, and mixed methods for comparison (Zhao, 2014). In terms of data analysis, a statistical analysis to qualitative methods may be used. Source acknowledgement was made for ensuring validity of the data presented in this study. If the quantitative results in an exploratory sequential design are consistent with the qualitative findings, data integration enhances the credibility of the latter (Shiyanbola, Rao, Bolt, et al., 2021). To identify the key components and elements of the conceptual model and to finalize the model, statistical analysis was done (Wipulanusat, et al., 2020).

- Ethical considerations

For validity, ethical considerations were applied, whereby a gate keeper's letter was approved for conducting the study. The researcher participated in a set of ethics orientation programmes. Further explanation in this regard is provided in section 5.11

5.10 DATA ANALYSIS

Data analysis is the process in which the researcher collects, examines, categorises, and interprets all the data. Data analysis also involves transforming collected data into valuable information. Various tools, such as modelling, are used to analyse patterns, relationships, and draw conclusions to aid the decision-making process. (Sumner & Tribe 2004:20; Start, 2006).

- *Data Coding*

Prior to data analysis, data must be organised and handled systematically. Researchers get ready for analysis by coding, which involves converting data into numerical form. Another initial task is to convert data from handwritten forms to Google Forms, which improves the data analysis process. We utilised inductive qualitative coding for this study by analysing semi-structured questionnaires and interviews with Community Health Workers (CHWs) and Recruitment officers to identify themes and patterns for analysis. This coding method enhances the researchers' analysis by making it more systematic and rigorous. It enhances transparency and reflexivity for the researcher and others by allowing the researcher to uncover insights that accurately portray the data, and the human element involved. The encoded data is entered into spreadsheets using statistical software to identify the variables.

Predictive analysis was utilised in this study to examine correlations. The researcher utilised historical and present data to make future forecasts (McGregory, 2013). Analysing previous Community Health Worker programs and comparing them to the current ones will assist in identifying the most effective strategies for future implementation. A statistician analysed the data and made use of the Statistical Programme for Social Science (SPSS).

- *Data storage*

The gathered data will be stored in a secured office for 3 to 5 years following the completion of the study. It will be utilized for potential review for referral. After the specified

time frame, all surveys will be destroyed using a paper shredder to prevent unauthorized access to the data.

5.11 ETHICAL CONSIDERATIONS

In recent times, there has been an increased focus on principles that go beyond just caring for human subjects. These values now also take into account the well-being of collaborators and partners, as well as the wider social impact of research (Schoonenboom & Johnson, 2017). For social scientific research to be ethical, researchers and participants must establish standards to protect people from harm, discomfort, and exploitation (Babbie 2001:470). This study was guided by a set of principles that provided the researcher with instructions on the appropriate ways for conducting research. The key principles addressed were informed consent, voluntary involvement, anonymity, and confidentiality. This study was conducted within the framework of community health workers and focused particularly on the procedures for recruiting and selecting individuals. The study was undertaken within the confines of the health sector framework, specifically examining human resource factors pertaining to administrative responsibilities rather than clinical ones.

This study was governed by a set of principles that directed the researcher on the necessary methods for conducting research. The concepts involved were informed consent, voluntary participation, anonymity, and confidentiality. This study was situated inside the community health workers' framework and primarily concentrated on the recruitment and selection procedures. The study was conducted within the parameters of the health sector framework, focusing on human resource factors related to administrative duties rather than clinical ones.

5.11.1 Permission to Conduct the Study

Social scientific professional associations have developed principles and guidelines to help think through these issues we have ethical obligations beyond the requirements of national laws and the regulations of institutional review boards (Schoonenboom & Johnson, 2017). The principles emphasise beneficence, respect for persons, and autonomy (Schoonenboom & Johnson, 2017).

Ethics in social scientific research require researchers and participants to agree on guidelines to safeguard participants from injury, discomfort, and exploitation (Babbie

2001:470). This ensures that protection measures for participants and the institution are addressed.

5.11.2 Gate keeper

Before commencing the study, the researcher sent a letter to the Department of Health: Sedibeng District Health services to introduce herself to the District CHW Coordinator and ask for permission to conduct study at the public health facilities. The researcher applied online on the National Health Research Database (NHRD) website to seek approval from the Departmental Research Committee. The research proposal and the provisional data-collection sheets accompanied the request made.

Upon approval to conduct the study, the researcher contacted the district CHW Coordinator who served as the intermediary for accessing amenities. Entry to the designated health facilities was managed by the clinic Facility Manager. The clinic Facility Managers and Outreach Team Leaders are in charge of maintaining the daily operations of the Community Health Workers (CHWs). They assisted the researcher by populating the surveys inside their work groups, facilitating the process of obtaining replies. The researcher also received a database from the district which contained contact information for the Community Health Workers (CHWs) in the SDM area. This information was used to deliver surveys in a Google Form format.

5.11.3 Costs

Participants freely contribute their valuable time to the research process by engaging in surveys or other forms of measurement (Schoonenboom & Johnson, 2017). The researcher guaranteed that the participant's time was not wasted. The time allocation for completing the survey was well organised. During the interviews, the researcher made sure to schedule appointments and adhere to the agreed-upon time.

5.11.4 Institutional review boards

Research review bodies exist at universities worldwide and at many independent research organisations and think tanks (Schoonenboom & Johnson, 2017). The Institutional review boards functions to protect their institution from liability for research gone awry, and to ensure responsible research practices (Schoonenboom & Johnson,

2017). The research protocol was observed. This is particularly amplified by the ethical requirements of the University's policies (Gogo and Musonda, 2022). The Higher Degree Committee offered workshops towards the development of the proposal. Thereafter, two ethics workshops were attended to be familiar with the ethics process.

5.11.5 Ethical Considerations Regarding Data Collection

Ethics in social scientific research require researchers and participants to agree on guidelines to safeguard participants from injury, discomfort, and exploitation (Babbie 2001:470). The following sections provides a summary about the practices undertaken to adhere to ethical protocol.

- *Survey*

The utilisation of an online data collection technology in the survey questionnaires effectively prevented participants from making incorrect choices and ensured that only legitimate answers could be selected from the Likert scale survey questions (Gogo and Musonda, 2022).

- *Voluntary participation*

Voluntary participation means that respondents are willingly choosing to take part in the research. The participants in this study were invited to take part through an introductory letter that was included with the shared questionnaire/survey.

- *Informed consent*

Participants should be well-informed about the research to make an informed decision on whether to participate or not (Polit & Beck, 2006; Johnson & Christensen, 2000). Polit & Beck (2006) highlights that researchers seldom acquire formal informed consent when using self-administered questionnaires as the main method of data collection. Consent is typically assumed. It is assumed that returning the completed questionnaire indicates the respondent's voluntary consent to participate.

The researcher made inquiries about the participants' willingness to take part in the study. This was done to obtain their consent. The researcher supplied the participants with sufficient information regarding the study conducted. The researcher utilised an informed

consent form that expresses the study's objective on the front page. Additionally, the consent form provided a detailed explanation of the research process to participants. The participants were provided with detailed instructions, allowing them to comprehend the study's background. A survey was distributed via mobile number, email, and a hard copy was available for participants without network access and insufficient data for online login.

- *Anonymity & Confidentiality*

The researcher followed the confidentiality clause rules and did not harm the reputation of Community Health Workers or the health sector. Any interactions between the researcher and participant were kept anonymous, and their identities were not needed on the data sheet. This ensured that protection measures for participants and the institution are addressed (Gogo and Musonda, 2022).

The district possesses the contact information of the Community Health Workers (CHWs) in its database, which was shared with the researcher for study-related communication. The researcher utilised the contact details but did not share them with anyone. All acquired information was securely maintained during the experiment, and any data considered unrelated to the study was promptly eliminated. The researcher adhered to ethical norms and principles to prevent errors and uphold voluntary involvement throughout the experiment. The ethical standards guaranteed that no person was coerced into participating. Each person in the study participated voluntarily.

All participants were given with a 7-day period to acquaint themselves with the prepared questions, and the deadline for submitting the surveys online was met.

- *Potential for harm*

Polit & Beck (2006) state that participants should not be exposed to unnecessary risks of harm or discomfort. Their participation is essential for accomplishing scientific and socially significant goals that may not be achieved otherwise. Harm and discomfort in research might manifest as physical, emotional, social, or financial. All potential harms were analysed. For instance, a Social Worker was on-standby in case there were complications with the research process, especially for the CHWs. In this study, participants were not exposed to scenarios that could lead to harm, fatality, or excessive discomfort.

5.12 CHAPTER SUMMARY

The research utilised a mixed methodology to ensure reliable analysis of the acquired data. The researcher adhered to appropriate study protocols and ensuring ethical issues were upheld. The Facility members and OTLs provided the questionnaires, but the researcher also got the chance to meet with some participants in person. The results presentation will be covered in the upcoming chapter. Typically, a research design defined the study's hypothesis and models. One could consider exploratory research to be a crucial part of superior research. Without the motivation to innovate, research would stagnate. When the qualitative phase of data collection and interpretation is followed by the quantitative phase, the exploratory sequential design is referred to as a mixed method study design. The systematic combination of quantitative and qualitative data, which can occur in a variety of ways and at various stages of a study, such as study design, methodology (data collection and analysis), and reporting/data interpretation, has been found to be beneficial in data integration.

The next chapter presents the study's finding.

CHAPTER: SIX

DATA ANALYSIS AND PRESENTATION OF RESULTS

6.1 INTRODUCTION

A big part of making sure that the Community Health Workers (CHWs) plan works is the hiring and selection process, especially in the Sedibeng District Municipality (SDM). This is mainly because CHWs are the main link between healthcare centres and people in the community, how well this process works has a direct effect on the level of healthcare services that are provided to the community. In this chapter, the results of a large study that looked at how well the hiring and selection process worked to improve the CHW plan in SDM are presented and discussed with greater detail.

To get information from a wide range of people, including present CHWs and key people involved in hiring and managing these workers, the study used both qualitative and quantitative methods. Through semi-structured interviews and structured questionnaires, the study aimed to find out the complex dynamics of the hiring process, the types of people who become CHWs, how satisfied they are with the hiring process, and how this affects their performance and ability to stay with the company.

The results in this chapter are broken into several theme parts that answer the research questions that were asked at the beginning of the study. Some of these themes are the types of people who answered, where and how they were recruited, how satisfied they were with the process, what made them decide to become a CHW, and how successful they thought the recruitment and selection processes were. In addition, the chapter looks at how management handles hiring and the specific skills that are thought to be necessary for CHW candidates.

The goal of this chapter is to give a critical analysis of how SDM currently hires people by comparing the results of the data analysis with previous research. The talk shows where these practices are similar to or different from well-known best practices and gives ideas for how to make things better.

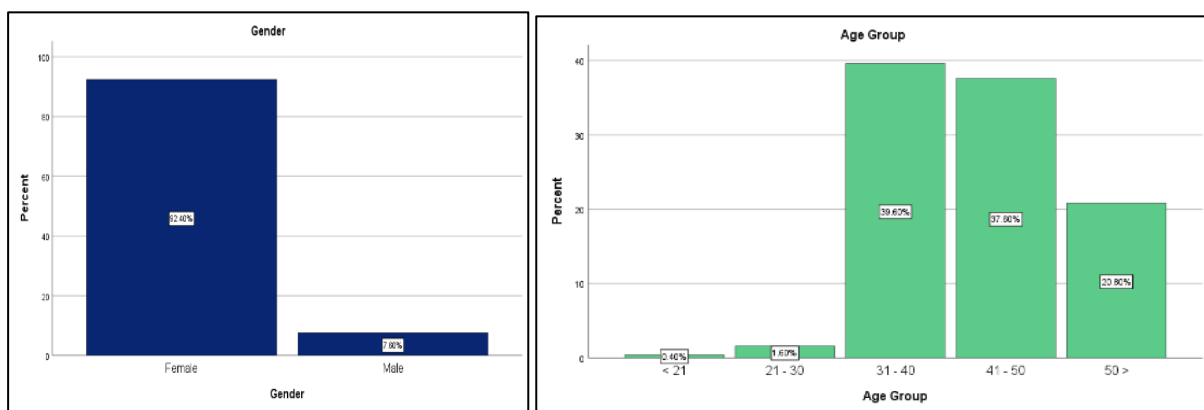
This study is very important for making rules that will improve the hiring and picking process, which will make the CHW programme stronger as a whole.

In the end, this chapter wants to add to the larger conversation about hiring and keeping CHWs by giving suggestions based on facts that are specific to the Sedibeng District Municipality. The chapter demonstrates and talks about the study results in great detail, which emphasises how important it is to have a good hiring and selection process for creating a skilled and driven CHW staff that can meet the community's healthcare needs.

6.2 DEMOGRAPHIC PROFILE OF RESPONDENTS

Several variables were used to establish the demographic profile of the respondents, and this included gender as well as the age profile

Figure 6.1: Gender and Age Profile of Respondents



Source: Author's own

As shown in Figure 6.1 above, the demographic profile of the respondents reveals a notable gender discrepancy within the field of Community Health Workers (CHWs) in the Sedibeng District Municipality (SDM). With just 7% male and 92.4% of respondents female, the results imply a female domination in this field. Current studies supporting the feminising of the CHW workforce worldwide confirm this tendency. Research by Lehmann and Sanders (2007) and Bhattacharyya *et al.*, (2001) and Armstrong & Laser 2006 highlight that CHWs are mostly women, mirroring more general global health trends whereby women typically assume caring responsibilities within their communities.

Respondent age distribution also shows that most fall between the 31 to 40 range (39.6%), closely followed by those between the ages of 41 and 50 (37.6%), The meagre 1.6% of people between the ages of 21 and 30 indicate that younger people might not be as eager or accessible to perform CHW responsibilities, maybe owing to other

professional or educational activities. This demographic trend reflects both the stability and the long-term character of such employment and corresponds with results of previous research in low- and middle-income nations where the CHW workforce tends to be older (Perry *et al.*, 2014).

Given older CHWs are likely to have developed closer links inside their communities, the much greater age profile of CHWs in SDM can be explained by the stability and community trust acquired during years of service. But it also begs questions about the sustainability of the CHW workforce, which emphasises the importance of policies drawing younger people into this important sector.

Table 6.1: The highest level of education completed

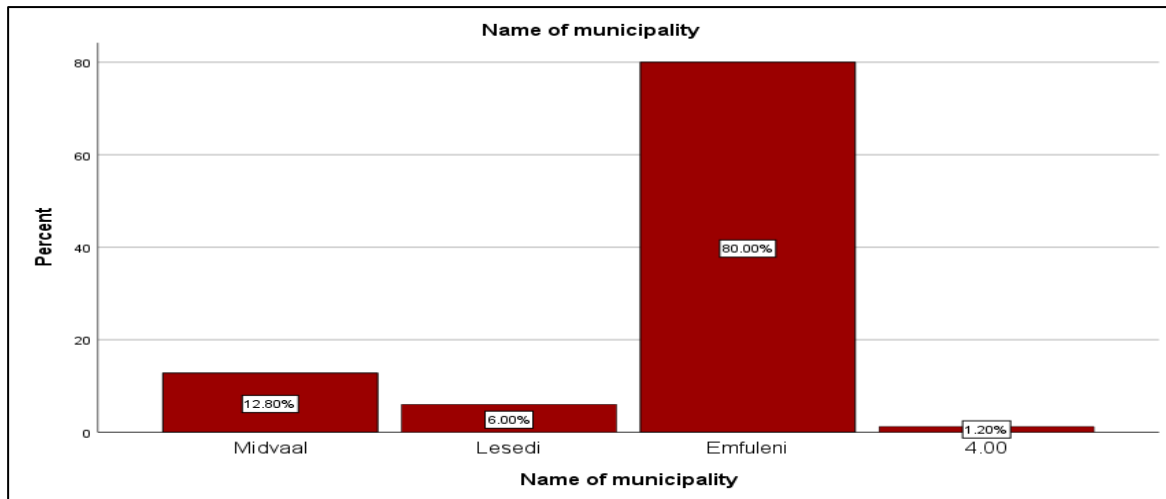
	N	%
Junior Certificate/Grade 10	59	23.6%
Matric/ Grade 12	101	40.4%
Certificate	26	10.4%
Diploma	7	2.8%
Degree	2	0.8%
Other	55	22.0%

In Table 6.1 above, which shows the respondents' educational experience, 40.4% have finished Matric/Grade 12, while only 0.8% have a bachelor's degree. Based on this educational background, it looks like official higher education is not the main requirement for SDM to hire CHW. Most of the people who answered have less schooling, which suggests that living in the community is more important than having a strong educational background. This result fits with research that indicates that school background can make CHWs more useful, but living in the community and trust are often more important (Kok *et al.*, 2015).

The low proportion of college-educated responders suggests CHWs need additional career progression. It's clear that CHWs need rigorous training to accomplish their tasks successfully. Well-structured training programmes can compensate for CHWs' lack of formal schooling, improving their performance and impact (Lehmann & Sanders, 2007; Perry *et al.*, 2014). Also, the fact that CHWs in SDM come from a range of educational

backgrounds shows that the hiring process is open to everyone, letting people with different levels of education help improve community health. That being said, this variety also means that CHWs with different levels of schooling need different kinds of training and help.

Figure 6.2 Name of Municipality



Source: Author's own

This study focused specifically on the recruiting and selection procedure at the Department of Health of the Sedibeng District Municipality in Gauteng province. Gauteng province's health sector is divided into five health regions/districts that provide primary health services: Sedibeng Health District (SDM), Ekurhuleni Health District, JHB Health District, West Rand Health District, and Tshwane Health District. The study was conducted at the Sedibeng Health District services, which forms a part of the SDM. SDM consists of three local municipalities, namely, Midvaal, Lesedi, and Emfuleni. With Emfuleni being the largest in size and population capacity. 80% of the respondents serve in Emfuleni Municipality.

The above sampling represents a true reflection of SDM, as there is a total of 32 clinics in the region, with 21 being situated in the densely populated Emfuleni area, seven in Lesedi, and the rest in Midvaal.

Figure 6.3: Location of residence



Source: Author's own

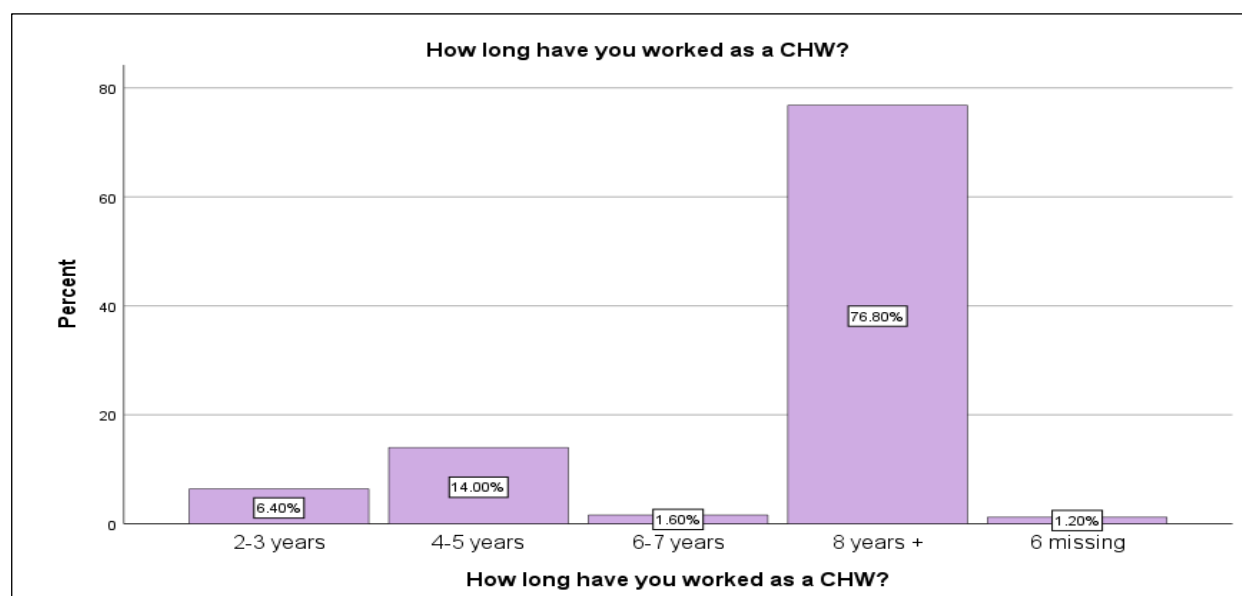
Table 6.2: Location of residence

	N	%
Evaton	49	19.6%
Sebokeng	53	21.2%
Sharpeville	28	11.2%
Boipatong	12	4.8%
Bophelong	34	13.6%
Meyerton	29	11.6%
Rathanda	12	4.8%
Vereeniging	8	3.2%
Vanderbijlpark	10	4.0%
Heidelberg	2	0.8%
Rustervaal	1	0.4%
Other	12	4.8%

Source: Author's own

The researcher judged that the data reflecting the location of residence was pertinent to this investigation. For this reason, both the graph and the table are provided to provide clear numerical data. The respondents' location is significant because, as previously indicated, the most important criteria in recruiting and selecting a CHW is the ability to serve in the community in which he or she lives. This is viewed as incredibly crucial since it promotes trust and eliminates the language barrier. According to Table 6.2 above, 4.8% of respondents at their place of residence selected the option 'other'. This can be interpreted as a source of concern given the clinics where the research was conducted were in the towns mentioned above. It is unclear what the 'other' place of residence could mean because there was no option to define it. Unless the respondent opted not to reveal for personal reasons.

