UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences
School of Health Care Sciences
Department of Nursing Science

CHALLENGES COMMUNITY HEALTH WORKERS PERCEIVED REGARDING HOME VISITS IN THE TSHWANE DISTRICT

Submitted in Fulfilment of the requirements for the degree

Masters in Nursing Education

at the

University of Pretoria

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November 2020

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DECLARATION

I, Hilda Kawaya
Student number: 18371028

Declare that:

"Challenges community health workers perceived regarding home visits in the Tshwane District"
Is my original work and that it has not been submitted before for any degree at the University of Pretoria or any other institution. All sources that were used or quoted have been acknowledged by means of a complete reference in text and in the list of references.

HKawaya *22 November 2020*

Signed **Date**

DEDICATION

In loving memory of:

- My late parents, Julius Mannya Sekgota and Emily Manchima Sekgota (nee Kganakga) they paved the way for me.
- My late youngest brother, Edison Monama Sekgota, I will always cherish your memories.

This work is also dedicated to the many people who inspired me to follow my dream:

- My brothers Gibson Mathole Sekgota and Jameson Mamatsheu Sekgota.
- My daughter Hilary Xaviera Sekgota and my son Honore Kawaya, for the support, patience and encouragement. The Lord will continue to bless you.
- My grandson Liam Nathan for always asking “koko where are you going?”

I thank you for your unconditional love and support you have given me through this journey.

I love you all!

ACKNOWLEDGEMENTS

I want to sincerely thank the following:

- SG Lourens Nursing College management for granting me the opportunity to further my studies and develop both personally and academically.
- My supervisor, Prof MM Moagi, for her guidance and consistent support. Thank you for being so patient with me. May the Lord continue to bless you.
- My co-supervisor, Prof MD Peu, thank you for your guidance and support. I won't forget your words that inspired me to become an intellectual and to take my studies seriously.
- The Department of Health of the Tshwane district, supervisors of community health workers, Outreach Team Leaders and facility managers for granting me permission to collect data in the Tshwane sub-district clinics.
- My study companions, Ms M Tulelo and Ms T Mokwele for the slogan "forward we go".
- To the participants of this study: Community health workers in the Tshwane District.

ABSTRACT

Introduction

Home visits form part of the integral role of improving the health of the society. Community Health Workers are an integral part of the Health Care System and their role regarding home visits is to enhance the health of the community, families and groups.

The aim of the study

To explore and describe challenges Community Health Workers perceived regarding home visits in the Tshwane district.

Design and Method

A qualitative descriptive, exploratory and contextual research design was used. Data were collected by doing face to face semi-structured individual interviews, using open-ended questions. Participants were purposively selected from Community Health Workers allocated at Primary Health Care Clinics in the Tshwane district. The interviews were audio recorded with the participants' permission, transcribed, coded and analysed into themes and subthemes.

The findings

Five themes and subthemes emerged as challenges perceived by community health workers in the Tshwane district namely the community challenges, logistics challenges, occupational challenges, human resource challenges and managerial challenges.

Conclusion and recommendations

The study concluded that the challenges will be made available to the Department of Health, Tshwane District Managers, Facility managers, Supervisors, Outreach Team Leaders Community Health Workers and staff at clinics.

Key words

Challenges, Perceived, Community Health Workers, Home visit.

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ABBREVIATIONS / ACRONYMS	TITLE
LIST OF ABBREVIATIONS / ACRONYMS	
CHW	Community Health worker
LMIC	Low Middle-Income Country
NEI	Nursing Education Institution
OTL	Outreach Team Leader
PHC	Primary Health Care
rPHC	Re-engineering of Primary Health Care
WHO	World Health Organisation
WBOTS	Ward Based Outreach Teams
WBPHCOTs	Ward Based Primary Health Care Outreach Teams

CHAPTER 1
OVERVIEW OF THE STUDY

1.1. INTRODUCTION

This chapter will provide the overview of the study through an introduction, background, rationale, problem statement, significance, aim, the objective, the question and clarification of concepts, delineation, research methodology and the overview of chapters.

