POLICY BRIEF
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Repairing trust among vulnerable communities and community health workers vital for better patient outcomes

In low- and middle-income countries (LMCIs) like South Africa, community health workers (CHWs) are critical to enabling marginalised communities to gain access to healthcare. They also help to trace and bring back patients who have withdrawn from medical treatment, which requires the ability to repair trust in the system.

Already fundamental to the relationships between patients, providers, and health systems, trust is even more hard-won in vulnerable communities stricken by unemployment, domestic violence, and alcohol abuse – and where the stigmas associated with HIV/AIDS, TB, and now COVID-19, abound. Due to the instability of their lives, these patients have often received poorer care. It has made them lose trust in their local health facilities and reluctant to seek treatment in future.

While navigating this structural poverty and complex health and social situations, CHWs also struggle with a lack of workplace trust themselves. Harsh employment conditions, challenging work environments, a lack of equipment, and colleagues who treat them unfairly are just some of the reasons why they feel marginalised, unrecognised, and undervalued.

Recommendations

The findings from this study illustrated that various forms of trust are needed to achieve better health outcomes for patients. Strategies to help build and strengthen these include:

- Creating opportunities for CHWs and nurses to gain more empathy and develop a better understanding of communities' health and social situations.
- Facility managers and nurses bridging existing hierarchies in health facilities.
- Ensuring that CHWs feel supported in the workplace, and that patients feel cared for.
- Inexperienced enrolled nurses (ENs) should be mentored while receiving training as CHW supervisors.
- Strong intersectoral collaborations with other services for CHWs and their supervisors in communities with complex social problems.
- Migrants obtaining the rights and means to access care.

For the system to deliver optimum outcomes, patients must be able to trust healthcare workers as well as clinics and facilities. At the same time, CHWs – who operate on the periphery of the formal sector and often feel disempowered and excluded – need to experience workplace trust to fulfil their potential.

In this study, we set out to understand how trust in its various forms plays out in South Africa's health system – and made recommendations based on our findings that would benefit patients and overall health goals. We evaluated CHWs' workplace trust, the interpersonal trust between patients and CHWs, and the institutional trust patients place in the health system – and their various impacts on health outcomes.

Workplace trust Trust in supervisors, colleagues, and employing organisations; being assured of respectful and fair treatment.

Patient-provider trust Rooted in interpersonal trust (for example, between patients and CHWs), this also requires institutional trust (like support at health facilities).

Institutional trust How much CHWs and patients can trust the system (supervisors, facility managers, clinic staff, social services, access to equipment and medication, etc.) to support CHWs to act in patients' best interests.

The vulnerability of communities and CHWs alike is inherent to the lack of workplace, interpersonal, and institutional trust that hampers health outcomes in South Africa, and often why patients do not seek or receive care. Apart from building and strengthening trust, strategies are needed to create better working conditions for CHWs, while making healthcare providers and supervisors more sensitive to social inequalities and the effects of structural poverty.

Study methods

Study design During an initial observation phase of a three-year intervention study, we looked at six CHW teams with different configurations of supervisors and locations in the Sedibeng district in South Africa's Gauteng Province. Trust was a dominant theme. This brief uses qualitative data from four non-intervention teams to examine its role. The teams served communities with different populations and geography. In each, we studied the types of trust between patients, providers, and the health system.

Data collection We conducted interviews; focus group discussions (FGDs); and observations of patients, CHWs, their supervisors, and facility managers between September 2016 and February 2017:

- CHWs were selected randomly at the start of a four-day observation period.
- Fieldworkers (FWs) observed CHWs – with or without supervisors – and took detailed notes using a template.
- Interviews lasted 15-60 minutes and FGDs 60-90 minutes.
- FGD topics included CHW activities, as well as their successes and challenges.
- All available CHWs participated in the FGDs, and all nurse supervisors and facility managers were interviewed.
- Data collection was conducted in person, audio-recorded, and then transcribed verbatim by the FWs who wrote reflective notes after each day.

Data analysis A manual thematic analysis was conducted by drawing out data on trust. We then compared segments and quotes under each theme across the sites and between the participants in an iterative process of reflection. This allowed for organising data under each form of trust, ordering quotes from broad to narrow issues, allowing the development of the logic of our argument.