Figure 6.4 Years spent as a CHW



Source: Author's own

Figure 6.4 above shows a significant number of responders who have been CHWs for more than 8 years. The 77% number suggests that being a Community Health Worker is a job that can be long-term if pursued for the correct reasons. The majority of respondents expressed a good attitude toward their jobs, which they attributed to their long tenure. A respondent was reported as saying "working as a CHW and knowing that I serve my community gives me some kind of happiness because they know me, and I know them, and they always co-operate with me when I visit".

6.3 RECRUITMENT AND SELECTION

Table: 6.3 Source of recruitment for a Community Health Worker

Newspaper	1	0.4%
Consultant	1	0.4%
Personal reference	4	1.6%
NGO	227	90.8%
E-recruitment	2	0.8%
Radio	1	0.4%
TV	1	0.4%
Health centre	6	2.4%
CHW cooperative	5	2.0%
Other	2	0.8%

Source: Author's own

Table 6.2 above shows that 90.8% of respondents were recruited by Non-Governmental Organisations (NGOs), highlighting their importance in recruiting Community Health Workers (CHWs) in Sedibeng District Municipality. This supports research that recognises NGOs as crucial to CHW recruitment and deployment, especially in low- and middle-income countries where health authorities may struggle to manage such procedures (Perry *et al.*, 2014; Glenton, 2013). NGO use before official recruiting processes illustrates a trend where NGOs cover public health institution deficits. Only 1.6% of respondents were recruited through personal referrals, and few were recruited by radio and TV. This supports recent research that show community-based and informal networks are essential for CHW recruitment (Bhattacharyya *et al.*, 2001). The low media-based recruiting percentages show that these strategies are less successful or used in SDM. The low recruitment through health centres (2.4%) and CHW cooperatives (2.0%) shows a lack of health infrastructure use for recruitment. This contradicts literature that stresses the necessity of integrating CHW recruiting into health systems to meet national health objectives and strategies (Lehmann & Sanders, 2007). The research reveals that

while NGOs are important, public health institutions must improve recruiting processes to ensure CHW programme sustainability and uniformity.

The results from Figure 6.5 below reflects a positive response from participants, with 95.2% rating their overall satisfaction with the recruitment process as good. This provides some relief that the recruitment of CHWs is viewed positively and is well received by the community. One respondent stated, "I am pleased with how the recruitment process was conducted because we were not told that we needed to have prior experience; they accepted me and provided me with training, and I was able to observe other girls when I first started so I could gain practical experience". Due to the fact that there is not enough time to provide extensive training for CHW's, it is imperative to be enthusiastic about entering the profession and willing to learn on the job. Most training is fast and on the go. With 95.2% of respondents evaluating their whole experience as positive, figure 6.5 shows a high degree of satisfaction with the recruiting process. This favourable feedback is crucial as it shows the general acceptability of the CHW functions in the society and the success of the recruitment plans used. Studies stressing the need of open, honest, and helpful hiring procedures in guaranteeing the motivation and retention of CHWs also confirm this satisfaction (Kok *et al.*, 2015).

Figure 6.5: Level of satisfaction with the recruitment process



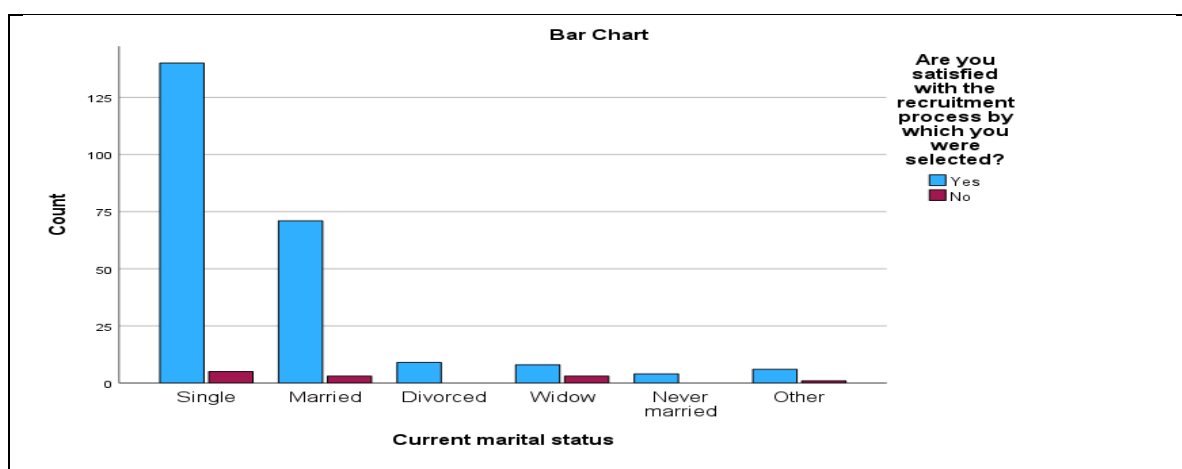
Source: Author's own

Respondents valued the post-recruitment training and practical experience given as their professional development and performance in their positions depend on it. The focus on

training corresponds with worldwide best practices, which underline the need of arming CHWs with the required skills and knowledge to carry out their responsibilities successfully (Lehmann & Sanders, 2007). Nonetheless, the fast-paced character of training as revealed by respondents points to the necessity of more organised and thorough training courses to guarantee CHWs are completely ready for their responsibilities.

Figure 6.5b and the accompanying crosstab analysis expose a complex link between respondents' marital status and their degree of satisfaction with the recruiting process. Comparatively to their married or widowed colleagues, single respondents expressed more contentment. The different personal and familial obligations that could affect opinions of the hiring process help to explain this variance. While those with families may have greater difficulties, single people—who might have fewer personal obligations—may find the recruiting process better fit for their circumstances (Perry *et al.*, 2014).

Figure 6.5b: Level of satisfaction with the recruitment process in regard to marital status



Source: Author's own

The chi-square tests show a notable correlation between married status and satisfaction with the recruiting process, indicating that personal circumstances really influence respondents' experiences. This result emphasises the need of adaptable recruiting policies that consider the varied backgrounds and obligations of CHWs. Customising recruiting and training plans to fit personal obligations can help to improve retention and satisfaction in every demographic group.

Crosstab

Are you satisfied with the recruitment
process by which you were selected?

			Yes	No	Total
Current marital status	Single	Count	140 ^a	5 ^a	145
		Expected Count	138.0	7.0	145.0
	Married	Count	71 ^a	3 ^a	74
		Expected Count	70.4	3.6	74.0
	Divorced	Count	9 ^a	0 ^a	9
		Expected Count	8.6	.4	9.0
	Widow	Count	8 ^a	3 ^b	11
		Expected Count	10.5	.5	11.0
	Never married	Count	4 ^a	0 ^a	4
		Expected Count	3.8	.2	4.0
	Other	Count	6 ^a	1 ^a	7
		Expected Count	6.7	.3	7.0
	Total	Count	238	12	250
		Expected Count	238.0	12.0	250.0

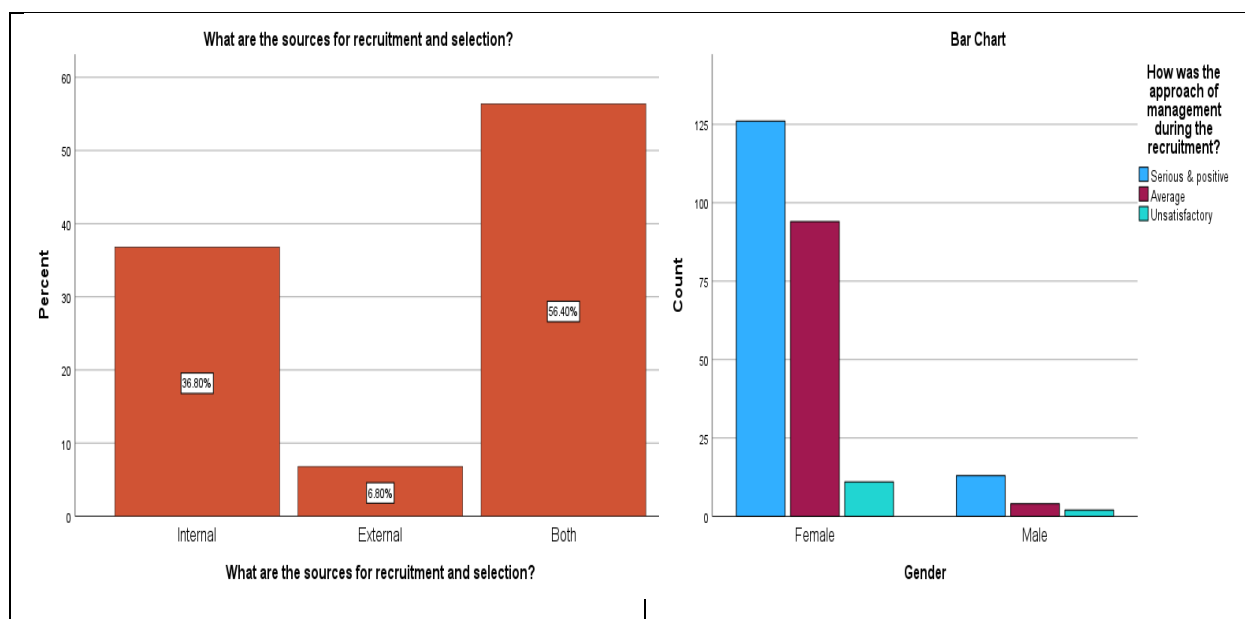
Each subscript letter denotes a subset of Are you satisfied with the recruitment process by which you were selected? categories whose column proportions do not differ significantly from each other at the .05 level.

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	14.861 ^a	5	.011
Likelihood Ratio	9.051	5	.107
Linear-by-Linear Association	4.919	1	.027
N of Valid Cases	250		

a. 6 cells (50.0%) have expected count less than 5. The minimum expected count is .19.

Figure: 6.6 Sources of recruitment and management approach during the recruitment



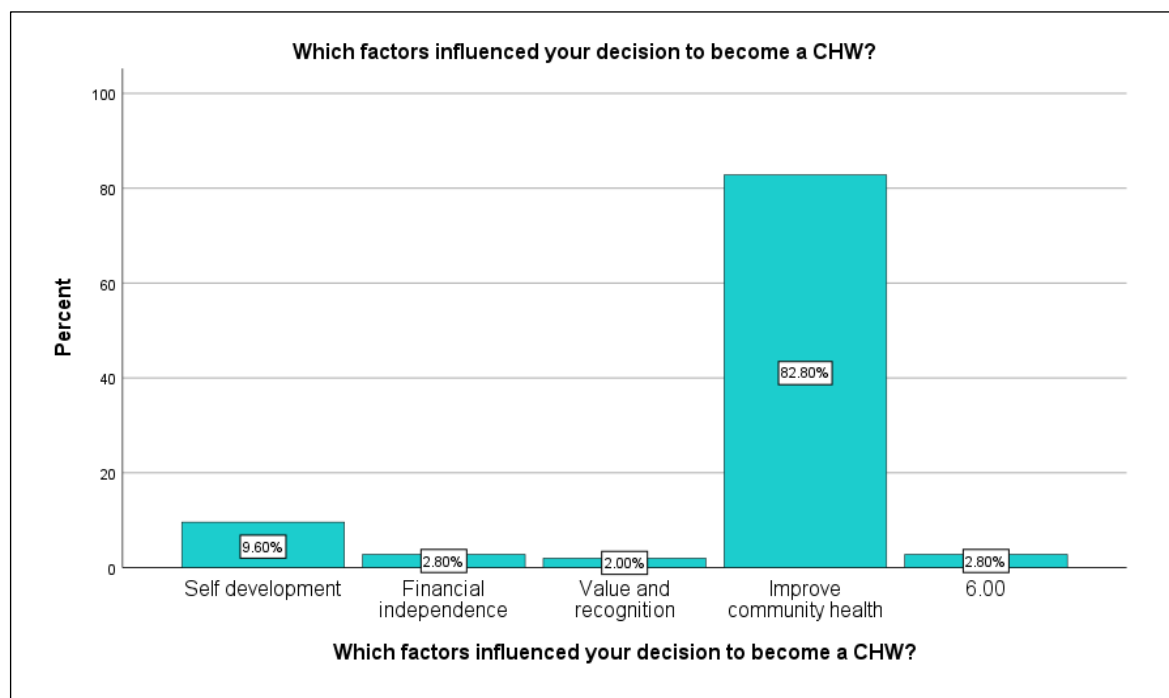
Source: Author's own

With 54% of respondents supporting this inclusive strategy, Figure 6.6 shows that both internal and external applicants are taken into consideration during the recruiting process. This approach conforms with the research supporting non-discriminatory hiring policies to provide a varied and qualified CHW workforce (Kok et al., 2015). The conflicting opinions on the recruiting management strategy show possibilities for development in management techniques: 55.5% of respondents thought it was serious and positive while 39.2% thought it was mediocre.

Maintaining the reputation and appeal of CHW positions depends critically on efficient administration and open hiring policies. According to the literature, CHW retention and motivation are much enhanced by management strategies seen as fair and helpful (Bhattacharyya et al., 2001). The conflicting emotions among the responses show the necessity of consistent and better management techniques to guarantee a good recruiting experience for every applicant. With a meagre number (2.8%) claiming financial independence as a justification, Figure 6.7 shows that the main reason one is becoming a CHW is to enhance community health. Literature emphasises that CHWs are generally inspired by a desire to assist their communities and meet local health needs, so this altruistic motive is very supported (Perry et al., 2014). Recruitment of people who are

naturally driven to support public health is reinforced by the great sense of community duty and pride in helping local communities.

Figure 6.7 Factors which influenced your decision to become a CHW

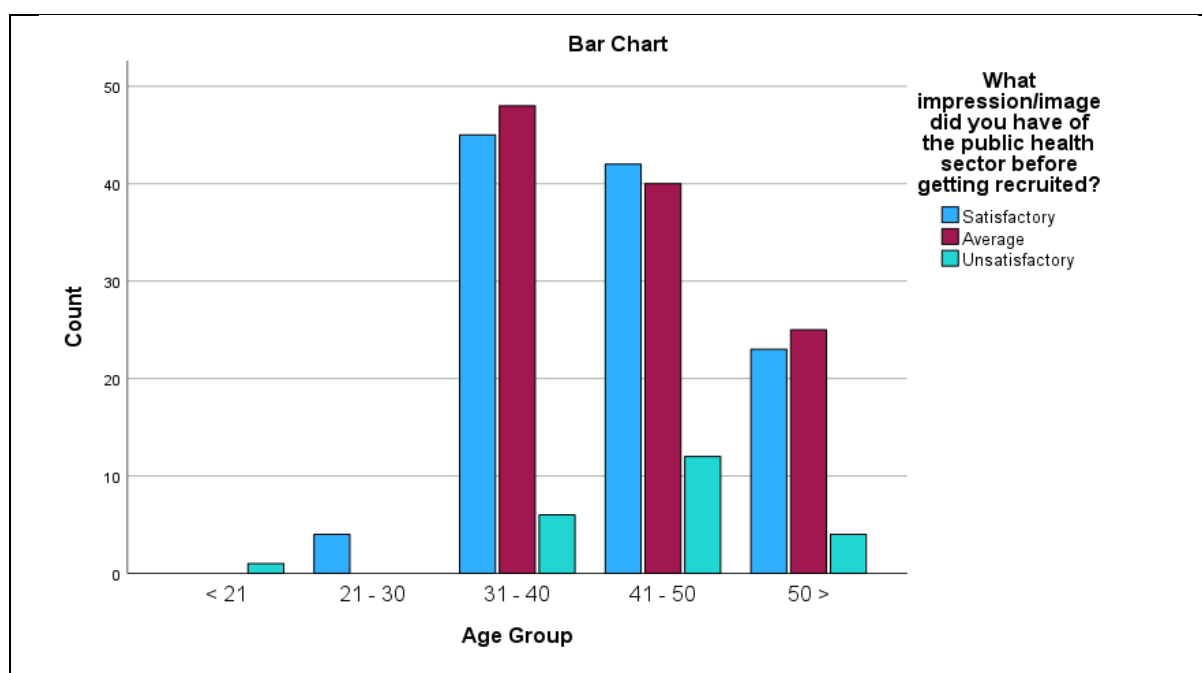


Source: Author's own

The low number of respondents claiming financial independence, however, also points to the importance of ensuring that CHWs are sufficiently paid and supported to maintain their involvement and prevent burnout even if their intrinsic motives are great. Studies have revealed that although generosity is a great motivator, retention of CHWs depends critically on both financial and non-financial incentives (Bhattacharyya et al., 2001).

Figure 6.8 shows that respondents had a neutral attitude on the public health sector as a whole prior to joining it. They were asked whether their overall impression was good, average, or bad. It is cut in the middle, with 45.6% indicating that they were satisfied with the public health sector prior to being recruited as a CHW. Almost the same percentage, 45.2%, said they thought it was simply average and could be improved significantly. When asked why they thought the public health sector was unsatisfactory, one individual specifically said "there seems to be a shortage of staff, which makes the wait at the clinics to be very long". A few other respondents also reiterated this.

Figure 6.8: Description of the overall impression of public health sector before being recruited



Source: Author's own

**Crosstab

		Satisfactory	Average	Unsatisfactory	
Age Group	< 21 - Count	0 _a	0 _a	1 _a	1
	Expected Count	.5	.5	.1	1.0
	21 - 30 - Count	4 _a	0 _a	0 _a	4
	Expected Count	1.8	1.8	.4	4.0
	31 - 40 - Count	45 _a	48 _a	6 _a	99
	Expected Count	45.1	44.7	9.1	99.0
	41 - 50 - Count	42 _a	40 _a	12 _a	94
	Expected Count	42.9	42.5	8.6	94.0
	50 > - Count	23 _a	25 _a	4 _a	52
	Expected Count	23.7	23.5	4.8	52.0
Total	Count	114	113	23	250
	Expected Count	114.0	113.0	23.0	250.0

Each subscript letter denotes a subset of What impression/image the respondents had of the public health sector before getting recruited? Categories whose column proportions do not differ significantly from each other at the .05 level.

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	17.646 ^a	8	.024
Likelihood Ratio	14.068	8	.080
Linear-by-Linear Association	.223	1	.637
N of Valid Cases	250		

a. 7 cells (46.7%) have expected count less than 5. The minimum expected count is .09.