1.2. BACKGROUND

A home visit is a face to face contact visit to an individual's home made by a health care professional; which allows for assessment of the home environment and family situation, to provide for health care related activities. It is done to reduce the defaulter rate, and to enhance compliance to treatment (Finello, Terteyan & Riewiets 2016:114). Home visits provide opportunities for professional development, as well as improving life orientation skills of student nurses (Backes, Haeffner & Dorin 2017:360).

Families and individuals in the community visit the Primary Health Care (PHC) clinic daily and/ or monthly to be assessed for acute and chronic ailments as well as to monitor compliance to treatment. Non-compliance to treatment will warrant that the Community Health Worker (CHW) conduct home visits more frequently to establish the reasons for clinic non-attendance and non-compliance to treatment regimens (Norful 2017:21).

CHW programs are designed to target hard to reach communities that are more than 5 km from a health facility or in the lowest socio-economic areas (Paintain, Willey, Kedenge, Sharkey, Kim, Buj, Webster, Schellenberg, & Ngongo 2014:461). The CHW program was designed to target vulnerable displaced populations with the aim of reducing morbidity and mortality by improving access to quality health care at community level. (Ruckstuhl, Lengeler, Moyen, Garro & Allan 2017: 3).

According to Schneider, Besada, Sanders, Daviaud, and Rohde (2018:61) as stated in the Ward Based Primary Health Care Outreach Team (WBPHCOT) Policy Framework and Strategy, the scope of CHW's duties include the following

- Conduct community household and individual–level health assessments
- Identify potential risks, screen and refer for further assessments and testing
- Identify pregnant women and conduct home visits during pregnancy and post-natal periods to promote health and safe births and identify danger signs
- Provide support for healthy maternal behaviors inclusive of breast feeding
- Provide screening and health promotion programmes in schools and early childhood development centers in collaboration with school health teams
- Counsel and provide support for family planning choices
- Follow up and support chronic cases, distribute medicines and assist in adherence to treatment and defaulter tracing
- Collaborate with other sectors to promote childhood development and geriatric care.

CHWs are responsible for home visits to make sure that the vulnerable groups are getting adequate care and do not fall through the cracks in the health system. These workers are currently paid stipends by the Department of Health and through Non-Governmental Organisations (Mottiar & Lodge 2018:55).

Currently an estimated five thousand four hundred and eighty two (5482) PHC outreach teams are servicing the uninsured population of South Africa and the teams need to reach eighty four percent (84%) of the total population who are based in rural areas, informal urban settlements and townships (White, Govender & Lister 2017:1).

In the financial year 2014/2015 it was estimated that there were eighty six (86) teams in Tshwane covering fourty six (46) wards, with thirty nine (39) trained team leaders and two hundred and seventeen (217) CHWs (Lerutla 2014:11).

1.3.RATIONALE

The PHC clinics provide preventive, promotive and rehabilitative services to the community within a five kilometer radius. These services are available, accessible and affordable (Dennill & Rendall-Mkosi 2015:10). The services should be provided at homes, schools and other public and private institutions because health care is a right for all citizens. The role of the CHWs amongst others is to do home visits.

In the study by Finello, et al. (2016:104) home visit services originated in Great Britain, dating back to the 1850's and originally focused on improving health and hygiene in families with young children, these families were visited for continuation of nursing, care and support. According to

According to Ichikawa, Fujiwara, and Nakayama (2015:13) evaluation of the effectiveness of the Home-visit program for high-risk pregnant women in Japan, found that at least one visitation during pregnancy was effective in preventing preterm births. Participating in the home- visit program reduced the risk of adverse outcomes in a disadvantaged population. In a study conducted by Mayo-Wilson, Grant, Burton, Parsons, Underhill and Montgomery (2014:1) it was found that some home visits are part of larger programs that might have positive effects on clients, including exercise programs and improved assessment methods by medical professionals.

In the study by Mascarenas, Wurzburger, Garcia, Tomedi, and Mwanthi (2015:182) home visits in Kenya should be done by skilled health workers, but in areas where there is a lack of health providers, trained community members, called CHWs, are used instead. These workers are trained to perform basic preventative and curative care and to assist families in seeking necessary care at a health care facility.