Main findings of the study

1 Workplace trust

Tough employment conditions Many CHWs felt that the Department of Health had failed them, for example, through insufficient stipends, unfair contracts, and not enough annual leave. They also wanted employment beyond 50 years of age.

Challenging environments Frustrations ran high due to poor conditions at facilities – from patients having to wait in the rain, leaky roofs, compromised infection control, and limited room for confidential discussions. CHWs sometimes felt unsafe when visiting households: for example, some feared being raped, and others had been harmed by dogs.

Lack of equipment CHWs were given equipment bags, yet glucose strips and batteries for blood pressure monitors were often not replaced. Not all CHWs received personal protective equipment.

Tragic situations Various social problems confronted CHWs – from families losing everything in shack fires to instances of drug use and physical abuse. Subjected to abject poverty, long-term migrants lacking legal documentation were not eligible for social grants and access to care. Often hailing from similar situations, witnessing such hardship affected CHWs profoundly and they tried in vain to resolve cases like these:

"We carry these stories because we are also human. I wish we could have one whole day just to talk about what we have seen and observed."

"You are breaking their hearts because you can't give them anything, besides filling in the form. You can't even say, 'I will get food parcels. There is nothing.'"

Fragile bonds Relationships between CHWs and their colleagues were brittle at best. CHWs were at lowest end of the hierarchy in facilities and did not feel valued. Trust and cooperation varied from team to team:

- While some supervisors deemed the CHWs unreliable, others praised them.
- Some supervisors empathised with the poverty in communities and realised that the CHWs could be valuable to them. They therefore supported the CHWs and helped them to build their skills.
- Some professional nurses (PNs) and ENs also worked hard to eradicate the hierarchy and make constructive use of the CHWs' abilities.
- Less experienced ENs often struggled to gain the respect of CHWs, and CHWs then rather relied on PNs for support and mentorship. One CHW even trained an EN – which caused anger and resentment due to wage discrepancies.
- There was however also evidence of teamwork between the ENs and CHWs.

2 Interpersonal trust – between patients and CHWs

There was a huge appreciation and respect for the work of the CHWs in the community and in

general, the CHWs were sensitive about patients' personal information, such as HIV results. However, living in the same community as their patients also made it hard to maintain confidentiality.

CHWs are also responsible for home-delivering medication to patients receiving treatment for long-term conditions. They were blamed when these were not received on time, despite many practicalities being out of their control.

3 Institutional trust – between patients, CHWs, and the health system

To be effective and gain the trust of patients, CHWs needed clinic support and the ability to refer patients to facilities for seamless care. However, their efforts were often thwarted by clinic rules and a failure to support patients, which reduced their credibility. Other problems that impacted patients' trust in CHWs and the system included:

- Communication breakdowns that lead to patients not receiving vital equipment such as wheelchairs.
- Instances of nurses treating patients rudely or poorly, leading them to withdraw from care.
- Instances of nurses being insensitive to stigmas and barriers to accessing care.
- CHWs, who were responsible for finding defaulting patients and repairing their trust, could not guarantee that patients would be treated better the next time – a vicious cycle.

Wrapping up

While various factors influenced the three types of trust that impacted the delivery of health services – and how communities engage with healthcare providers – the vulnerability of both communities and CHWs were inherent to the lack of trust that weakened the overall system.

Despite the considerable interpersonal trust between the CHWs and patients, low levels of workplace trust, poor work and employment conditions, the plight of long-term migrants, and structural poverty hampered the CHWs' efforts. Supervisors who recognised these conditions, as well as inequalities in the health system, were able to meaningfully support CHWs, which can in turn help community members to overcome barriers to much-needed care. Going forward, this could be a valuable strategy to create workplace trust, empower CHWs, and unlock their potential – while repairing institutional trust in vulnerable and marginalised communities.

Source: Anstey Watkins J, Griffiths F & Goudge J. 'Community health workers' efforts to build health system trust in marginalised communities: a qualitative study from South Africa.' *BMJ Open* 2021;11:e044065. doi:10.1136/bmjopen-2020-044065

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