Directional Measures

	Value
Nominal by Eta Age Group Dependent	.036
Interval What impression/image did you have of the public health sector before getting recruited? Dependent	.190

Symmetric Measures

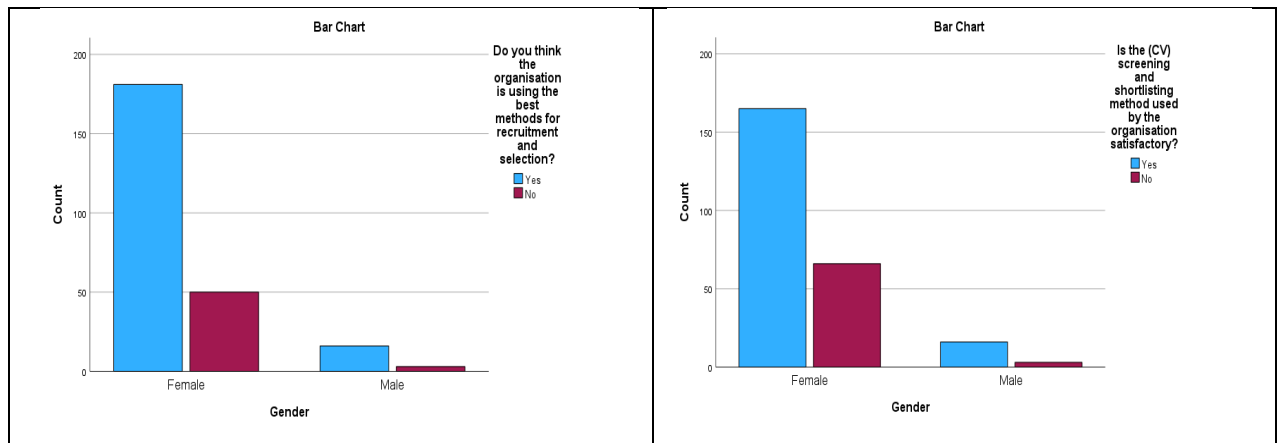
	Approximate Significance
Nominal by Nominal Contingency Coefficient	.024
Measure of Agreement Kappa	.034
N of Valid Cases	

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

When participants responded to this question, they expressed a strong sense of enthusiasm. 78.8% of respondents stated that the best recruitment and procedures are being used. Only approximately 21.2% appeared to disagree with this statement. The similar results can be obtained for CV screening and shortlisting level of satisfaction. The percentages are comparable, with 72.4% giving a good answer and 27.6% responding negatively, indicating that the screening and shortlisting process might be improved.

Figure 6.9: Best methods for recruitment and selection and screening/shortlisting methods



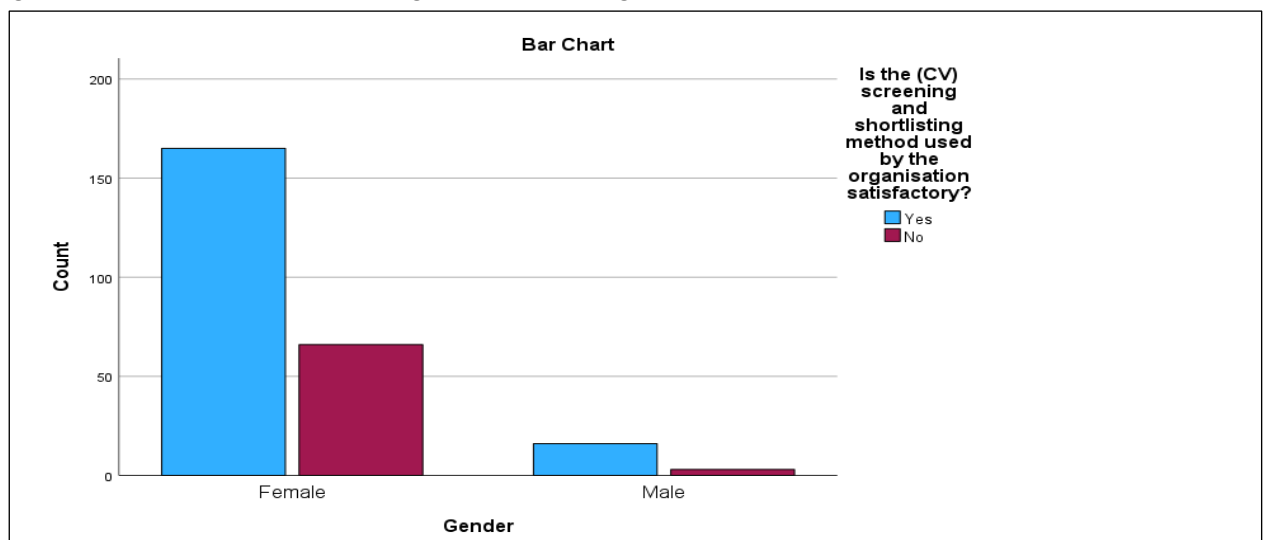
Source: Author's own

Under the conditional independence assumption, Cochran's statistic is asymptotically distributed as a 1 df chi-squared distribution, only if the number of strata is fixed, while the Mantel-Haenszel statistic is always asymptotically distributed as a 1 df chi-squared distribution. Note that the continuity correction is removed from the Mantel-Haenszel statistic when the sum of the differences between the observed and the expected is 0.

Tests of Conditional Independence

	Chi-Squared	df	Asymptotic Significance (2-sided)
Cochran's	.360	1	.548
Mantel-Haenszel	.095	1	.758

Figure 6.10: Level of the screening and shortlisting



Source: Author's own

Tests of Conditional Independence

	Chi-Squared	df	Asymptotic Significance (2-sided)
Cochran's	1.435	1	.231
Mantel-Haenszel	.864	1	.353

Under the conditional independence assumption, Cochran's statistic is asymptotically distributed as a 1 df chi-squared distribution, only if the number of strata is fixed, while the Mantel-Haenszel statistic is always asymptotically distributed as a 1 df chi-squared distribution. Note that the continuity correction is removed from the Mantel-Haenszel statistic when the sum of the differences between the observed and the expected is 0.

Mantel-Haenszel Common Odds Ratio Estimate

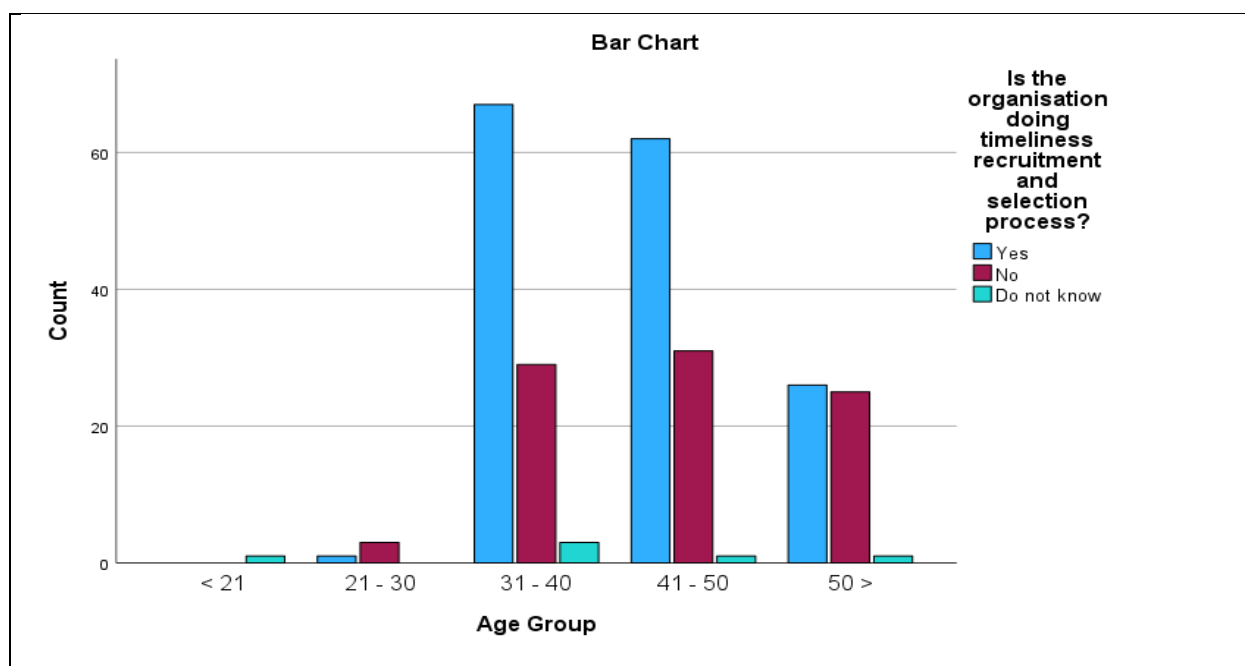
Estimate					.469
ln (Estimate)					-.758
Standard Error of ln (Estimate)					.646
Asymptotic Significance (2-sided)					.241
Asymptotic Interval	95%	Confidence	Common Odds Ratio	Lower Bound	.132
				Upper Bound	1.662
			ln (Common Odds Ratio)	Lower Bound	-2.023
				Upper Bound	.508

The Mantel-Haenszel common odds ratio estimate is asymptotically normally distributed under the common odds ratio of 1.000 assumption. So is the natural log of the estimate.

Referring to Figure 6.11, respondents were asked if the organization is doing timely recruitment and selection. According to age, age groups between 31-40 and 41-50 strongly agree that the organization is effectively doing recruitment and selection of CHWs in a favourable manner, which simply means that there are no gaps in the recruitment and selection process, according to the respondents' views. When it relates to the age group of 50 and up, they are split in half, with nearly half saying yes, recruiting

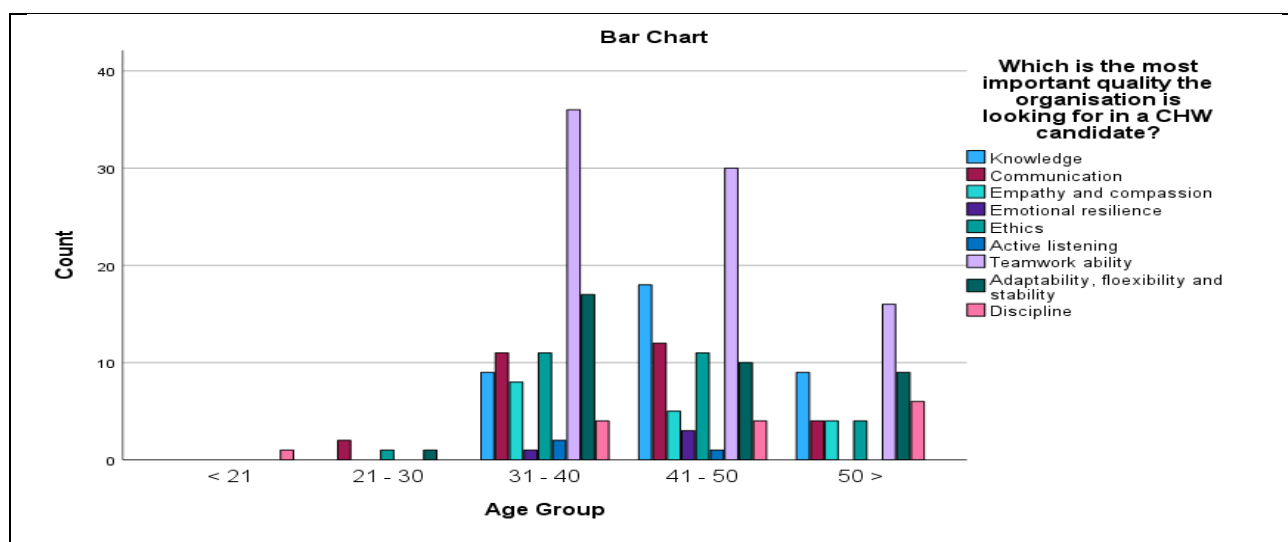
and selection are done quickly, and the other half saying 'no'. It appears that elder CHWs believe that more efforts should be made in terms of when and how CHWs are recruited.

Figure 6.11: Level of timeliness recruiting and selection



Source: Author's own

Figure 6.12: The most important quality required for a CHW candidate



Source: Author's own

This is undoubtedly one of the most essential questions posed because respondents could only choose one trait that they individually believed was the most important for being an efficient and productive CHW. The accompanying graphic shows that it was a difficult answer because all of these attributes are considered valuable. In that way, each

quality was chosen individually. According to our responders, the most essential requirement is to be a team player. As can be seen, it is the sole feature that is clearly superior to the others and was chosen by 32.8% of respondents. Adaptability, flexibility, and stability are the second most important qualities, accounting for 14.8%. This was reiterated by one of the respondents when they mentioned how many adjustments had been made as a result of the Covid-19 outbreak, which began in South Africa in March 2020. According to one response, the community found it difficult to open their houses to them for fear of the virus spreading. This is when flexibility and adaptation come into play. "As a CHW, you must be able to quickly adjust to change because conditions can alter on a daily basis". Only a few respondents mentioned you need to have emotional resilience, which would suggest that the CHWs take their roles in a professional manner and don't necessarily work based on their feelings because that could come in the way of fulfilling their roles or duties.

Which is the most important quality the organisation is looking for in a CHW candidate?

			Ethics	Active listening	Teamwork ability	Adaptability, flexibility and stability
Gender	Female	Count	25 _{a, b}	2 _{a, b}	80 _a	35 _{a, b}
		Expected Count	24.9	2.8	75.8	34.2
	Male	Count	2 _{a, b}	1 _{a, b}	2 _a	2 _{a, b}
		Expected Count	2.1	.2	6.2	2.8
Total	Count		27	3	82	37
	Expected Count		27.0	3.0	82.0	37.0

Crosstab

			Which is the most important quality the organisation is looking for in a CHW candidate?	
			Discipline	Total
Gender	Female	Count	13 _{a, b}	231
		Expected Count	13.9	231.0
	Male	Count	2 _{a, b}	19
		Expected Count	1.1	19.0
Total		Count	15	250
		Expected Count	15.0	250.0

Each subscript letter denotes a subset of Which is the most important quality the organisation is looking for in a CHW candidate? Categories whose column proportions do not differ significantly from each other at the .05 level.

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	20.296 ^a	8	.009
Likelihood Ratio	14.649	8	.066
Linear-by-Linear Association	1.837	1	.175
N of Valid Cases	250		

a. 10 cells (55.6%) have expected count less than 5. The minimum expected count is .23.

Directional Measures

			Value
Nominal by Interval	Eta	Gender Dependent	.285
		Which is the most important quality the organisation is looking for in a CHW candidate? Dependent	.086

Symmetric Measures

		Approximate Significance
Nominal by Nominal	Contingency Coefficient	.009
Measure of Agreement	Kappa	.104
N of Valid Cases		

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

The most significant characteristic for a Community Health Worker (CHW) applicant was identified by numerous field-valued traits. The survey found that 32.8% of respondents considered collaboration the most important trait. Teamwork in healthcare is stressed in the literature (Kane *et al.*, 2019). Effective cooperation improves patient outcomes and healthcare professional job satisfaction.

The second most essential attributes were adaptability, flexibility, and stability, with 14.8% of replies. Given the fast change in healthcare circumstances and needs, this is especially important. These attributes became even more significant as CHWs acclimated to new protocols and worked under atypical settings during the COVID-19 pandemic (Litam *et al.*, 2021). One responder said, "As a CHW, you must be able to quickly adapt to change because conditions can alter on a daily basis."

Several respondents highlighted emotional resilience, implying that while it is important, it may not be as vital as teamwork or adaptability. Emotional resilience is needed to deal with work-related stress and feelings (Schneider *et al.*, 2020). CHWs have to be polite and good at their jobs even when things are tough, and resources are limited. It was also found that men and women make different decisions about important quality issues. The answers from men were more varied, while the answers from women supported working together. George *et al.*, (2017) say that this gender gap may be due to differences in job experiences and views. The Chi-square test shows that the values of male and female respondents are very different, so we need hiring and training courses that take gender into account. Compared to earlier study, these results show that CHWs need to work together, be flexible, and be strong. Healthy treatments need people to be able to adapt and work together (Perry *et al.*, 2020). Even more so when they happen in public places. The fact that mental strength was rated low in this study shows that people need more training and help. The new study on the mental health needs of healthcare workers (Bettinsoli *et al.*, 2020) agrees with this.

QUALITATIVE ANALYSIS

The following part of the study discusses the qualitative analysis which had two key informants. Purposive sampling was utilised to investigate the recruiting and selection procedure from the District CHW Programme Coordinator and the Human Resource Manager of the Sedibeng District Health Services at Johan Heyns CHC.

6.4 MAJOR THEME 1: UNDERSTANDING RECRUITMENT AND SELECTION PROCESS WITHIN THE HEALTH SECTOR

6.4.1 SUB-THEME 1.1: DEVELOPMENT AND CRITERIA OF RECRUITMENT

Semi-structured interviews illuminate Sedibeng District Municipality Community Health Workers (CHW) recruiting development and needs. Participants reported strict demographic and educational recruiting criteria. The hiring standards emphasise pre-service and competency training in addition to a Matric qualification. The annual recruiting data showed how allocations and administrative policy changes affected CHW recruitment over time budget. The district-level recruiting management emphasises the localised approach to meeting each facility's and catchment area's demands.

The interview data showed that formal education, particularly the Matric certificate, was a key recruiting criterion. This aims to standardise entrance standards and guarantee CHWs have a minimal education. The necessity to reconcile educational standards with community health work's practical demands also affected these criteria. The statistics also showed that the recruiting procedure has changed to meet the municipality's health sector's demands. Phased scaling up of CHWs matches financial and other resources.

“Not yet. The suggestions were that CHWs must have a Matric certificate.” (Participant 1)

“It was at the district level. Looking at the needs per facility and the catchment area.”
(Participant 2)

Participants' extracts show that merely a Matric certificate was previously required for recruitment. This suggests that the district must adapt recruitment techniques to local health needs and geography. Participant 2's comment on district-level management illustrates recruitment decentralisation, ensuring that recruiting tactics meet the needs of local health facilities.

Comparing the data with current research shows that Sedibeng's recruiting criteria and processes follow global health workforce initiatives. This study's district-level management supports Lehmann and Sanders (2007)'s call for localising recruiting to satisfy community needs. Educational credentials and pre-service training are required for CHWs to perform their duties, according to WHO (2018). Budget constraints affect recruitment, emphasising a frequent literature issue: financial stability is needed for health

staff expansion (Dahn *et al.*, 2015). Sedibeng's approach is best practises, but financial and policy stability are crucial for the CHW programme's long-term success.

The literature states that established recruiting criteria choose qualified candidates and professionalise CHWs. According to Zulu *et al.*, (2014), clear hiring criteria boost CHW job satisfaction and retention by setting role expectations. The Sedibeng District Municipality findings highlight the need to update and refine these criteria to address new health sector concerns. Kok *et al.*, (2015) found that localised recruiting better meets community health needs and circumstances, validating Sedibeng's district-level management model.

6.4.2 SUB-THEME 1.2: COMMUNICATION AND OUTREACH STRATEGIES

The Sedibeng District Municipality used multiple methods to promote CHW jobs, according to interview data. Participants discussed neighbourhood meetings, churches, social gatherings, leaflets, newspapers, and radio spots to spread the word. This multimodal approach engages many community members. Current CHWs are asked to recommend applicants to CBOs. This is intriguing since it uses networks and community trust. These methods are needed to reach job seekers who may not see job adverts.

Data reveals that these strategies are cost-effective and culturally appropriate since they employ existing community institutions and contact channels. This method is very important in rural and underserved places where it might be hard to get to major media. The reliance on community networks and recommendations helps find people who are well-integrated into the community. This makes it more likely that they will be successful and accepted as CHWs. The different ways of communicating also show that they know how different people in the community like to talk to each other. This makes sure that information about CHW jobs gets to a lot of people.

“Announcing positions at community meetings, churches, and other social gatherings.”
(Participant 1)

“Obtaining ideas from well-established and well-connected community-based organizations to help identify applicants.” (Participant 2)

These participant answers emphasise community inclusion in recruiting. Community meetings and CBOs make recruiting more inclusive and boost credibility and reach. This

method helps discover community-trusted individuals, improving CHW programme efficacy and acceptance.