In the study by Seutloali, Napoles, and Bam (2018:3) the role of CHWs in Lesotho dates back to 1979 until the country embraced Primary Health Care (PHC), and scaled up the efforts to reach underserved and remote areas. In the Tshwane district the CHWs' scope range from core roles of disease prevention, early detection of ill-health, community advocacy, outreach services, assisting in accessing services through referrals and home visits. The CHW's have understanding of their roles and responsibilities regarding health promotion. However, the changes in the burden of disease have resulted in a shift in roles which is affecting their health promotion practice and experience. The shift caused a lot of challenges experienced by the CHWs in the Tshwane district.

You, Chen, Bogg, Wu, Duan, Ye, Liu, Yu, Diwan and Dong (2013:5) reported that the health workers doing home visits for at-risk mothers in the United States of America have outcomes that appear to be less effective when compared to that provided by nurses, although it enhances physical as well as psychological health, and decreases the use of emergency medical services. Rotheram-Borus, Tomlinson, Le Roux, Harwood & Comulada (2014:5) reported that home visiting has been demonstrated as being effective when provided by professionals, but Low and Middle-Income Countries (LMIC) such as South Africa cannot afford nurses, and will not be able to train the personnel adequately to render such support until at least by the year 2050.

In 2010, the South African National Department of Health (NDoH) launched a National PHC initiative to strengthen health promotion, disease prevention and early disease detection called re-engineering of Primary Health Care (rPHC), which aims to provide a preventive and health-promoting community-based PHC model (Bheekie & Bradley 2016:242). A key component of rPHC is the use of Ward-Based Outreach Teams (WBOTS) staffed by generalist CHWs to do home visits and provide care to families and communities (Austin- Evelyn, Rabkin, Macheka, Mutiti, Mwansa-Kambafwile, Dlamini, & El-Sadr 2017:2).

In the study by Grant, Wilford, Haskins, Phakathi, Mntambo and Horwood (2017:2) health facilities are challenged by limited staffing, resources and infrastructure, and access to PHC clinics is affected by distance, financial constraints and transport availability. CHWs are a core in the community-based PHC model thus the complex contextual challenges they face during home visits and development of skills in community care needs specific attention.

1.4. PROBLEM STATEMENT

Home visits are perceived as an obstacle in delivery of health care services due to shortage of nurses at PHC clinics (Shihundla, Lebese & Maputle 2016:3). Community nurses working at the clinics are expected to conduct home visits irrespective of work overload which is one of the pivotal roles in the prevention of diseases and promotion of health (Darikwa 2016:58).The introduction of PHC re-engineering by the government to recruit CHWs to lessen the workload of community nurses brought a shift in their role of conducting home visits to CHWs (Le Roux, Le Roux, Mbewu & Davies 2015:117).CHW's in Primary Care Centres serve as liaison between communities and health systems to assist in prevention and management of diseases, however CHWs experience social barriers that are related to safety during home visits (Schoen, Mallet, Grossman-Kahn, Brentani, Kaselitz & Heisler 2017:6).

In the study of e-Thekwini district, CHWs reported challenges of insufficient knowledge and skills on diseases, lack of transport to reach the clients' homes, violent community and insufficient supervision related to home visits (Ndlovu, Sokhela & Sibiya 2018:4). The challenges in the Tshwane district about home visits are not yet researched and therefore not well known, and it would be beneficial to PHC services for managers to take action that is necessary to address these challenges.

Tsolekile, Schneider and Puoane (2018:5) report that training of CHWs was haphazard; they performed jobs which were outside of their prescribed roles, were faced with challenges when

visiting homes and did not have a clearly defined scope of work (Seutloali, Napoles, & Bam 2018:2). This study will explore and describe the challenges CHWs perceived regarding home visits in the Tshwane sub-district so that recommendations can be made to improve primary health care practice to individuals and the community.

1.5. SIGNIFICANCE OF THE STUDY

- This study will inform the Department of Health about the challenges CHWs perceived regarding home visits since the introduction of rPHC services in the Tshwane district and may improve their working conditions.
- The Nursing practice will be informed about different challenges that CHWs faced with when doing home visits and contribute to the body of nursing knowledge regarding areas of capacitation and development of CHWs curriculum.
- The finding will be reported to facility managers to plan, organise and implement the recommendations.
- The findings will improve PHC service that CHWs give to individuals and the community.