Multichannel communication follows established best practices. Perry *et al.*, (2014) found that CHW recruiting communication should use many channels to increase awareness and accessibility. Community meetings and CBOs are also endorsed by Crigler *et al.*, (2013), who emphasise using local networks and trust to improve recruitment. Diversity in communication modalities is also compatible with Bhattacharyya *et al.*, (2001), who urge a complete outreach strategy that encompasses both old and new outlets.

These methods work, but the research emphasises the necessity for ongoing review and adaption. Bhattacharyya *et al.*, (2001) proposes regularly analysing recruiting methods to stay relevant and reach the target group. This is essential in dynamic cultures with shifting communication preferences and methods. Sedibeng District Municipality observed that current communication and outreach methods work but need continual monitoring and adaptation.

This literature also suggests that successful communication and outreach programmes should recruit and involve CHWs. Kok *et al.*, (2015) observed that frequent contact and assistance help CHW retention and effectiveness. This involves regular updates, feedback, and problem-solving. Continued support for Sedibeng's multi-channel communication approach would improve the CHW programme.

6.4.3 SUB-THEME 1.3: INFLUENCE OF RESOURCES ON RECRUITMENT

Resources and distribution substantially impact Sedibeng CHW recruiting. Participants noted that budget constraints limit the quantity and kind of CHWs that can be hired. A successful recruitment strategy requires funds for marketing, training, and CHW support. Participants also said that the province level is mostly in charge of providing resources, with help from the national and area levels every once in a while. This tiered resource management system shows that local recruitment efforts depend on higher-level funds, which can slow down the process and make it less certain what will happen.

Based on the data, the phased scale-up method, in which the number of CHWs increases as more funding comes in, seems like a good way to make sure that recruitment efforts are in line with the resources that are available. But this method also shows how vulnerable the hiring process is to changes in the budget and delays in getting money. It is very important to have a steady flow of funds so that CHWs can keep getting hired and getting help. The answers from the participants show that people are aware of the money problems and know that new ideas are needed to better get and use resources.

“Because health service provision priorities compete for a share from a finite budget, a phased scale-up approach is advised such that CHW numbers are increased as more funding becomes available.” (Participant 1)

“Budget need to be allocated for recruitment.” (Participant 2)

These quotes show a point of showing how difficult it is to hire people when money is tight. Participant 1's statement of a phased scale-up method shows a practical way to match recruitment efforts with available funds, making sure that the process can last even if it's done slowly. Participant 2's focus on budgeting shows how important it is to have the money you need at the right time to carry out your job plans successfully.

In the larger body of research on the health workforce, the problem of how to hire people is well known to be affected by money issues. Research by Campbell *et al.*, (2013) and WHO (2016) constantly shows that limited funds are a major issue when it comes to expanding health worker programmes, such as those that use CHWs. The step-by-step plan that Participant 1 described fits with what experts say should be done to deal with limited resources while gradually increasing the size of the workforce (McPake *et al.*, 2015). Literature also supports the need for funding and support at multiple levels. It calls for organised efforts at the national, local, and district levels to make sure that resources are allocated properly and on time (Cometto *et al.*, 2013). So, even though the Sedibeng District Municipality faces problems that are similar to those seen around the world, their flexible approaches and use of phased application show that they have found a useful way to deal with limited funds in the hiring process.

Also, the research shows how important it is to come up with new ways to pay for things in order to solve the money problems that come up when trying to hire health workers. Public-private agreements and other finance sources can increase CHW investment,

according to Dahn *et al.*, (2015). These techniques may lengthen the recruiting process, Sedibeng found. Literature recommends financial planning and administration for resource efficiency (World Health Organisation, 2018). These methods may help Sedibeng recruit and retain CHWs.

6.5 MAJOR THEME 2: SPECIFIC RECRUITMENT NEEDS FOR THE CHW PROGRAMME IN SDM

6.5.1 SUB-THEME 2.1: DEMOGRAPHIC REQUIREMENTS AND PRE-SERVICE TRAINING

In Sedibeng District Municipality, semi-structured interviews showed several demographic and pre-service training requirements for Community Health Workers (CHWs). Participants emphasised gender, age, marriage, and decent housing. These traits help CHWs serve their communities by understanding local norms and traditions. Pre-service education, including a Matric certificate, is crucial. Prioritising standard competence training for CHWs before deployment to prepare them for their tasks.

Interviews show that the recruiting process prioritises educated, demographically fit candidates to increase social acceptance and influence. The focus on demographic fit and education guarantees that CHWs can meet community health requirements. Participants stated CHWs require pre-service training on basic health problems and abilities.

“CHWs must have a Matric certificate and should preferably reside within the community they will serve.” (Participant 1)

“The training includes foundational health education and skills to ensure CHWs are competent in their roles.” (Participant 2)

Participants' statements emphasise the recruiting standards' dual emphasis on education and community inclusion. A Matric certificate assures a baseline education, and CHWs should live in their community to use their local knowledge and contacts. The fact that Participant 2 said that they got basic health information and skills training shows how thorough CHW training programmes are before they start working.

By comparing these numbers to other research, we can see that the social and educational details of Sedibeng CHW are in line with what is considered best practice around the world. By hiring CHWs from the group they work with, Lehmann and Sanders (2007) found that trust is built, and health outcomes are better. Standardised pre-service training is what the WHO (2018) says CHWs should get to do their jobs. These ideas support Sedibeng District's focus on living in the area and being a part of the community, which makes CHWs more culturally competent and acceptable.

Literature also suggests that educational standards and training before starting work are necessary to make CHWs professionals and keep them that way. According to Zulu *et al.*, (2014), clear educational and training requirements set professional standards and allow CHWs to advance in their careers, which makes them happier at work and more likely to stay with the company. According to the Sedibeng District Municipality, these standards are being met well, which makes the CHW programme stronger and longer lasting. The focus on standard competency training is also online with Kok *et al.*, (2015), who say that well-trained CHWs can better deal with the different health problems in their areas.

6.5.2 SUB-THEME 2.2: ROLES AND RESPONSIBILITIES

Interviews show what CHWs in Sedibeng District Municipality do every day. As examples of basic care services provided by CHWs, participants named home visits, health education, illness screening, and help for mother and child health, tuberculosis (TB), and HIV/AIDS. In interviews, CHWs were also told about their clear roles and what was expected of them on the job, so they know what they need to do from the start.

Interviews show that CHWs have many responsibilities that require them to work closely with people in the community. These include going to people's homes to teach and support good health, checking for illnesses, treating minor health problems, and sending patients to other medical professionals. CHWs also give out medicine, offer emotional support, and plan events to raise knowledge about health. People who took part said that CHWs need to keep learning and getting reviews of their work in order to know what their jobs and responsibilities are.

“CHWs conduct household visits, screening, and health education. They also provide support for TB and HIV patients.” (Participant 1)

“The roles are clearly defined, and CHWs are trained to understand their day-to-day responsibilities and job expectations.” (Participant 2)

The excerpts from the participants show how broad the CHW's job is. It includes a lot of different tasks that are meant to improve health and keep people from getting sick. It's clear how important CHWs are to basic healthcare that Participant 1 named specific jobs like going to people's homes to check for diseases and follow ups. Making tasks and standards clear is what Participant 2 does to show that there is an organised way to make sure that CHWs are ready for their jobs and know what they need to do.

Because these results match up with other studies, it's clear that CHWs in Sedibeng do the right things and follow the best practices around the world. Porter *et al.*, (2014) did a study that showed CHWs do their best work when they know what their jobs are and are taught how to do a variety of health-related tasks. The different tasks listed in Sedibeng are in line with the all-around approach pushed by the WHO (2016).

This approach says that Community Health Workers should do many basic healthcare tasks to meet the needs of all types of people in the community.

Several pieces of writing also stress how important it is for CHWs to always learn their jobs and know what they're supposed to do. Studies by Bhattacharyya *et al.*, (2001) and Crigler *et al.*, (2013) say that CHWs need to know what their jobs are and be trained on a regular basis in order to stay inspired and do a good job. They are being used properly, as shown by the Sedibeng results which makes the CHW programme more successful. Putting more attention on feedback and performance reviews is also in line with what Kok *et al.*, (2015) say should be done. They say that for CHW projects to keep getting better and last, they need to be reviewed and helped on a regular basis.

6.5.3 SUB-THEME 2.3: RECRUITMENT TIMELINE AND COVERAGE AREA

The interview results show that the hiring schedule and frequency for CHWs in Sedibeng District Municipality are affected by a number of factors, such as the supply of resources and limited funds. The people who took part said that hiring usually happens once a year,

but the number of CHWs hired each year depends on the district's budget and health goals. The catchment population and the geographic places that CHWs serve are also important factors because they help to assign CHWs to different groups of people based on their specific medical needs.

The talks made it clear how important it is to have a well-planned hiring schedule for CHWs so that they can meet the health needs of the community quickly. People who took part said that recruitment efforts are sometimes focused on areas with the most urgent health needs. This makes sure that CHWs are sent to places where they are most needed. The numbers also showed that the exact number of CHWs patrolling each area is carefully measured to make sure that there is enough coverage and that no single CHW is overworked. This planned distribution makes sure that every community in the district gets the health care services it needs and helps the CHW scheme work better.

“Recruitment is done annually, and the number of CHWs recruited depends on the budget and health priorities.” (Participant 1)

“We allocate CHWs based on the catchment population and specific health needs of different geographic areas.” (Participant 2)

The participants' statements demonstrate CHW recruitment and allocation strategy. Participant 1's statement of the annual recruiting cycle and budget illustrates practical issues and planning. Participant 2's catchment population and health needs-based CHW assignment shows the district's personalised health care distribution.

These data and current literature suggest that Sedibeng's recruiting period and coverage area strategies meet health workforce planning best practices. Campbell *et al.*, (2013) offer a budget-, population-health-, and geographic-distribution-based recruiting and allocation method. Sedibeng's yearly recruitment cycle and strategic CHW allocation follow these guidelines to place workers where needed.

Flexible and responsive recruiting and allocation are recommended by research. McCake *et al.*, (2015) and Cometto *et al.*, (2013) recommend adjusting health workforce planning to changing requirements and resources. Participants' gradual recruiting meets district financial and health goals. Focusing on catchment population and geographic coverage

supports Lehmann and Sanders (2007), who think health worker allocation minimises health inequities and improves results in neglected areas.

6.6 MAJOR THEME 3: PROVINCIAL CONTEXT AND STRATEGIES FOR SUCCESSFUL RECRUITMENT

6.6.1 SUB-THEME 3.1: TRAINING AND SKILL ENHANCEMENT

Semi-structured interviews showed that Sedibeng District Municipality CHWs get pre-service, in-service, and short-term training. CHWs learn communication, problem-solving, and culture via these programmes. CHWs can undergo weekly, monthly, three-times-a-year, or annual trainings, based on their needs and plans.

The data show that pre-service training gives new CHWs the skills they need to do their duties. In-service training tackles new health challenges and practices and expands on earlier training. CHWs must take refresher programmes to keep updated on health requirements and improve their abilities. Given the diverse communities CHWs serve, communication and cultural competency are essential. They can respectfully and successfully communicate with community members.

“We provide comprehensive pre-service training to ensure CHWs are well-prepared before they start their duties.” (Participant 1)

“Refresher courses are conducted regularly to update CHWs on new health practices and protocols.” (Participant 2)

The participant quotes show that the training courses were organised and lengthy. Participant 1's explanation of substantial pre-service training highlights the necessity to prepare CHWs before they start work. Participant 2's concentration on continual learning and development refresher courses indicates a dedication to CHW awareness and competence.

These findings and previous studies demonstrate that Sedibeng's health worker training and skill-building programmes are superior. Lehmann and Sanders (2007) recommend extensive pre- and in-service CHW training. This assures CHWs receive help and are ready for their employment. Cultural competence and communication are also stressed by the WHO (2018). They underline that working effectively with people from many backgrounds depends on CHWs possessing strong people skills.

The article also emphasises the need of routinely obtaining regular training and skill enhancements. Regular training and repeat classes are very important for CHWs to keep being effective and adaptable to changing health needs and practices, as shown by studies by Perry *et al.*, (2014) and Zulu *et al.*, (2014). The results from Sedibeng support these suggestions, with an organised approach to training that includes regular reports and always getting better at what you do. This method not only helps CHWs do their jobs better, but it also makes them happier at work and more likely to stay with the company because they feel supported and valued in their roles.

6.6.2 SUB-THEME 3.2: SUPERVISORY AND MANAGEMENT SUPPORT

The interviews show that Sedibeng District Municipality's CHW programme needs supervisory and management assistance. Participants noted a CHW unit and supervisors who advise and support CHWs. This supervision system ensures CHWs get the support they need to do their jobs. Transport to catchment populations helps CHWs reach rural regions and provide health services efficiently.

The data shows that CHWs are regularly evaluated and supervised. These assessments pinpoint areas for growth and offer feedback for professional development. A specialised CHW unit and supervisors provide CHWs with ongoing assistance and resources, helping them meet community health requirements.

“We have a dedicated CHW unit with supervisors who provide regular support and guidance.” (Participant 1)

“Transport is provided to ensure CHWs can reach their assigned areas and deliver health services.” (Participant 2)

The quotes from the participants stress how important it is for CHWs to have an organised support system. Participant 1's discussion of a special area for CHWs and regular supervision shows how important good management is for helping CHWs do their jobs. Making sure that CHWs can get to and help their places is really what Participant 2 is all about when they talk about travel.

These findings, along with those from other studies, make it clear that Sedibeng's ways of helping with supervision and management are the best ways to run a CHW project.

Kok *et al.*, (2015) say that good management and support are necessary for CHW projects to work because they give CHWs the direction, tools, and drive they need to do their jobs. Crigler *et al.*, (2013) say that structured direction and ongoing professional growth are very important for CHWs. The fact that there is a dedicated CHW unit and regular performance reviews backs this up.

Literature also shows how important it is for CHWs to have real help, like rides, so they can do their jobs well. Bhattacharyya *et al.*, (2001) and Lehmann and Sanders (2007) both show how important it is for CHWs to be able to get to the people they are meant to help and provide important health services. This is especially true in rural and remote areas. Sedibeng's results back up these ideas. They show that the CHW programme can work better and faster with a full support system that includes organisational, managerial, and management help.

6.6.3 SUB-THEME 3.3: COMMUNITY INVOLVEMENT AND SUPPORT

The results of the interview highlight the need of community involvement for supporting the CHW initiative in the Sedibeng District Municipality. Those who participated underlined the need of long-term relationships amongst members of the community in order to locate and employ CHWs. Working together and based on trust, these ties enable CHWs to become totally involved in the organisations they assist. Involving community leaders in the hiring process strengthens the programme since it guarantees that CHWs are selected according on their knowledge and popularity among the community.

The figures also highlight the need of attending community activities as a means of involving people and attracting fresh members. These gatherings allow CHWs to meet potential candidates and members of the community, therefore disseminating knowledge of the CHW programme and its advantages. Participating in local activities and community leaders help to make the surroundings more useful for CHWs, so facilitating their job performance and acceptance.

“We have long-standing relationships with the community, which help in identifying and recruiting CHWs.” (Participant 1)

“Community leaders are actively involved in the recruitment process, ensuring that CHWs are well-integrated into the community.” (Participant 2)

Participant quotes highlight CHW programme community connection. The comment of participant 1 about long-standing links reveals community confidence and involvement with the CHW project. Participant 2 underlines the active participation of community leaders since CHW recruiting and integration depend on local support.

Previous studies and our results indicate that CHW projects require community involvement and support. Lehmann and Sanders (2007) found that community-supported CHWs are more successful. Bhattacharyya *et al.*, (2001) encourage community leaders and local actions to attract CHWs.

The literature shows that community participation boosts CHW recruitment, retention, and programme effectiveness. Since society trusts and accepts CHWs, Zulu *et al.*, (2014) and Perry *et al.*, (2014) found that community support and engagement improve health outcomes. To progress the CHW initiative, Sedibeng recommends maintaining strong community relationships, engaging local leaders, and sponsoring community events.

6.7 MAJOR THEME 4: CRITERIA OF SELECTION FOR CHWs

6.7.1 SUB THEME 4.1: SELECTION CRITERIA AND DEMOGRAPHIC FACTORS

This sub-theme's semi-structured interviews discuss Sedibeng District Municipality's Community Health Workers (CHWs) and hiring process. The study found that education and training matriculation being best are most essential. Pre-service training and competency testing prepare CHWs. To ensure CHWs match their communities, age, gender, marital status, and location are considered.

Results demonstrate that the recruiting process searches for persons with the correct demographics to interact with neighbours and fulfil education and training criteria. This makes CHWs more informed and personable to customers, improving the programme.

“We prioritize candidates with a matric certificate to ensure they have a basic level of education.” (Participant 1)

“Pre-service training and competency assessments are essential to prepare CHWs for their roles.” (Participant 2)

Participants' comments illustrate how significant educational background and training are when hiring. The fact that Participant 1 talks about how important it is to have a matriculation certificate shows how important education is seen to be. That's what

Participant 2 says about pre-service training and skill evaluations: they're two very important parts of getting CHWs ready for their jobs.

When you compare these results to those from other studies, you can see that they all stress how important educated and trained CHWs are. According to Olaniran *et al.*, (2017), good CHW programmes give applicants with basic schooling the most attention and train them well to make sure they are ready for their jobs. Also, the World Health Organisation (2018) says that to keep care and service delivery at a high level, people should get training before they start working and be tested on a regular basis.

The data showed that demographic factors were important. This is in line with what Lehmann and Sanders (2007) say should happen when choosing CHWs: they should be able to connect with the people they work with. This means thinking about things like their age, gender, and where they live. It is important for community health workers (CHWs) to be able to talk and connect with people in the community in a way that improves health outcomes and programme success.

6.7.2 SUB-THEME 4.2: RECRUITMENT COSTS AND RESOURCE ALLOCATION

The data gathered from the semi-structured interviews shows that the process of hiring CHWs in Sedibeng District Municipality is affected by marketing costs and the distribution of resources. Participants pointed out that the tools that are available have a direct effect on how easy it is to hire and keep CHWs. For example, promoting jobs, holding interviews, and giving training are all things that need money to be done efficiently. There are different levels of government that provide these resources. Some come from the state and national levels, while others are managed at the district level.

The results show that for employment to go well, resources need to be carefully distributed so that all parts of the process have enough money. This covers not only the initial steps taken to hire CHWs, but also their ongoing help and training. The number of CHWs that can be hired is also limited by the resources that are available. If money is scarce, you may not be able to recruit extra personnel.

“Recruitment costs are a major factor; without sufficient funding, it’s challenging to recruit and train new CHWs.” (Participant 1)

“We rely on resources from both provincial and national levels, but local budget constraints can limit recruitment.” (Participant 2)

Participants: remarks indicate how expensive hiring is. Participant 2 discusses the need of multi-level government assistance and how local budget constraints might impact things. Participant 1 stresses the need of funding CHW hiring and training.

These findings and a new research show that CHW groups worldwide struggle to allocate funding. According to Bhattacharyya *et al.*, (2001), insufficient funding might make it difficult to employ and retain CHWs, reducing health programme effectiveness. According to Crigler *et al.*, (2013), CHW programmes need consistent funding to employ, train, and support staff. Sufficient resource allocation is crucial.

The Sedibeng District Municipality results corroborate these principles and demonstrate the importance of a well-planned resource sharing strategy. This entails securing money from several levels of government and ensuring local budgets are enough to employ and retain CHWs. Long-term funding sources are very important for keeping CHW projects going as well as they should. This is clear from all the talk about funding sources.

6.7.3 SUB-THEME 4.3: EVALUATION AND MONITORING OF THE SELECTION PROCESS

Semi-structured interviews showed that Sedibeng District Municipality's CHW selection procedure relies on tracking and evaluation. Frequent performance evaluations help to identify areas where CHWs might develop and show how effectively they are performing. Apart from these assessments, CHWs are continuously under observation and supervision to ensure they receive the necessary tools and instruction to do their roles effectively. These evaluations provide us comments that we apply to improve the choice process and match what the community and health system require.

According to the statistics, leaders whose sole responsibility is to monitor the work of CHWs have a good tracking mechanism in place. This system comprises chances for professional development, performance reviews, and discussion forums. The monitoring systems are supposed to assist CHWs constantly and ensure them maintain high degrees of service performance and care.

“Regular performance evaluations help us identify strengths and areas for improvement in our CHWs.” (Participant 1)

“We have a dedicated supervision team that provides ongoing support and monitors the performance of CHWs.” (Participant 2)

The quotes from participants make the point that job reviews and keeping an eye on the hiring process are important. Participant 2 talks about how CHWs have a specific team of supervisors who help them all the time. First participant discusses about how reviews point up areas needing work.

Earlier research indicates that the effectiveness of the CHW initiative depends critically on tracking and evaluating. To keep high standards and provide managers and CHWs with the necessary abilities, Kok et al. (2015) advise routine assessments of them. The WHO also advises tracking and feedback strategies to raise CHW activity (2018).

The results of the Sedibeng District Municipality confirm these values and show the need of organised assessment and validation. Often examined, supervised, and given comments, CHWs help to advance their careers and hasten employment. Making sure CHWs have the correct tools and satisfy high quality guarantee.

6.8 MAJOR THEME 5: GUIDELINES FOR STRENGTHENING CHW PROGRAMME

6.8.1 SUB THEME 5.1: DEVELOPING EFFECTIVE RECRUITMENT STRATEGIES

Respondents to this sub-theme claimed that the Sedibeng District Municipality has enabled Community Health Workers (CHWs) to creatively plan. People can be recruited at community meetings, through community-based networks, and by word-of-mouth at social events. Improvement methods that keep going are also used to make these ways of hiring better over time.

Currently, it looks like creative approaches, like using community-based groups to look for possible candidates, have worked very well. People in the area know and trust these groups, which makes them great spots to find good CHWs. The city has also started to do things like post job openings at neighbourhood events and meetings so that everyone can be a part of the hiring process, and a lot of people are affected.

“We have found that community-based organizations are instrumental in identifying candidates who are well-suited for the role of CHW.” (Participant 1)

“Announcing positions at community meetings has helped us reach a wider audience and find candidates who are already trusted members of the community.” (Participant 2)

The responses of the participants show the value of direct community involvement in recruiting as well as of community-based organisations. While Participant 2 stresses the importance of community events in increasing recruitment activities, Participant 1 stresses the participation of community-based organisations in locating eligible candidates.

These samples illustrate that direct community connection and community-based groups help to guarantee that CHWs are trusted and welcomed by their respective communities as well as help to increase recruiting. Essential for CHWs' effectiveness is trust since it facilitates their communication and cooperation with community people. The constant development actions of the participants indicate their dedication to enhance recruiting strategies to satisfy evolving needs.

Comparatively to literature, our results align with CHW recruiting best practices. Since they have strong ties to the community and can find possible CHWs, Bhattacharyya et al. (2001) suggest including community-based groups into the hiring process. Direct community involvement in recruiting, according to Crigler et al. (2013), fosters trust and helps CHWs be included into local communities.

6.8.2 SUB THEME 5.2: ENHANCING TRAINING AND SKILL DEVELOPMENT

The interviews that were not fully planned show that ongoing training and classes to brush up on skills play an important role in the Sedibeng District Municipality CHW scheme. The goal of these training courses is to help people get better at speech, solving problems, and understanding other cultures. CHWs are kept up to date on the latest changes and best practices in healthcare through meetings and updates where people share what they know.

The results show how important it is for CHWs to keep learning so that they can do their jobs well. Training courses are designed for basic and continuous skill improvement. Classes that build on basic training and update CHWs on new healthcare laws and practices are prioritised.

“Our training programs include regular refresher courses to ensure that CHWs are always up to date with the latest healthcare practices.” (Participant 1)

“We focus on enhancing skills such as communication and cultural competency, which are essential for CHWs to effectively engage with the community.” (Participant 2)

The athletes stressed the need of improvement. Participant 1 emphasises refresher training for CHWs, whereas Participant 2 emphasises conversational and cultural sensitivity.

These examples demonstrate how crucial ongoing training and skill development are for CHW programmes. The training updates CHWs on modern healthcare practices and essential skills for community interaction and high-quality treatment. This strategy motivates and delights CHWs since they feel ready to work.

These findings and past research suggest that effective CHW efforts require continual training and skill improvement. Kok et al. (2015) advised CHWs to be motivated and competent. Frequent refresher courses maintain CHWs current on new techniques and help to reinforce first training. The World Health Organisation also emphasises in its 2018 recommendations for enhancing CHW programmes the need of CHWs continuing to study and developing their abilities.

6.8.3 SUB THEME 5.3: ENSURING COMMUNITY AND ORGANISATIONAL SUPPORT

The interviews somehow show indication that Sedibeng District Municipality CHW scheme needs help from the community and other groups in order to be successful. The results make it clear how important it is to hire more people from the community, build strong ties with community leaders, and make sure that organisations give CHWs the help and tools they need.

The numbers show that letting the community help hire CHWs helps make sure that the people who live in the neighbourhood like and trust them. Community health workers (CHWs) should also develop good relationships with community leaders. Community leaders can advise and assist CHWs. The company must also give CHWs the tools they need to succeed and be happy at work.

“Community involvement in recruitment helps to ensure that CHWs are well-integrated into the community and trusted by community members.” (Participant 1)

“Building strong relationships with community leaders is essential for providing support and guidance to CHWs.” (Participant 2)

The comments from the participants show that the CHW project needs help from the community and from organisations. Participant 2 stresses the value of good relationships with community leaders, while Participant 1 focuses on community involvement and jobs. These examples show how important it is for community and group support for CHW projects. Giving the community the power to hire CHWs and build ties with community leaders increases support and trust. CHW success depends on motivation and job satisfaction, which may be achieved with the correct tools and organisation.

6.9 DISCUSSION OF THE FINDINGS

Candidates are hired in an organized manner within primary health care, particularly Community Health Workers (CHWs). It is critical to hire personnel with the necessary skills and ability to accomplish the job. This is what CHWs must complete before they may assist patients with their health requirements.

Interviews with a framework showed that the SDM hiring process has more than one step. For example, jobs are posted, individuals are screened, and interviews are held. Word spreads through local media, community meetings, and social activities. As many people as possible can hear it. The WHO advised us to undertake these things because the community must be involved in employing CHWs.

Individuals are selected based on school performance and community reputation. Potential employees must have completed high school and pre-service training to demonstrate their competence. This two-step method ensures CHWs are polite and skilled. Bhattacharyya *et al.*, (2001) and Crigler *et al.*, (2013) demonstrate this method's efficacy. The community must trust selected CHWs and their training. They demonstrate an open, fair selection process with clear norms and procedures to eliminate prejudice. People must trust each other and think only the best CHWs are chosen.

6.9.1 Specific Recruitment Needs for the CHW Programme in SDM

Health issues in the neighbourhood and among residents necessitate hiring a CHW. Because CHWs treat many health issues, many individuals desire to hire them. To provide good service, you must select CHWs based on both application volume and quality. Finding qualified CHWs who understand different cultures and the location is crucial. To satisfy this demand, community-based groups can assist recruit individuals and hear what community leaders believe. The study proposes that CHWs frequently undergo training and retraining programmes to update their health practices and improve their communication, problem-solving, and cultural awareness. Kok *et al.*, (2015) found that CHWs must constantly learning.

The CHW initiative requires school and governmental funds to continue. This include giving them money to assist with hiring, training, getting to work, and keeping a watch on them. The WHO's (2018) ideas stress how important it is to give the CHW programme the tools it needs to succeed.

6.9.2 Provincial Context and Strategies for Developing a Successful Recruitment Process for CHWs Programme in SDM

Province condition is vital for SDM CHW recruiting. The findings show that province health policies and goals affect tactics. These guidelines guarantee the district follows state health goals and requirements and manages affairs.

Creating a state-wide employment process that could satisfy the needs of any area was vital. In this framework, recruiting procedures, the hiring process, and party roles are clearly defined. The standardisation ensures that the hiring procedure is equitable and consistent around the province. Standardised models are required, according to Lehmann and Sanders (2007), to guarantee that CHW initiatives are of great quality and effectiveness.

Provincial health officials participating in the recruiting process is another strategy. They are thus supervising, providing tools for, and helping with district-level recruitment campaigns. According to the statistics, handling issues like not having enough money and logistical difficulties depends much on this kind of top-notch assistance. Crigler *et al.*,

(2013) also address how local level provincial health officials may assist with recruitment campaigns. They underline the need of having support from several angles when implementing CHW projects.

The condition of the province influences also the training and development strategies for CHWs. According to the data, provincial health authorities are quite active in ensuring that training courses complement most current health policies and practices. This site prepares community health professionals for local health challenges.

6.9.3 Criteria for Selection of CHWs

The standards used to choose CHWs in SDM are meant to make sure that applicants have the skills, knowledge, and good image in the community to do their jobs well. The data shows that the selection criteria is affected by many things, such as schooling, community recommendations, and training before starting work.

Candidates must have at least a high school diploma, which is one of the most important standards. This rule makes sure that CHWs know just the bare essentials to understand health facts and do their work well. Bhattacharyya *et al.*, (2001) say that the standard of the care they give is a big part of what makes CHWs choose a school background.

Going to school before starting work is still another very important condition. The numbers show that people who want to apply go through tough training courses that teach them basic skills as well as important traits like how to communicate well, understand other cultures, and fix problems. These classes make sure that CHWs are ready to meet all of society's health needs. It's also important for Kok *et al.*, (2015) to train CHWs before they start working so that they have the skills and knowledge they need.

What people in the neighbourhood say has a big impact on the choosing process. The results show that leaders and neighbourhood groups help find people who might be good candidates. So, the people who are picked are sure to be honest members of society. It meets the best standards set by the WHO (2018) and stresses how important it is for the community to be involved in picking CHWs. As part of the hiring process, CHWs also have to go through regular performance reviews to make sure they keep meeting the requirements for their jobs. These reviews are done by supervisors, and people in the

community give comments. The CHW programme is popular and of high standard because it is constantly evaluated.

6.9.4 Framework Regarding Recruitment and Selection Process for Strengthening CHW Programme

There are several ways that SDM could improve how it hires and picks CHWs based on the study's results. These ideas are meant to fix the issues that have been found with the hiring process and make the CHW plan work better all around.

To begin, there should be a thorough and uniform way to hire people that can be changed to fit the needs of any place. It should be clear how to hire people, what to do, and what the role of each partner is in this system. Standardisation makes sure that the same set of rules are used to judge all prospects. This makes sure that the hire process is always fair.

For the second part of the hiring process, jobs should be posted on several websites so that a lot of people can see them. There is news about the area, neighbourhood meetings, social events, and websites. You can get a bigger range of candidates and reach more people when you use more than one route.

Thirdly, the process of choosing must consider all educational credentials, training before starting work, and neighbourhood ideas. Applicants get the skills and knowledge they need during pre-service training, but they need to show proof that they have at least a bachelor's degree. People can get in touch with trustworthy and well-known people in their area through recommendations.

Fourthly, more attention should be paid to CHWs' ongoing education and growth. This includes chances to move up in your job, classes to improve your skills, and training programmes that keep people trained. Trainee community health workers (CHWs) all the time to make sure they can do their jobs and keep their skills and drive up to speed.

Fifthly, performance checks for CHWs should be a regular part of the hire process to make sure they keep doing their jobs. People from the community and the CHWs' bosses should give you feedback on these ratings so that you can get a full picture of how well they did.

Finally, the CHW project should continue as long as needed due to provincial and local funding. This includes both the money to train and hire new people and help with things like tracking and transportation. Health officials at the provincial level should help solve problems like a lack of funds and trouble with operations by keeping an eye on and helping with employment efforts at the district level.

6.10 CHAPTER SUMMARY

Chapter 6 examined the Sedibeng District Municipality (SDM)'s Community Health Workers (CHW) hiring and selection processes to determine their efficacy. This chapter uses the demographics of respondents, their experiences and contentment with hiring, and the ways that managers change these processes to come to some conclusions. The study's results will make the CHW scheme better in SDM and other places as well.

A study of demographics found that most of the people who worked on the CHW project were middle-aged women. This difference between men and women shows that targeted employment programmes are needed to get more men to apply and encourage gender diversity in the workplace. Also, CHWs' educational backgrounds show that the hiring process is good at finding people with the skills and desire to help their communities, even though formal education levels range.

Non-governmental organisations (NGOs) were very important in the early stages, as shown by the recruiting sources. This shows a move towards more formalised and organised recruitment methods. The fact that respondents were very happy with the hiring process shows that the methods used were good. To keep and raise these levels of satisfaction, there needs to be constant growth, especially in closing the feedback gaps between CHWs.

The data also showed how important it is to hire people from within the community and to look at both domestic and international candidates. This approach for including everyone creates a wider pool of applicants, which promotes fair opportunities and raises the quality of the CHW workforce. The study also found that hiring management has a big impact on how fair and effective things are. Management styles that are positive and helpful help to hire and keep CHWs.

The study says that CHWs choose their jobs based on their desire to improve the health of the community. It's important to keep your own motivation up by growing professionally and having helpful management. According to the figures, financial incentives are not the main reason for the work, but they do keep it going. Finding a balance between intrinsic and extrinsic rewards is important for long-term retention and job happiness.

The need to hire people quickly and from a variety of backgrounds in the public health field point to deliberate action. Targeted policies and practices can make it easier to hire people and meet the needs of the community and health sector.

In the end of this chapter, it is said that the Sedibeng District Municipality CHW scheme benefits from good hiring and selection practices. The SDM can build a strong CHW staff by making sure these processes are in line with best practices and filling in any gaps. This study helps researchers come up with targeted ways to improve community health, professional growth, and hiring. The results' suggestions based on evidence show how to keep developing the CHW project so that it meets the needs of both the community and the health sector.

The next chapter will be providing practical guidelines for recruitment and selection of CHW.

CHAPTER: SEVEN

PRACTICE AND FRAMEWORK FOR CHW RECRUITMENT AND SELECTION

7.1 INTRODUCTION

In this chapter the researcher seeks to present a framework aimed at enhancing the recruitment and selection practices for CHWs. The reviewed literature indicates that CHW's continue to play a critical role in enhancing the MDG regarding the PHC. This chapter draws from the literature reviewed on the recruitment and selection process for CHW's, the programmes established on an international as well as on a local scale. The discussion and presentation of the proposed guidelines of the empirical findings in relation to the research questions and relevant theories.

Recruitment and selection are a crucial process which needs the utmost caution in order to ensure efficiency and sustainability. Throughout this study, we emphasised the relevance of recruiting and selection in strengthening the CHW Programme. This is important because the CHW programme must be both sustainable and enhance efficiency throughout primary health care. Recruitment is the process of identifying possible applicants for current or anticipated organisational vacancies. Alternatively, it can be viewed as a connection activity that connects job seekers and employers. Better recruitment and selection procedures increase organisational outcomes (Kumari & Malhotra, 2013) Selection is the process of choosing qualified persons to fill positions in an organization. Selection entails much more than simply choosing the finest applicant. This approach aims to find a balance between the applicant's skills and the organization's needs (Kumari & Malhotra, 2013).

CHWs are professionals or non-professionals who operate at the forefront of the healthcare system. They typically serve a community where they reside, which results in a strong awareness of the local language and culture. They can overcome cultural, language, and moral barriers to provide services to communities, linking the formal and informal sectors. These individuals play numerous functions, including promoting health and providing healthcare services (Kangovi, Mitra, Grande, Huo, Smith, Long, 2017).

Today CHWs and their allies participate in meetings with other members of the public health and healthcare fields talking about this novel CHW intervention, yet CHWs are often not even identified as part of inter-professional teams. Numerous organizations, let alone some community members, do not understand the presence, roles, and power of CHWs on the frontlines of public health domestically and internationally. In light of the U.S.'s current substantial investment in CHWs during the COVID-19 pandemic, we must ask if CHWs programs will be the first to be downsized as funds dissipate. Despite significant investments, CHW jobs are often part-time, without benefits, and without sufficient workspaces and equipment (such as desks and computers). We underinvest in CHWs and even isolate them so that they are not fully integrated into the fabric of our health and human services systems. Yet, CHWs can weave us into whole cloth and fill many gaps.

7.2 OUTCOMES OF RECRUITMENT AND SELECTION OF CHWs

Throughout the study, the definitions of recruitment and selection were defined to understand the context in which it relates to the Community Health Worker programmes and how its effectiveness strengthens the programme. An essential part of human resource management is recruitment and selection. They have an impact on the workforce's quantity and quality in the healthcare industry (Brown, McManus, Davison, Gill, & Lilford, 2019). Recruitment and Selection of CHWs requires finding candidates that demonstrate the abilities, expertise, and qualities needed to enable them to serve the community in an efficient manner.

CHWs are continuously provided with a variety of training options that provide them with the skills necessary for today's demands. To ensure that language, culture, and lived experience are all represented in the community they serve, it is also essential to have a varied workforce or team of CHWs.

One of the most crucial components is community involvement, since it requires the participation of the community in the recruitment process for CHWs. Community engagement or participation builds strong bonds between the CHWs and the communities they serve by establishing credibility and trust. Effective recruitment and selection processes lead to better health outcomes. This is because CHWs receive

training on how to provide higher-quality services and support, which eventually leads to better health outcomes for community members. Efficient hiring and selection processes further enhance the CHW programme's legitimacy.

7.3 THEORETICAL LINK TO RECRUITMENT AND SELECTION OF CHWs

Any firms' long-term success depends on having the right people in the right places at the right times. The staffing function significantly affects whether a firm will be competitive if a firm's human capital resources are a significant factor in determining its capacity to compete (Ployhart & Weekley, 2014).

7.3.1 RESOURCE BASED THEORY

The Resource Based View (RBV) places an emphasis on resources and capabilities when developing strategies to create long-lasting competitive advantages. It does this by analyzing and interpreting the internal resources of the businesses. Resources can be thought of as inputs that businesses use to carry out their operations. Businesses make strategic decisions based on their internal resources and competencies when competing in their external business environment. Some businesses can also grow into new markets, create new goods, and add value to the consumer value chain thanks to their capabilities. To create long-lasting competitive advantages, the RBV makes use of the organizational resources and competencies. RBV states that not every resource a company has will be strategic and therefore a source of competitive advantage. Competitive advantage only materializes in specific circumstances (Madhani, 2010).

The primary goal of the study of strategic management was to try and figure out why certain businesses do better than others. It was discovered that the term "performance" was quite unclear, both philosophically and practically (Peteraf, & Barney, 2003). For example, a firm's performance was assessed by some writers in relation to its expenditures on capital (Porter, 1980: 3), by others in relation to industry competitors' accounting performance (Fisher & McGowan, 1983), and still by others in relation to the performance a firm would produce in a market with perfect competition (Barney, Ketchen, & Wright, 2021). A company operating in a particular industry or possessing specific resources and competencies may have a competitive advantage that translates into improved performance. RBV assists managers in comprehending the reasons behind the

perception that abilities are a firm's most valuable asset and in appreciating the ways in which those assets may be leveraged to enhance company success (Madhani 2010).