1.6.RESEARCH QUESTION

The research question that guided the aim/objective of this study was as follows:
What are the challenges CHWs perceived regarding home visits in Tshwane district?

1.7.THE AIM OF THE STUDY

To investigate challenges CHWs perceived regarding home visits in Tshwane district.

1.8.THE OBJECTIVE OF THE STUDY

To explore and describe challenges CHWs perceived regarding home visits in Tshwane district.

1.9. CONCEPT CLARIFICATION

1.9.1 Challenges

Challenges represent the situation of being faced with something that needs great mental and physical effort in order to be done successfully and which test a person's ability (McIntosh 2013:222). In this study challenges describe the situations that are present in the community which make it difficult for the CHW to do home visits.

1.9.2 Community Health Worker

A Community Health Worker is an individual with an in-depth understanding of the community culture and language and has received standardised job-related training which is of shorter duration than that of health professionals, and the primary goal is to provide culturally appropriate health services to the community (Olaniran, Smith, Unkels, Bar-Zeev & Van den Broek 2017:8). In this study a CHW is an individual employed by the Government, allocated at a PHC facility by a Non- Governmental entity and receives a stipend for the services rendered to the community.

1.9.3 Home visit

Home visit means visiting the family at their place of living to assess the health needs, to provide services such as preventive, promotive, curative or rehabilitative services at their door step by the community health nurse or health workers (Sujatha 2015:3).In this study home visit means visiting homes of families to follow up individuals and families, who are defaulting on their treatment as well as other risk factors concerning individuals and family health.

1.9.4 Perceive

Perceive means to become aware and form an opinion of something or have a belief about something (McIntosh 2013:1053). In this study perceive describes how the CHWs view challenges related to home visits as one of their roles in caring for the individual and families in the community.

1.9.5. Primary Health Care

Primary Health Care (PHC) is essential health care based on scientifically evidence-based care by socially acceptable standards, universally accessible to individuals and their families at a cost the community and the country can afford by being self-reliant and by self-determination (White 2014:3). In this study PHC is the care rendered to individuals and families who are residents of the area surrounding the PHC clinic serviced by community nurses and CHWs.

1.10. PARADIGM AND PHILOSOPHICAL ASSUMPTIONS

A paradigm is a worldview, a general perspective on the complexities of the world. (Polit & Beck 2017:9). The constructivism paradigm often called naturalistic paradigm was used which assumes that knowledge is maximised when the distance between the researcher and the participants is

minimised (Polit & Beck 2017:11). In this study the researcher interacted with participants and asked questions about challenges CHWs perceived regarding home visits. Philosophical assumptions are the basic principles that are believed to be true without confirmation (Polit & Beck 2017:10). Assumptions may influence the understanding of reality. The following assumptions about knowing and reality of ontology, epistemology and methodology are shared.

1..10.1. ONTOLOGICAL ASSUMPTIONS

Ontology refers to the multiple and subjective nature of reality which is mentally constructed by individuals with simultaneous shaping, without cause and effect (Polit & Beck 2017:10). The world view of the constructivist researcher assumes reality as being subjective and multiple, whereby individuals seek an understanding of the world that they live and work in. The meanings are multiple and different, which leads the researcher into searching for a complexity of views rather than narrowing the meaning to a few categories or ideas (Creswell 2007:17). The researcher interviewed participants individually to obtain their views on challenges they perceive regarding home visits.

1..10.2. EPISTEMOLOGICAL ASSUMPTIONS

Epistemology means the way the researcher is related to the participants, and refers to reality of how the participants answer the research question (Polit & Beck 2017:10). The researcher interacted with participants and interviewed them individually by asking the research question, what are the challenges they perceived regarding home visits. Constructivists emphasise what is called subjectivist epistemology (Polit & Beck 2017:10). In subjectivist knowing, people may have the same interpretation of a certain situation while others may have a different interpretation of the same situation. The participants reported different experiences according to what they individually perceived during home visits.