Table 7.1 RESOURCE BASED VIEW: CONCEPTS AND PRACTICES

Authors (year)	Major Contribution
Penrose (1959)	Showcases a company's internal resources. The resources of a company determine its growth, which is constrained by management resources.
Andrews (1971)	Places a focus on internal resource management
Lippman and Rumelt (1982)	Healthy long-term competitive advantage stems from delicate relationships between distinctiveness and causal uncertainty
Wernerfelt (1984)	Companies as collections of assets
Rumelt (1984)	Based on the notion that companies are collections of resources, strategic theory of the firm
Barney (1986)	Elements of the market influence a company's chances of generating rent.
Rumelt (1987)	Companies as tenants. The significance of separating systems to collect rent
Rumelt (1987), Dierickx and Cool (1989)	An overview of imitability hurdles that prevent (or make highly expensive) imitation from rivals, such as causal ambiguity and isolating processes like asset collaboration and asset stock efficiency
Day and Wensley (1988), Aaker (1989) Grant (1991), Wernerfelt (1989)	Models of strategic formulation where business resources are the primary idea and the sources of long-term competitive advantage
Prahalad and Hamel (1990)	Corporate strategy and diversification are driven by core strengths. Core abilities should be leveraged and exploited by businesses. Businesses should expand into complementary industries that allow them to use and strengthen their core competencies.
Hansen and Wernerfelt (1989), Rumelt (1991)	Empirical research that backs up the theory that organizational characteristics or firm-specific resources account for a greater portion of a firm's superior performance than industry variables
Barney (1991)	Strategic competitive advantage can arise from key strategic resources that are precious, rare, hard to replicate, and non-replaceable.

Conner (1991)	Comparing alternative economics-based strategic approaches with the resource-based theory of the company. explanation of the resource-based theory's underlying presumptions and how they relate to techniques for collecting rent
Peteraf (1993)	A framework for strategic competitive advantage based on integrative resources. suggests that companies might achieve better performance by gaining market power in product marketplaces or by renting out scarce and productive resources.
Day (1994)	The framework of capabilities for strategic competitive advantage. differentiates between spanning, inside-out, and outside-in capacities
Collis and Montgomery (1995)	Managerially focused evaluation of the RBV
Grant (1996)	A knowledge-based perspective emerges that views knowledge as a company's primary or strategic asset.
Teece, Pisano, and Shuen (1997)	Dynamic capacities as sources of edge over competitors
Adapted from Olavarrieta & Ellinger, 1997; Mahoney, 2004	

7.3.2 TANGIBLE AND INTANGIBLE RESOURCES FOR CHWs

Every company has a diverse range of assets and competencies. Differentiating between such diverse resources is essential for a deeper comprehension of resources. A practical method for classifying resources is to divide them into two groups: tangible and intangible resources.

Table 7.2: Types of Resources and Capabilities

Tangible Resources and Capabilities	Examples
Financial	Capacity to generate internal finances: The CHW programme is funded internally, with monies coming from the provincial government. SDM depends on the government's funding. To help sustain the quality of service, the district must find funding from nonprofit organizations like private businesses.
Physical	When CHWs visit communities, they carry out house-to-house campaigns and provide health support by administering patients' medications and raising awareness of health issues.

	In most of the clinics we visited, there wasn't enough room for the CHWs. They frequently appear to be sitting outside beneath the tree when they are at the clinics for their reports.
Technological	Mobile health technologies need to be constantly improved to help CHWs improve their technical proficiency.
Organizational	The district coordinator, command, and control should be formally put into place. Information systems for integrated management
Intangible Resources and Capabilities	Examples
Human	Managerial abilities from CHW's, such as effective communication, understanding of organizational culture, and the capacity to interact with the CLR, stakeholders, and OTL
Innovation	- The ability to invent new products, processes, and services through research and development (R&D) - Capabilities for organizational innovation and change - Adding a formal curriculum for advancement of CHW's to create a permanent, and well recognized structure - Creating safety for CHW's
Reputational	Positive characteristics of a CHW include the need for: - Personal growth - Enhancement of the community's health - Value and Recognition amongst the community

7.3.2 EQUITY THEORY

What drives individuals to labour? Equity theory states that it is the sense of fairness and unfairness. "Inequity exists for person whenever he perceives that the ratio of his outcomes to inputs and the ratio of others' outcomes to others' inputs are unequal," according to Adams (1965). It follows that when someone benefits excessively or too much, there is unfairness involved.

Two sides are the focus of equity theory: the input and the result. An employee compares the inputs and outcomes ratios of their work. If an employee notices unfairness, they will take action to make the situation right. The worker might do a job of lower quality or with less productivity. Inequalities frequently result in higher absenteeism and even

resignations within a business. Since equity theory addresses human motivations, it should be widely used to comprehend organizational behavior. Human resource experts have been paying greater attention to equity theory lately, particularly when it comes to the fairness of results. Industry, labor, and government all have serious concerns about equity, or more accurately, inequity. Employees typically view the fairness of the exchange between their employer and themselves as involving more than just economic considerations; rather, it involves a question of relative justice (Al-Zawahreh & Al-Madi, 2012).

As part of their interaction with their employers, human resource educators handle a range of administrative duties for various results. Among the results that HRM manages are pay, salary, bonuses, promotions, and disciplinary measures. When it comes to how fair outcomes are regarded by employees, HRM is crucial (Al-Zawahreh & Al-Madi, 2012).

7.3.2.1 EQUITY THEORY IN RELATION TO CHW RECRUITMENT AND SELECTION

Equity theory is pertinent to CHW recruitment and selection because it emphasizes the importance of maintaining justice and fairness in the allocation of opportunities, resources, and benefits. The goal of equity theory is to address the injustices and inequities that CHWs frequently encounter. Despite their widespread popularity and demand, they frequently continue to be marginalized and lack sufficient funds. Budgetary constraints are evident and prevent CHWs from operating effectively. Below the researcher provides several ways on how Equity Theory can be applied in relation to CHW.

- *Fair remuneration:*

SDM CHWs are paid a salary in addition to benefits like medical coverage. However, one respondent believed that their earnings would increase if they could obtain more formal education to become healthcare workers. In consideration of their abilities and the community they are proud to serve, it is critical to make sure that CHWs are compensated fairly for their hard, selfless work.

- *Resource distribution:*

Prioritizing resource distribution is necessary for CHWs to carry out their responsibilities and duties in an efficient manner. It is imperative that resources such as support, equipment, and training are provided without any delays. As a result, it's critical to provide resources that address every individual's specific needs to assist eliminate the challenges

that CHWs have while carrying out their duties. Some respondents mentioned that they occasionally struggle to get the appropriate kits, often ending up having to divide the kits. It is therefore crucial for the distribution of resources to be done efficiently.

- *Prospects for professional advancement:*

CHWs should have a fair and equal chance to progress in their work. New cadres can be assimilated and given that platform for growth if CHWs are given an advancement in terms of expanding within the healthcare industry. CHWs must be provided with the chance to advance their studies and assume leadership positions. Progress will guarantee that growth occurs continuously.

- *Cultural sensitivity:*

The district must acknowledge and give particular importance to the different experiences, backgrounds, and perspectives of the CHWs working in the SDM area. Cultural barriers to healthcare must be continually addressed.

- *Power dynamics:*

To ensure that CHWs around SDM feel empowered to make decisions and act, when necessary, power imbalances between CHWs, healthcare systems, and communities must be addressed to maintain efficiency.

Applying equity theory can help healthcare systems and organizations support CHWs more effectively, improve their working conditions, and raise the standard of care given to underserved communities.

7.3.3 HUMAN CAPITAL THEORY

The knowledge, abilities, and experience that a person gains from education and training are collectively referred to as human capital (Armstrong, 2010; Odhong *et al.*, 2014). The combined skills, knowledge, and talents that comprise an organization's staff are referred to as its human capital, as was discussed in Chapter 2.

The tangible part of an institution's human capital is only important during the recruitment and selection stages of human resource procedures. The premise that investing in CHWs' skills, knowledge, and talents would undoubtedly yield results in the form of improved health outcomes, higher productivity, and directly enhances quality of care makes human capital the most essential theory linked to this study. Based on the results, the researcher will go over a few important points that have an immediate impact on CHWs and Human Capital Theory below:

- *Investment in training:*

To ensure that CHWs' skills and competences are continuously improved, SDM must give them the high-quality education and training they need.

- *Capacity building:*

Building capacity is essential for CHWs since it will enhance their unique abilities and prepare them for potential future duties, responsibilities, and leadership roles that they will need to hold.

- *Health knowledge and skills:*

For CHWs to interact with the community with confidence and contribute to building trust between the community and the CHW, SDM must make sure that CHWs possess a thorough understanding of health concepts, disease management, and prevention measures.

- *Development of soft skills:*

It's important to nurture soft skills, such as problem-solving, interpersonal, and communication abilities.

- *Continuous learning:*

Constant learning is crucial since new advancements keep coming about throughout time. Therefore, for the district to be certain that CHWs remain updated on best practices and evidence-based treatments, it is crucial that SDM provide support for CHWs in the form of mentorship, ongoing education, and training.

- *Credentialing and certification:*

Certification is beneficial since it sets educational standards and recognizes the knowledge and skills of CHWs. It serves as motivation as well because the certification earned can be applied to advance a CHW's career.

- *Opportunities for career advancement:*

SDM needs to create effective avenues for CHWs to continue their professional development, they need to provide a platform where CHW's can confidently take on new challenges, and enhance their earning potential, all of which are critical for an individual to experience.

Human Capital Theory has the potential to do the following when used by healthcare systems and organizations:

Boost the efficacy and performance of CHW's.

- Improve the standard of the services and care offered.
- Boost the work satisfaction and retention of CHWs.
- Strengthen the healthcare workforce as a whole.

7.4 PROPOSED FRAMEWORK FOR RECRUITMENT AND SELECTION OF CHWs

Programs for community health workers could make a significant contribution to achieving universal health care. Yet, because they are often seen as non-essential cadres, CHWs have frequently continued to work on the outside of the health care system throughout the world. Often when programmes are scaled up, many of them lose their efficacy. According to WHO (2018), the structure, implementation, and resource allocation of CHW programmes continue to provide ongoing issues. Among the most urgent programmatic difficulties are inadequate training, equipment shortages, and disjointed supervisory mechanisms (WHO, 2018).

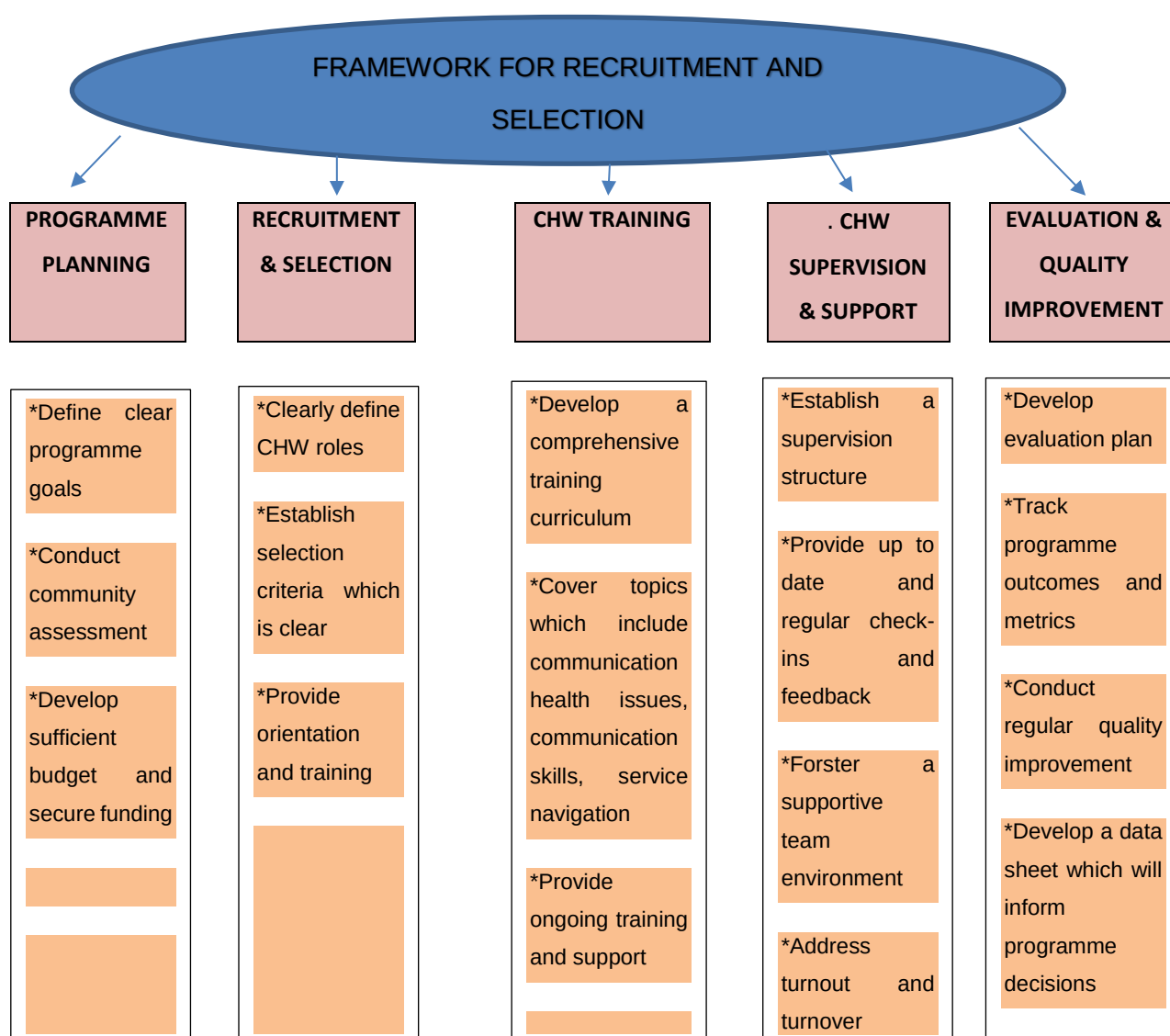
7.4.1 Programme Planning

An important factor in determining a programme's effectiveness is its planning. Ineffective planning will prevent the CHW programme from reaching its full potential and from continuing to be sustainable. The reasons behind the short lifespan of CHW programmes are not implementation errors, but rather a degree of inefficiency in the monitoring and assessment process. The definition of the programme must be precise and effective. A well-defined set of goals and objectives is essential for the programme to ensure proper implementation and ongoing assessment.

A needs assessment of a specific community is another step in the planning of a programme. SDM is a region with significant unemployment rates and a wide territory that, regrettably, CHWs are unable to reach all the communities due to a lack of funding to support their duties. Planning for programmes also picks up steam when relationships with neighborhood organizations are nurtured. This will guarantee that more resources are made accessible and that there is a greater impact, which may prove advantageous to the community as well as the CHWs, who ultimately benefit the health sector. The

review of the literature included information on funding and ineffective procedures. The recruiting and selection procedure for Community Health Workers (CHWs) heavily depends on financial resources, which is frequently the reason why programs lose steam. In the early stages of planning, it's critical to create a budget and obtain the appropriate amount of funding from various sources; both public and private funding can support a CHW programme's ongoing financial needs.

Figure 7.1: Proposed Framework for recruitment and selection of CHW's



Source: Researcher illustration

7.4.2 Recruitment and Selection

To guarantee that the best candidate is chosen for each position, the recruitment procedure should be fair, open and consistent. An ineffective recruitment procedure might be expensive. Since education is a dynamic field, CHWs must continually improve and broaden their skill set to meet the socio-economic issues facing the community in which they serve. The roles of CHWs must be explicitly defined as well as the duties and assignments. Important selection criteria should include things like education level, language proficiency, communication skills, and ties to the community. The education level will aid in narrowing the pool of candidates and provide a platform where candidates can be evaluated based on a predetermined standard and extra training can be added to ensure transparency and fairness.

The recruitment of Community Health Workers (CHWs) still favors members of the targeted community for reasons that have been discussed, such as overcoming cultural barriers and building community trust. However, survey participants indicated that in certain cases, the community withdraws because they fear being exposed to the fact that their health conditions may not be confidential as the CHW reside in the same area and treat the same people. As a result, some of the community members refuse to even open the door for a CHW to visit. Because of this, a participant suggested being stationed in a different community than their home would make their tasks less difficult and would allow the community to also feel more comfortable in being open and honest. The CHW's believe it would bring about better co-operation.

7.4.3 CHW Training

There is a great need for more advanced training, which is necessary to improve CHW initiatives. Community health workers should receive sufficient training, and the community and health clinics should collaborate on this practice. Effective implementation of quality, monitoring, and safety is facilitated by this kind of training. Establishing an all-encompassing training programme is crucial. The significance of CHWs is either ignored or not accorded the respect it merits. This is primarily because CHWs are not professionals with training and may not have the same educational requirements as other health practitioners. A comprehensive training programme offered at higher education establishments like FET colleges will greatly elevate a CHW's standing.

Literature reviewed has indicated that positions held by CHWs typically display traits like part-time work, no benefits, and insufficient workspace and equipment, including computers and desks. CHWs are underfunded and frequently encounter isolation, which hinders their complete integration into the health and human services systems. Community Health Workers in SDM are employed full time and receive benefits such as housing allowance and medical aid benefits, they do however emphasize the need for more growth within the health sector and that is the reason training should be prioritized and given proper structure. Based on the respondents' view, training is not consistent and done timeously, which also hinders their development, hence a need for proper upfront training is essential. A participant can be quoted as saying:

"I would like if I could be given an opportunity to do full nursing course (D4) because the community only recognizes us as CHW, but they say we are not nurses and we are uneducated for the work we are doing. If we go to the field after completing D4 that would be much better, and a huge improvement and empowerment and the community will start to take us seriously and treat us in a good manner".

Several respondents shared the same sentiments:

"I want to be recognized, in the sector, want to be given a chance to grow to the next level".

CHWs have been raised in research have chosen this specific job path because they desire to see people educated about health issues and to assist those who are unable to help themselves. Based on the findings, their primary motivation for becoming a CHW is to enhance the health of the community in which they reside. Being a CHW requires enthusiasm and self-motivation because the duties and obligations can change from time to time. Having said that, it is crucial that their contribution receives the recognition it merits. The respondents desire to advance in the health field by having more possibilities to learn and develop their skills.

Since health difficulties cannot be categorized into one area and it cannot be assumed that all SDM residents have the same health issues, CHW training must be particular when it comes to themes such community health issues that are prevalent in each of the

local municipalities within the SDM. It will be effective to base training on the issues that each municipality addresses and how to resolve them even in the face of challenges more so if they emphasize the difficulties that specific community faces. Other topics which need to be addressed in the training are communication skills, cultural competence and service navigation. Communication skills for a CHW are crucial. The literature study and survey findings indicate that effective communication is crucial for a CHW. A CHW will be unable to carry out their duties in an efficient manner if they are unconfident in their ability to interact with the community.

7.4.4 CHW Supervision and support

The most underprivileged and isolated areas can benefit greatly from CHW programmes by having better access to maternity and child health care, which will benefit both moms and kids. On the other hand, there is little evidence of successful mentorship and supervisory strategies for CHWs (Horwood, Butler, Barker, Phakathi, Haskins, Grant, Mntambo, & Rollins, 2017). In addition to proper training, CHW programmes must also have support and efficient supervision that is coordinated with PHC services to be implemented and successful (Haines, Sanders, Lehmann, Rowe, Lawn, Jan, Walker & Bhutta, 2007).

Creating a framework that supports innovation and progress is crucial. In the medical facilities around SDM, the facility manager is in charge. In any health facility, the facility managers serve as your initial point of contact. After that, you will be referred to as the Outreach Team Leader, or OTL, as your second point of contact. Effective leadership fosters transparency and gives team members a sense of efficient leadership. The CHW spends four days a week primarily outside carrying out their tasks; on Fridays, they come inside the office to complete their reports. A mechanism for frequent check-ins and feedback is required. CHWs frequently experience neglect.

For CHWs to successfully do their duties, SDM must consciously cultivate a positive team atmosphere. Some of the respondents said that they saw a lot of traumatic things during the COVID-19 pandemic, and it was hard for them to fully fulfill their duties because of the stigma that the virus came with. The CHW's also mentioned that they were burned out from the workload and the amount of area they had to cover, and regrettably, they did

not get the help they needed. For this reason, it is crucial that SDM create oversight and support systems that will continuously check the mental health of CHWs. CHWs must experience a deep sense of identity. A respondent is quoted as saying:

“Our ward councillor could involve us in community meetings because some of the community members still don’t know about our role in the community hence, they’re not welcoming in their homes when we conduct households’ registration and when we do campaigns.”

7.4.6 Evaluation and Quality Improvement

One method CHWs can be assessed is through continuous quality improvement (CQI) methods of mentorship and WHO Community Case Management (CCM) training (Sousa, Tiedje, Recht, Bjelic, & Hamer, 2012). For SDM to gauge the effectiveness of the training it provides, a strong assessment strategy must be in place. The abilities of CHWs providing community care will be enhanced and maintained with the use of an assessment plan.

For SDM to effectively measure the programme's outcome and metrics, a program tracker must be carefully developed. This will instill a sense of accountability in CHWs and promote increased programme efficiency. To track and assess progress, this needs to be uploaded into the system on a regular basis. A programme may lose its momentum and fail without anyone really noticing where the crack was if it remains stagnant and does not adapt and improve with the times or significant changes. Tracking programme decisions with a formalized data sheet is always beneficial, and for best outcomes, it should be updated on a regular basis.

7.5 CHAPTER SUMMARY

The chapter above covered the theoretical idea and made a connection between it and the study by offering pertinent examples drawn from the data. The primary health care system depends on CHWs to relieve extreme pressure; thus, it is impossible to ignore the growing demand for these non-professionals. Ensuring CHWs' drive to stay active and, thus, productive in their responsibilities, is essential to maintaining their efficacy. Existing literature acknowledges supportive supervision as a critical strategy for preserving CHW motivation; nevertheless, practical experience has shown that achieving

this in extensive public sector CHW programmes is extremely challenging. To examine prospective programme modifications, supportive supervision should involve regular monitoring of CHWs at their tasks, getting input from CHWs, and guaranteeing the safety and well-being of CHWs at work.

CHW recruiting is an important aspect of any community health programme since the process of selecting and deploying relevant and well-qualified CHWs will create the basis for the programme.

To increase the efficacy of the CHW programme, the researcher offers a suggested set of guidelines for CHW recruitment and selection as the chapter ends. There were six major proposals made that will alter the way individuals perceive CHWs. The next and final chapter will be providing the findings and conclusions of the study and will also provide recommendations that will further enhance the study of CHW's.

CHAPTER: EIGHT

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

8.1 INTRODUCTION

The recruitment and selection process for community health workers was the main topic of the study. An overview of the research done to achieve the goals outlined in Chapter 1 is given in this chapter. An overview of the research and its conclusions will be presented, along with its contribution to existing literature, its findings and recommendations. The conclusions in this chapter are based on the data that was shown in chapter 6. There will be two presentations of the recommendations. Firstly, the findings and suggestions from the investigation are shared. Secondly, the researcher contributes ideas for possible directions in future study.

8.2 THE SUMMARY OF THE STUDY

The research project consisted of seven chapters. These were structured as follows:

Chapter One

The study began with a brief introduction and background, followed by a problem description. An outline of research questions and study objectives were created to guide the process. The study followed guidelines for research design, methodology and ethics.

Chapter Two

Chapter 2 provided an overview of recruiting and selection. It presented the study's theoretical and empirical reviews, as well as its conceptualisation. This chapter also included a review of the literature on recruiting and selection, as well as a summary and conclusion.

Chapter Three

Chapter 3 focused on the evolution and history of the CHW workforce. The legislative framework governing CHWs was discussed. This was because CHW programmes are part of public policy. The chapter also described the current models of care that involve CHWs as part of health service delivery, such as: member of care delivery team, navigator, screening and health education provider, outreach-enrolling-informing agent,

and organizer. The chapter ended with a brief overview of the CHW programme's contributions to health service delivery.

Chapter Four

The fourth chapter provided an overview of South Africa's institutional structure for recruiting and selection programmes. It gave a grasp of HR policy papers, rules, and criteria for the growth of recruiting and selection programmes in South Africa, as well as global perspectives. The chapter also examined CHW recruitment processes, including developing criteria, communicating CHW opportunities to discover individuals, interviewing and selecting CHWs among candidates, and hiring selected CHWs.

Chapter Five

Chapter 5 presented an overview of research technique. It described how the research was conducted. It explained the sample technique, data collection tools, and data analysis. This chapter addressed the study's strengths as well as its drawbacks. The conclusion of validity and reliability, as well as ethical implications were also explored.

Chapter Six

The research findings were given in Chapter 6. The survey and questionnaire results were analysed and discussed, as well as the findings. Both quantitative and qualitative findings were interpreted.

Chapter Seven

In this chapter, the researcher used the study's findings to increase an understanding of improving recruitment and selection methods for CHW programmes. The proposed framework for empirical findings in connection to research questions and applicable theories was discussed and presented in detail.

Chapter Eight

The final chapter presents the study's findings. The researcher describes the main results, outcomes, and any other information that is pertinent to the study. This chapter contains recommendations based on viewpoints that are backed by the research findings. The limits and contributions of the study are also discussed.

8.3 REVIEW OF THE STUDY OBJECTIVES

As discussed above, the study consisted of eight chapters that addressed the research objectives presented in chapter one. The study sought to satisfy the following objectives:

- **Objective 1:** To provide a theoretical explanation of the concept of recruitment and selection process with reference to CHW in the health sector.
- **Objective 2:** To describe the specific recruitment needs for the CHW programme.
- **Objective 3:** To evaluate the district's context and strategies for developing a successful recruitment process for CHWs programme.
- **Objective 4:** To identify the criteria for selecting CHWs.
- **Objective 5:** To formulate guidelines regarding recruitment and selection process for strengthening CHW programmes.

The realisation of the above objectives will be discussed below in section 8.4.

8.4 SUMMARY OF FINDINGS

Below the researcher provides an overall summary of the findings.

8.4.1 Objective 1

To provide a theoretical explanation of the concept of recruitment and selection process with reference to CHW in the health sector.

- *Theoretical explanation of recruitment in reference to CHW's in the health sector*

Recruitment was defined as operations that are carried out to recruit enough individuals who have the capacity and abilities to fulfill job criteria and aid the public health institution in accomplishing its objectives. The recruited CHWs must have the skills and competencies to help the health sector accomplish its strategic goals and objectives. Another theoretical definition of recruiting is the process by which a CHW is identified, goes through a selection process, and is then assigned to a community. Both worldwide and locally, it is viewed as effective to have community members serve as CHWs because they are familiar with the members' backgrounds and visible needs. This is regarded as one of the most significant criteria.

- *Theoretical explanation of selection in reference to CHW's in the health sector*

The selection procedure comes next after recruitment is complete. The process of selecting the best applicants among those who applied for the available position is known

as selection. Several activities that have the potential to yield excellent outcomes characterize this approach. When choosing CHWs, several crucial variables are considered, such as the following:

- i. **Social Theory:** CHWs must have a desire to learn and develop. They are chosen based on their aptitude for learning and their capacity to quickly adjust to the demands of the community.
- ii. **The role theory:** Additionally, CHWs are chosen based on their capacity to take on responsibilities in the community, such as promoting awareness and prevention and providing health education.
- iii. **Theory of Culture:** The selection of CHWs is based on their knowledge and ability for understanding the unique characteristics of the group they work with.

8.4.2 Objective 2

Description of the specific recruitment needs for the CHW programme

- i. An important aspect in determining a program's sustainability is recruitment. Some of the recruitment needs, as determined by the research and findings, are as follows:
 - Relationship with the community:** Previous research indicates that a CHW's membership in the community they serve is crucial. This guarantees that they are deeply connected to the intended community in which they serve.
 - Language proficiency:** Possessing language abilities in that community facilitates communication and fosters improved relationships between the CHW and the community.
 - Cultural Competence:** When recruiting, CHWs must be aware of and sensitive to the unique cultural quirks and values of the group they will be working with.
- ii. **Communication skills:** In order to overcome language obstacles, CHWs need to be able to speak in the language that members of the community understand the best. Strong interpersonal skills are also shown by effective communication.
- iii. **Problem-solving abilities:** When hiring CHWs, candidates must possess the capacity to exercise critical thought and effectively resolve issues that may come up in the course of their work.
 - Flexibility and adaptability:** CHWs must be able to adjust to occasionally shifting community needs and goals, so this is a crucial recruiting requirement.

Leadership potential: Because CHWs are vital members of the community, they must be able to lead others. This will facilitate community participation and mobilization.

- iv. **Technical competence:** Seek CHWs who demonstrate a working knowledge of computers and the ability to use digital tools for data collecting and reporting.

8.4.3 Objective 3

Evaluation of the District's context and strategies for developing a successful recruitment process for CHWs programme

The human resource manager and district manager have listed a number of improvements they have made to the recruitment process. The data presented in Chapter 7 includes the participants' confirmation of the various means of spreading the word, such as neighborhood meetings, churches, social events, brochures, newspapers, and radio spots. Because it guarantees transparency and fosters confidence, this strategy benefits the community as well as the district. The CHWs also acknowledged that on occasion, they do make recommendations for people they think would be a good fit for the position. This is an excellent idea because, as a CHW, you are already familiar with the responsibilities, tasks, and obligations necessary for this kind of employment, and CHWs can provide recommendations based on their expertise.

The majority of the communities surrounding Sedibeng District Municipality are rural and underserved, particularly the Emfuleni Local Municipality, which makes it difficult for the residents to have access to the internet or social media platforms, which are the primary places where jobs are posted. In order to successfully recruit CHWs and improve the current program, the aforementioned tactics seek to remove barriers in this regard. Using the platform to publicise possibilities at community meetings, churches, and social gatherings—places where the bulk of job searchers are typically found—is one of the other tactics the district has implemented to create a successful recruitment process. In order to help find applications and get advice, the district also makes sure to interact closely with community members by contacting well-known and linked community-based organisations. This demonstrates the inclusive attitude that the SDM maintains in order to accomplish their shared goal of reaching the SDG for primary healthcare while also

making sure that the community has the greatest opportunity of being hired and developing a sense of independence.

As a result, the district is making sure that communication is equitable and sustainable by making use of various channels to raise awareness and improve accessibility. The researcher evaluated these tactics, and the results support that regular interaction and support enhance CHW efficacy and retention. Regular updates, criticism, and problem-solving are all part of this. The CHW program might be greatly enhanced by this ongoing support for Sedibeng's multi-channel communication strategy.

8.4.4 Objective 4

Identification of the criteria for selecting CHWs

Based on the results of the study and the interviews, the most crucial conditions for hiring Community Health Workers (CHWs) are a number of pre-service training and demographic requirements. The HR Manager emphasised the significance of age, marital status, and gender. CHWs can better serve their communities by learning local customs and conventions thanks to these qualities. Pre-service training is essential, and a Matric certificate is one of them. Prioritising CHWs' standard competence training before deployment is critical in order to better equip them for their roles.

In order to improve social acceptance and influence, the recruitment procedure gives preference to candidates who are educated and fit demographically. The emphasis on education and demographic fit ensures that CHWs can fulfill community health needs. The district said pre-service education on fundamental health issues and skills is necessary for CHWs.

Matriculation ensures a foundational education, and Community Health Workers (CHWs) ought to reside in their locality to make use of their personal connections and knowledge of the area.

8.4.5 Objective 5

Formulation of guidelines regarding recruitment and selection process for strengthening CHW programmes

- **Programme Planning**

In order to effectively strengthen the CHW programme, it is important to have a solid plan in place. There needs to be specific requirements written down which will support the entire execution of the CHW programme from start to finish. If a plan is not done efficiently from the beginning, it is more likely that the programme will take off but will not remain sustainable. According to the findings, one of the reasons a program does not remain sustainable, is a lack of funds. A budget is one of the most important aspects to be considered when a programme is being planned. Having the correct budget will help in ensuring the costs are met and nothing is compromised in regard to quality.

- **Recruitment and Selection**

According to the participants, CHW hiring occurs once a year, but the number of CHWs hired each year is determined by the district's budget and health goals. The findings indicate that the availability of resources and financial constraints have an impact on the hiring schedule and frequency for CHWs in Sedibeng District Municipality. To ensure that the most qualified applicant is selected for each position, the recruitment process should be transparent, equitable, and fair.

- **CHW Training**

More advanced training is of vital importance, as it is essential to enhancing CHW initiatives. The socioeconomic challenges that the community they serve need CHWs to constantly expand and enhance their skill set. Health clinics and the community should work together to implement this strategy, and community health workers should receive enough training.

- **CHW Supervision and support**

The information indicates that CHWs get routine supervision and evaluation. These evaluations identify areas that require improvement and provide input for career advancement. CHWs receive continuous support and resources from supervisors and a dedicated CHW unit, which enables them to fulfill community health needs. Better access to maternity and child health care will assist mothers and children in the most remote and impoverished locations, and this can be achieved through CHW initiatives.

- **Evaluation and Quality Improvement**

Careful development of a program tracker is necessary for SDM to measure the program's outcome and metrics efficiently. This will encourage greater program efficiency and provide CHWs a sense of accountability. This needs to be regularly updated into the system in order to monitor and evaluate progress. If a program is stagnant and does not change and improve with the times or undergo considerable change, it may lose its impetus and fail without anyone really realising where the crack was.

8.5 CONTRIBUTION OF THE STUDY

The study made a notable contribution in that it produced a substantial theoretical addition in the area of the efficacy of creating a questionnaire (s) because the tool used in the investigation was valid, dependable, and supported by statistical evidence.

This study argues that a spoilt recruitment and selection process, would only produce mediocre CHWs, whereas a merit and credible means of employing the CHWs, would produce competent and qualified CHWs, who can positively contribute to delivery of quality health care services at the municipality level and ensure sustainability of developed programmes more especially in upcoming towns.

In accordance with objective 3 of chapter one — “To evaluate the district’s context and strategies for developing a successful recruitment process for CHWs programme”—the study employed a qualitative and quantitative approach and established successful strategies that will guarantee not only the implementation of the CHW program but also its success and sustainability. In order to improve the work of a CHW and stay relevant in the face of ever-increasing social, cultural, and technical demands, it is critical to lay a strong basis for what makes a great program. The importance of CHWs has been statistically demonstrated over a long period of time, and it is crucial that they be integrated into a more formal framework to increase youth motivation for careers in health care. The 4th objective, which is also important — “To identify the criteria for selecting CHWs,” — has also guaranteed the study would always be pertinent and would make a substantial contribution to the field of research in that if a criterion is not identified, it may somehow compromise on how the recruitment and selection process goes and will not remain fair.

This study certainly has contributed significantly to ensuring that CHWs are acknowledged and given the necessary support and platform to advance both personally and professionally because there is not much published research on the recruitment and selection procedures used in the SDM. In-depth planning, training, monitoring, quality improvement, and assessment are all necessary, and this study provides an integrative theoretical framework and set of guidelines along these lines.

The researcher aspires to publish articles in prominent journals in the appropriate fields of study.

8.6 TESTING OF THE HYPOTHESIS

The study's hypothesis was that a well-defined recruitment and selection process may be used to boost the Community Health Workers Programme in SDM. The findings from both the literature review and the empirical research substantially support the preliminary statement. This is because efficient recruiting processes guarantee that CHWs have the requisite skills, knowledge, and attitudes to provide high-quality services, hence increasing program effectiveness.

8.7 RECOMMENDATIONS OF THE STUDY

The findings of the research prompted the following suggestions:

- Opportunities for advancement

In the field of health, CHWs continue to play a crucial role, and their contribution to primary healthcare should not be undervalued. CHWs can become formalised in our educational system and function as the backbone of the health sector if given the proper framework and assistance. Systematic education and training programmes can have a significant impact on recruitment and selection processes and emphasise the value of hiring people with the necessary skills and training. They will undoubtedly become more valuable and have more prospects for growth if they receive quality formalisation.

- Safety measures

Safety is still a major issue, particularly for CHWs in their line of work. Numerous participants raised the concern of their safety in the research outcomes. As has been mentioned throughout the document, the majority of CHWs in SDM carry out their

responsibilities by foot. The participants indicated there is a lack of security precautions in place—some participants feel it is necessary in certain situations—as their door-to-door campaigning can occasionally leave them vulnerable. The presence of a safety officer in a car might significantly impact the CHWs' performance since it would instill a sense of confidence and safety in them.

- Collaboration

The CHWs' structure can be strengthened and developed through collaboration. Partnerships with healthcare providers, social services, and community organisations can be formed and maintained in order to guarantee that all opinions are considered when designing the CHW program, that recruitment and selection proceed efficiently, and that the needs of the community and the increasing demand are consistently satisfied. A key factor in the effectiveness of a CHW's recruitment and retention efforts is participation. Consequently, the district must raise community understanding of the value of community members collaborating with CHWs to achieve the shared objective of providing comprehensive healthcare to those who most need it.

- Continuous recruitment

Undoubtedly, there is a strong requirement for a continuous hiring and selection procedure. This is due to the fact that some locations have a higher population than others, and the participants believed that more CHWs were necessary to meet the requirements of the entire community rather than just a small subset of it.

- Diversification into the urban setting

In SDM, the CHWs are stationed in the rural areas. However, the researcher believes that integrating them into metropolitan areas is crucial. By tackling health inequities like mental health, diabetes, and asthma that are also more common in urban areas, CHWs can make a significant contribution in these settings. By guiding community members through the many existing systems and by assisting them in accessing resources such as social services, healthcare, and other urban resources, CHWs can be highly beneficial also in urban settings. By means of fostering connections with local companies, religious institutions, and community organisations, CHWs can have a significant impact on the urban region.

The vulnerable populations in metropolitan areas can receive assistance from the CHWs. Due to the constantly increasing demand, low-income and marginalised populations in urban regions have restricted access to healthcare. By offering services like educating the community on illness prevention, healthy eating habits, and the treatment of chronic diseases, CHWs can aid in bridging that gap. Promoting policy changes that address urban health challenges through community organisation and policy changes is one way to engage in campaigning. CHWs can help address specific health issues and inequalities that urban populations face by working in urban areas.

8.8 RECOMMENDATIONS FOR FURTHER RESEARCH

In order to effectively strengthen the CHW programme, this thesis has concentrated on the recruitment and selection procedure for CHWs. The study indicates that the majority of CHWs are female, with relatively few men working in this sector. Future research may look into the reasons for the apparent gender discrepancy in this regard. To encourage men to become CHWs, more research can be done to find out the reason only a few men are working in this sector and how to make them feel welcomed, remain excited and to consider it a career of choice.

Future studies could investigate into the integration of CHWs into urban areas within the Sedibeng District Municipality. If there is a need to outsource or expand CHW's. The study can look how feasible it would be and how the urban community as well as the primary health care can benefit from this shift.

8.9 CHAPTER SUMMARY

In any type of an organisation, recruitment and selection process will always remain the backbone of a company simply because they help in finding the most suitable candidates for the jobs at hand. It is evident that recruitment and selection are imperative functions in HRM, because they are designed to make best use of employee strength in order to meet strategic goals and objectives of the employers as well as the organisation at large (Recruitment and selection, 2016). Connaboy and Richard (2005), adds that transparent HRM practices and policies remain the foundation for creating professional public services including the health fraternity (Connaboy & Richard, 2005). It's critical that SDM acknowledge the significant impact that CHWs make and how, with proper recruiting and

selection procedures, this benefits the community as well as the district. Clear and precise guidelines will prevent delays and guarantee that the CHW programme is not adversely impacted by changes and delays. The provision of CHWs with both recognition and opportunities for professional growth and development within the health community will go a long way in enhancing their confidence. This could assist the District to recruit and retain its CHWs.

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ANNEXURE A: PERMISSION REQUEST TO CONDUCT RESEARCH



Private Bag X1174, Vanderbijlpark
South Africa 1900

Tel: +2716 310-3660

Web: <http://www.nwu.ac.za>

Faculty of Humanities: School of Government
Studies

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06 June 2023

The Sedibeng District Health Services / Human Resource

RE: Permission to conduct research at the Sedibeng District Health Services

Mrs Nthabeleng Malope, is a PhD student under the guidance of Professor Loraine Boitumelo Mzini, at the North-West University in the Faculty of Humanities, School of Government Studies. She requests permission to conduct a study which seeks to understand the CHW recruitment guidelines and selection criteria on how a CHW is identified, selected, and assigned to a community. The title of the study is: "Effectiveness of the Recruitment and Selection process for strengthening Community Health Workers' Programme. A case study of Sedibeng District Municipality".