Constructivist epistemology emphasises that knowledge is regarded as the meanings of the participants' perceptions (Polit & Beck 2017:10). In this regard, the activities that individual participants offer during home visits can be interpreted differently. The CHWs report the challenges differently regarding the same phenomenon, and acknowledging thus acknowledging multiple realities and multiple truths.

1..10.3. METHODOLOGICAL ASSUMPTIONS

Methodological assumptions refer to the way researchers obtain knowledge and varying interpretations can be refined through interaction between the researcher and participants (Polit & Beck 2017:10). The researcher listened to and recorded the views narrated by participants during face to face individual interviews to have an in-depth understanding and to obtain evidence. Methodological assumptions were discussed in more detail in chapter 2.

1.11. DELINEATION

The study was conducted at Provincial Primary Health Care Clinics in the Tshwane district where CHWs are allocated; they reported to supervisors before going to do home visits.

1.12. RESEARCH DESIGN AND METHODS

The researcher followed a qualitative descriptive, exploratory and contextual approach which focused on challenges CHWs perceived regarding home visits. The study was conducted at three selected facilities in the Tshwane district. The researcher utilised the qualitative approach to highlight the challenges as told by the CHWs. The study population consisted of CHWs allocated at the selected clinics. The participants were purposively selected and the researcher utilised semi structured individual interviews as data collection method. The technique ensures that the researcher obtains the information required and give participants the freedom to respond in their own words, provide as much detail as they wish, and offer illustrations and explanations (Polit & Beck, 2017:510). The research design and methods will be explained in more details in Chapter 3.

1.11. ETHICAL CONSIDERATIONS

The research proposal was submitted to the Student Research Ethics Committee, Faculty of Health Sciences at the University of Pretoria for approval before commencement of the actual research.

Permission to conduct the study was obtained from the Gauteng Provincial Department of Health, Tshwane District Service office, facility managers and WBPHCOT supervisors. (See attached application for permission to do the study in Annexure F).

The following Ethical principles of beneficence and respect for human dignity and justice were maintained as indicated by the Belmont report and adherence to the Declaration of Helsinki (Polit & Beck 2017:138) where care is exercised to protect participants from harm in non-therapeutic research.

1.11.1. BENEFICENCE

Polit and Beck (2017:139) define beneficence as performance of some good or protection of participants from physical and psychological harm and exploitation. The researcher fully described to participants their rights, risks and benefits of participating in the study.

1.11.1.1. The right to freedom from harm and discomfort

Polit and Beck (2017:139) define non-maleficence as an obligation by the researchers to avoid, prevent or minimise harm in studies with humans. The researcher was vigilant in anticipating such problems by being sensitive when asking questions.

1.11.1.2. The right to protection from exploitation

Polit and Beck (2017:139) explain that a research study should not place participants at a disadvantage or expose them to situations for which they have not been prepared. The researcher explained and reassured participants that their participation or information provided will not be used against them in any way.

1.11.2. RESPECT FOR HUMAN DIGNITY

Dignity is defined as “the state of being worthy of honor or respect” and dignity is associated with the adjective to say, that all human beings possess equal and inherent worth (Brownsword, Scotford & Yeung 2017:180).This principle includes the right to self-determination and the right to full disclosure in the Belmont Report (Polit and Beck 2017:140). The researcher respected all participants’ viewpoints and their contributions.

1.11.2.1. Right to self-determination

Right to self-determination means that humans should be treated as autonomous agents capable of controlling their own activities and that prospective participants can voluntarily decide whether

to take part in the study, without risk of prejudicial treatment, with the right to ask questions, to refuse and withdraw at any time (Polit & Beck 2017:140).The researcher did not coerce participants to take part in the study and respected their decisions to withdraw from the study or not to participate, should they wish to do so at any time.

1.11.2.2. The right to full disclosure

The right to full disclosure means people's right to make informed, voluntary decisions about participation requires full disclosure. Full disclosure means that the researcher has fully described the study, the person's right to refuse participation, the researcher's responsibilities and likely risks and benefits (Polit & Beck 2017:140). The researcher obtained informed consent from the participants after they were given information which explained the purpose, potential risks and benefits of the study. (See attached information leaflet and informed consent in Annexure C**)**.