Mrs Malope requests' access to the following information: Assistance from respondents (final year students and Human Resource Unit); within the respective directorate/ unit to co-operate in completing the questionnaire and for interviews. The research conducted is mainly for academic benefits and the researcher intends to publish the findings of the study in a professional journal and/ or at professional meeting like symposia, congresses, or other meetings of such a nature. She intends to protect the personal identity of the participants by assigning each respondent a random code number.

Yours sincerely

Prof LB "Tumi" Mzini Study leader

A handwritten signature in black ink, appearing to read 'Tumi Mzini', is written over a horizontal line.

Access to the Institution approved

Access to the Institution not approved

ANNEXURE B: APPROVAL LETTER FROM DISTRICT TO CONDUCT STUDY



GAUTENG PROVINCE

REPUBLIC OF SOUTH AFRICA

Sedibeng District Health Services
Enquiries: Ms. N. Tswana
Tel: 016 850 6255
Email: Nyirumiso.Tswana@sedibeng.gov.za

Ms. Nthabeleng Malape
North West University
65 Charles Swan. Avenue
Vereeniging
1929

Dear Ms. Malape

RE: THE EFFECTIVENESS OF THE RECRUITMENT AND SELECTION PROCESS IN STRENGTHENING THE COMMUNITY HEALTH WORKERS PROGRAM: THE CASE STUDY OF SEDIBENG DISTRICT MUNICIPALITY

Please be informed that permission has been granted for you to carry out the above-mentioned research at Sedibeng District Health Clinics, CHCs and Hospitals. It is noted that you have already obtained Provincial Ethics Committee as well as Research Ethics Clearance from the North West University.

Kindly note that a copy of the report on the findings (especially) that concerns Sedibeng District Health Services should be submitted to the Chief Director's office at the completion of the study.

This permission is also subject to the conditions stated in the protocol and any change in design and methodology must be communicated to the Chief Director.

We wish you success in your research endeavours.

Recommended / Not recommended / Recommended as amended

Prof. OB Omole
Chairperson: Sedibeng District Research Committee
Date: 15/10/2023

Approved / Not approved / Approved as amended

Ms. M.A. Madala
Acting Chief Director: Sedibeng District Health Services
Gauteng Health Department
Date: 22/10/2023

NHRD REF: GP_202308_087

Sedibeng DHS, Off Frikke Meysers & Pestoor Huis, Private Bag X 023, Vanderbijlpark

ANNEXURE C: DATA COLLECTION TOOLS/QUESTIONNAIRES

QUESTIONNAIRE FOR THE COMMUNITY HEALTH WORKERS IN THE SEDIBENG DISTRICT MUNICIPALITY

Enquiries: Mrs. Nthabeleng Malope (PhD student)

Supervisor: Prof. Loraine Boitumelo Mzini

Title: “The Effectiveness of the Recruitment and Selection process for strengthening Community Health Workers’ Programme. A case study of Sedibeng District Municipality”

The objective of this study is to assess the effectiveness of recruitment and selection process for strengthening CHW programmes in the Sedibeng District Municipality (SDM). This study is conducted by Mrs. Nthabeleng Malope in the field of Public Management and Governance under the guidance of Professor Loraine Boitumelo Mzini. This study assesses the Recruitment and Selection process for Community Health Workers’ Programme in the Sedibeng Health Services. These questions have been designed to capture the required information to make this study effective. Thus, the information gathered will be utilized in the PhD thesis to help formulate guidelines regarding recruitment and selection process which will strengthen CHW programmes.

Confidentiality

All the information you provide will be treated with **STRICT CONFIDENTIALITY**. While results will be made available by the health department, you are guaranteed that neither you, nor the institution of which you work under will be badly affected as a result of this study. The results will be used for academic purposes only. *Participation in this survey is voluntary and any individual may withdraw at any time.*

The researcher will ensure that all results will be kept confidential and no ethical guidelines will be breached. Only the researcher, the supervisor and statistician will have access to the data being captured. After the specified timeframe the data collection process will end and the statistical analysis will commence, which will take place scientifically and ethically.

Instructions and Information in completing the interview questions.

- Please answer the following questions with honesty and transparency.
- Participants can provide extra information if the need arises.
- This questionnaire should take approximately 20 minutes of your time.

I thank you in advance for your willingness to participate in this research project.

SECTION A: BACKGROUND INFORMATION/DEMOGRAPHIC DATA

Please tell us about yourself.

Cross all that applies with an X.

Or Tick all that applies with a ✓

A1. Gender

Male	Female	Other

A2. Age Group

≤21	21-30	31-40	41-50	>50

A3. What is your race?

African	White	Colored	Asian	Other

A4. Highest level of education completed?

Junior Certificate/ Grade 10	Matric/ Grade 12	Certificate	Diploma	Degree	Other

A5. What is your current marital status?

Single	Married	Divorced	Widow	Widower	Other

A6. Which Municipality do you reside in?

Midvaal	Lesedi	Emfuleni

A7. Which location do you reside in?

Evaton	Sebokeng	Sharp eville	Boipatong	Bophelon g	Meyerton	Rathanda	Veree niging	Vanderbijlpark

A7. How long did you live in your current location?

1-4	5-10	11-15	15-20	20+

A8. How long have you worked as a CHW?

1 year or less	2-3 years	4.5 years	6-7 years	8-10 years	11+

SECTION B: RECRUITMENT AND SELECTION**B1. Identify the source from where you came to know about the CHW job?**

Item		Choice (multiple answers)
a)	Newspaper	
b)	Consultant	
c)	Personal reference (word of mouth)	
d)	NGO	
e)	E- recruitment	
f)	School (high school/ college/ university)	
g)	Radio	
h)	TV	
i)	Health Center	
j)	Health Committee	
k)	CHW cooperative	
l)	Elected by community	
m)	Community councilor	
n)	Other (Specify)	

B2. Are you satisfied with the recruitment process used to recruit you?

- a) Yes b) No

B3. What are the sources for recruitment and selection?

- a) Internal b) External c) Both

B4. How was the approach of management during the recruitment?

- a) Serious & Positive b) Casual c) Negative

B5. What impression/ image did you have of the public health sector before getting Recruitment?

- a) Satisfactory b) Average c) Unsatisfactory

B6. Is the organisation doing timeliness recruitment and selection process.

- a) Yes b) No

B7. How would you rate the HR department's performance in recruitment and selection?

- a) Poor b) Adequate c) Excellent

B8. Does the organisation consider experience during the selection process?

- a) Yes b) No

B9. Which is the most one important quality the organization is looking for in a CHW candidate?

- a) Knowledge b) Communication c) Empathy and Compassion
d) Emotional Resilience e) Ethics f) Active Listening
g) Teamwork ability h) Adaptability, Flexibility, and Stability
i) Discipline j) Other

B10. Do you think an organization is using the best methods for recruitment and selection?

- a) Yes b) No

B11. Is the (CV) screening and shortlisting method used by the organization satisfactory?

- a) Yes b) No

B12. How do you rate the selection policy of the organization?

- a) Poor b) Average c) Good

SECTION C: EXPERIENCES ABOUT THE CURRENT ROLE AS A CHW

This set of questions will focus on your thoughts and experiences about your current role as a CHW.

C1. Which factors influenced your decision to become a CHW?

Self-development	Financial independence	Value and recognition	Use of available time	Improve community health

C2. Language Spoken

Sepedi	Sesotho	Setswana	Swati	Tshivenda	Xitsonga	Afrikaans	English	Ndebele	Xhosa	Zulu

C3. Which location do you serve?

Evaton	Sebokeng	Sharpeville	Boipatong	Bophelong	Meyerton	Rathanda	Vereenig	Vanderbijlpark

C4. Do you use any means of transportation for your health-related activities?

Yes	No

C5. Which means of transportation do you use for your health-related activities?

Bus	Own bicycle	Institution bicycle/scooter	Own vehicle	Institution vehicle	Taxi	Rented car	Train	Other	None

C6. In a typical week (7 days), how many hours do you spend providing health services to your community?

C7. CHW PAYMENTS

Item	Yes	No
Do you receive any form of payment as a CHW?		

SECTION D: TRAINING AND SERVICES

Item	Yes	No
Have you received training since you joined the CHW role?		

SECTION E: CHW RESOURCES

Item	Yes	No
a. Did you receive a CHW working kit?		
b. Do you share working kits with other CHWs?		
c. If yes, how many CHWs do you share the kit with?		

SECTION F: COMMUNITY HEALTH WORKER SATISFACTION

In this part of the questionnaire, I would like to ask you some questions regarding your satisfaction with your role as a Community Health Worker. How would you rate the following aspects of your work? Read from the list below and ask which category applies (1-5)

Item	1 = Poor	2 = Unsatisfied	3 = Not applicable	4 = Satisfied	5= Excel lent
a. Working relationships with clinic staff					
b. Working relationships with Civil Society Organizations					
c. Community support					
d. Relationships with local community leaders					
e. Availability of equipment for CHW					
f. Your training opportunities to upgrade your skills and knowledge					

g. Work ethics of other CHW members					
h. Your compensation					
i. Additional benefits (travel allowance, etc.)					
j. Your perception of safety and security to live and practice in the community					
k. Your supervisor's recognition of your work					
l. Your opportunities for advancement in health field					
m. Overall, your satisfaction with your role					

SECTION G: COMMENTS

G1. How has COVID-19 affected your integration into your Health Center? Did your roles change or alter?

G2. What are some of the changes you would personally like to see happen within your ward to improve your role as a CHW?

Thank you for taking the time to participate in my questionnaire!

QUESTIONNAIRE FOR DISTRICT HEALTH MANGER AND HUMAN RESOURCE MANAGEMENT

STUDENT NAME: Mrs. Nthabeleng Malope, North-West University (Vanderbijlpark Campus)

INTERVIEW DATE: _____

I would like to thank you for taking the time to participate in my research on the Effectiveness of the Recruitment and Selection process for strengthening Community Health Workers' Programme. A case study of Sedibeng District Municipality. The questions asked is pertaining to the recruitment and selection criteria used for Community Health Workers within your organization. This is an important study as CHW's are trusted members of the community who play a pivotal role between the community and SDM. Today's information will be used to help develop a strategy which could be adopted in strengthening the CHW's programs and seeking ways to maintain retention by finding innovative ways which can help future development.

SECTION A: RECRUITMENT

Recruitment Process

Does the Department/ facility have a developed CHW Recruitment Criteria?

When was the CHW Recruitment Criteria developed?

How many CHWs in total were recruited during the below years?

2020	2021	2022	2023

Is recruiting managed at the national, regional, provincial, district or other lower (clinic) level?

What is the timeline for recruitment?

Communication for CHW Position Opportunities

How does the Department/ facility communicate CHW position opportunities?

Item	Mention	No mention
i. Announcing positions at community meetings, churches, and other social group gatherings		
ii. Conducting face-to-face or internal recruitment		
iii. Obtaining ideas from well-established and well-connected community-based organizations to help identify applicants		
iv. Receiving referrals from current CHWs		
v. Posting fliers at shared community spaces, local recreational centers, municipalities, and health facilities;		
vi. Placing newspaper advertisements		
vii. Announcing positions on the radio		
viii. Announcing positions at community meetings, churches, and other social group gatherings		

Criteria of selection for CHWs

What are the criteria of selection of CHWs?

Item	Mention	No mention
i. Demographic elements		
ii. Gender		
iii. Age		
iv. Marital status		
v. Usual place of residence		
vi. Education level		
vii. Pre-service training		
viii. Ability to successfully complete training on standard competencies		
ix. The roles and responsibilities they will undertake		

Recruitment costs

How do available resources influence CHW recruitment?

Which level or organization will provide the resources for recruitment?

What are the resource requirements for successful CHW recruitment?

SECTION B: CHW ROLE

B1. What current CHW programme(s) is/ are in place?

B2. What primary care services are included in the CHW strategy?

B3. What specific tasks are CHWs expected to carry out?

B4. What will be their workload?

B5. What current CHW programme is in place?

B6. Are CHWs clear on their role, their responsibilities, and other job expectations?

B7. How many days per month or hours per week are CHWs expected to dedicate to completing the tasks? Is their commitment full-time or part-time?

SECTION C: TRAINING

What training will the CHWs receive to ensure their ability to complete assigned tasks (e.g., pre-service training or in-service training)?

Item	Yes	No
i. Does the institution provide training to new CHW's recruits?		
ii. Does the institution provide ongoing training to reinforce initial training?		
iii. Are there refresher trainings provided to keep knowledge updated, discuss problems, replenish supplies and strengthen motivation?		

Which essential skills are offered to enhance the duties of CHWs after recruitment?

Item	Mention	No mention
i. Communication		
ii. Problem-solving		
iii. Critical thinking		
iv. Cultural competency		

What is the frequency of the training offered to keep knowledge updated, discuss problems, replenish supplies and strengthen motivation?

Item	Mention	No mention
i. Weekly		
ii. Monthly		
iii. Quarterly		
iv. Annually		

SECTION D: EQUIPMENT AND SUPPLIES

What is the catchment population and geographic area for which CHWs are responsible?

Midvaal	Lesedi	Emfuleni

How many CHWs cover a single area?

Evaton	Sebokeng	Sharpeville	Boipatong	Bophelong	Meyerton	Rathanda	Vereeniging	Vanderbijlpark

Item	Yes	No
Will they receive transport support to reach their assigned catchment populations?		

SECTION E: SUPERVISION

This section seeks to understand if the Department has a supervisory and other management support for recruited CHWs.

Item	Yes	No
Does the institution have a dedicated CHW unit?		
Are there allocated supervisors for the CHWs?		
Is there sufficient support offered to CHW's		

Item	Mention	No mention
Doctors		
CHW Supervisor		
Programme Manager		
Human Resource Unit		

SECTION F: INDIVIDUAL PERFORMANCE EVALUATION

Item	Yes	No
Is there evaluation conducted to fairly assess work of CHWs during a set period of time.		

SECTION G: INCENTIVES

“A balanced incentive package includes financial incentives such as salary and bonuses and non-financial incentives such as training, recognition, certification, uniforms, medicines, etc. appropriate to job expectations”.

Item	Yes	No
Are the CHWs compensated or are they working on a volunteer basis?		
Is compensation a salary, an hourly wage, or a stipend?		
Is there a certification policy after training at the district level		

SECTION H: COMMUNITY INVOLVEMENT

Item	Mention	No mention
Is there a long-standing relationships and process with communities in identifying the CHWs for respective jurisdictions?		
Does the Department/ Facility actively involve community leaders in defining a role for the CHW?		
Does the Department/ Facility attend community events to connect with potential candidates?		

Which of the following has the Department/ facility reach out to help promote your programme and recruit CHWs:

Item	Mention	No mention
City/Local council members		
Neighbourhood association presidents		
Community leaders		
Schools		
Faith-based organizations (Churches)		
Community centers		
Community-based organizations		
Workforce development agencies		
Other organizations that are active in the community		

SECTION I: REFERRAL SYSTEM

A process for determining when a referral is needed, a logistics plan is in place for transport and funds when required, and a process to track and document referrals.

SECTION J: OPPORTUNITY FOR ADVANCEMENT

Is there a possibility for growth and advancement for CHWs? Please elaborate.

What steps are being taken to ensure retention of the CHW's?

What are some of the benefits of working as a CHW?

SECTION M: PROGRAMME PERFORMANCE EVALUATION

Is there a general programme evaluation of performance against targets, overall program objectives, and indicators carried out on a regular basis? Please provide examples.

SECTION N: COMMENTS

What are the biggest challenges in a CHW programme?

Thank you for participating in the study

ANNEXURE D: CERTIFICATE OF EDITING

Mhlongo Goodfriday writer's box

Independently contracted editing work

7/12/2024

TO WHOM IT MAY CONCERN

EDITING CERTIFICATE LETTER

This serves to confirm that the academic work in a form of a PhD
Thesis belonging to:

MALOPE N

Titled

**The effectiveness of the recruitment and selection process in strengthening the
Community Health Workers' Programme: The case study of Sedibeng District
Municipality**

was proofread, grammatically and technically edited by the undersigned
language specialist during the period December 6-7, 2024.



Mhlongo Goodfriday
Senior Lecturer and Language Practitioner

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ANNEXURE E: ETHICS APPROVAL



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Basic and Social Sciences Research Ethics
Committee (BaSSREC)

Faculty of Humanities Ethics Office for Research,
Training and Support
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Email: Erhabor.Idemudia@nwu.ac.za

Senate Committee for Research Ethics

Tel: 016 103 4446
Email: Fozlwa.Mseleni@nwu.ac.za

18 January 2024

ETHICS APPROVAL LETTER OF STUDY

Based on approval by the **Basic and Social Sciences Research Ethics Committee (BaSSREC)** on **16/01/2024**, the Basic and Social Sciences Research Ethics Committee hereby **approves** your study as indicated below. This implies that the North-West University Senate Committee for Research Ethics (NWU-SERC) grants its permission that, provided the special conditions specified below are met and pending any other authorisation that may be necessary, the study may be initiated, using the ethics number below.

Study title: The effectiveness of the recruitment and selection process in strengthening the Community Health Workers' Programme: The case study of Sedibeng District Municipality.

Study Leader/Supervisor (Principal Investigator)/Researcher: Prof. T. Mzini

Student/Research Team: N. Malope (23236094)

Ethics number:

N	W	U	-	0	1	0	0	3	-	2	3	-	A	7

Institution Study Number Year Status
Status: S = Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation

Application Type: Single Study

Commencement date: 16/01/2024

Risk: Low risk

Expiry date: 16/01/2025

Approval of the study is initially provided for a year, after which continuation of the study is dependent on receipt and review of the annual (or as otherwise stipulated) monitoring report and the concomitant issuing of a letter of continuation.

Special in process conditions of the research for approval (if applicable):

General conditions:

While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, the following general terms and conditions will apply:

- The study leader/supervisor (principal investigator)/researcher must report in the prescribed format to the BaSSREC:
 - annually (or as otherwise requested) on the monitoring of the study, whereby a letter of continuation will be provided, and upon completion of the study; and
 - without any delay in case of any adverse event or incident (or any matter that interrupts sound ethical principles) during the course of the study.

- The approval applies strictly to the proposal as stipulated in the application form. Should any amendments to the proposal be deemed necessary during the course of the study, the study leader/researcher must apply for approval of these amendments at the BaSSREC, prior to implementation. Should there be any deviations from the study proposal without the necessary approval of such amendments, the ethics approval is immediately and automatically forfeited.
- Annually a number of studies may be randomly selected for an external audit.
- The date of approval indicates the first date that the study may be started.
- In the interest of ethical responsibility, the NWU-SCRE and BaSSREC reserves the right to:
 - request access to any information or data at any time during the course or after completion of the study;
 - to ask further questions, seek additional information, require further modification or monitor the conduct of your research or the informed consent process;
 - withdraw or postpone approval if:
 - any unethical principles or practices of the study are revealed or suspected;
 - it becomes apparent that any relevant information was withheld from the BaSSREC or that information has been false or misrepresented;
 - submission of the annual (or otherwise stipulated) monitoring report, the required amendments, or reporting of adverse events or incidents was not done in a timely manner and accurately; and / or
 - new institutional rules, national legislation or international conventions deem it necessary.
- BaSSREC can be contacted for further information or any report templates via [BaSSREC-Admin@nwu.ac.za](mailto:Admin@nwu.ac.za).

The BaSSREC would like to remain at your service as scientist and researcher, and wishes you well with your study. Please do not hesitate to contact the BaSSREC or the NWU-SCRE for any further enquiries or requests for assistance.

Yours sincerely



Prof. E. Idemudia

Chairperson NWU Basic and Social Sciences Research Ethics Committee