1.11.3. JUSTICE

Justice refers to the right to fair treatment and the right to privacy (Polit & Beck 2017:141). The participants were treated equally and fairly without discrimination.

1.11.3.1. The right to fair treatment

The right to fair treatment means that the researcher must select participants based on study requirements, not to exploit them and to treat people who decline to participate in a nonprejudicial manner (Polit & Beck 2017:141).The researcher showed respect for the participants' beliefs, cultures, religions, habits and lifestyles by selecting participants who volunteered freely and those involved in doing home visits in the Tshwane sub-districts.

1.11.3.2. The right to privacy

According to Polit and Beck (2017:141) research with humans involves intrusion into personal lives and the right to privacy is protected through various confidentiality procedures of anonymity. The researcher maintained privacy at all times by storing data safely under lock and key not to be available to unauthorised persons to access.

1.13.3.2.1. Anonymity

Anonymity means protection of a participant's identity so that the researcher cannot expose the individual's personal data in the study (Polit & Beck 2017:719). The participants' names were not

used, but codes were used instead of their names and records were kept safe according to the Policy of the University of Pretoria: Safekeeping of research documents.

1.13.3.2.2. Confidentiality

Confidentiality means protection of study participants so that data provided are never publicly divulged (Polit & Beck 2017:723). The participants were assured when signing the Informed consent forms that confidentiality would be maintained at all times and the researcher would need their permission to divulge their names when necessary.

1.14. OUTLINE OF THE STUDY

Chapter 1: Overview of the study
Chapter 2: Literature Review
Chapter 3: Research Design and Methodology
Chapter 4: Discussion of Findings and Literature Control
Chapter 5 Conclusion, Limitations and Recommendations

1.15. SUMMARY

This chapter outlined the topic, the background, rationale, the problem statement, aim, objective and significance, the research question, concept clarifications, delineation, the research methodology and overview of chapters. Chapter two will discuss the literature review.

CHAPTER 2
LITERATURE REVIEW

2.1 INTRODUCTION

The previous chapter provided the overview of the study. This chapter will focus on the literature reviewed. De Vos, Strydom, Fouche and Delport (2018: 297) define literature review as a review of the existing scholarship or available body of knowledge that helps the researcher to see how other scholars have investigated the research problem that they are interested in. Brink, van der Walt and van Rensburg (2018:57) describe literature review as finding, reading, understanding and forming conclusions about published research and theory as well as presenting it in an organised manner. Polit and Beck (2017:257) refer to literature review as a critical summary of existing knowledge on the topic in order to contextualise the research problem.

Creswell (2013:57) states that literature review helps to determine whether the topic is worth studying and provides insight into which the researcher can limit the scope to a needed area of inquiry. Gray, Grove and Sutherland (2018:120) state that the purpose of conducting a literature review is to discover the recent, relevant information about a particular phenomenon. The literature sources reviewed will identify the gap between what has been written about the topic and what has not been written as well as possible flaws in the literature (Maree 2018:26).

The aim of the literature review conducted by the researcher was to explore relevant literature using peer-reviewed journals and 'grey' literature related to the challenges Community Health Workers perceived regarding home visits globally. This chapter will cover aspect methodology and discussion of findings from the literature reviewed.

2.2 METHODOLOGY

The methodology will be discussed under the following headings: search strategy for peer-reviewed journals, the inclusion and exclusion criteria and data extraction.

2.2.1 Search strategy for peer-reviewed journals

The researcher launched Literature search on the databases MEDLINE and PubMed. These databases are deliberated on the basis that they are the largest abstract and citation databases for peer-reviewed literature, providing superior support for the literature research process in academia and giving the researcher a global view. Brink et al. (2018:57) state that in order to develop a search strategy the researcher needed to achieve trustworthiness of the review.

An electronic search was further launched on the following databases: Cumulative Index of Nursing and Allied Health Literature (CINAHL), Ebscohost, WorldCat.org, Wiley Online Library database, Google and Google Scholar databases. Librarians at the University of Pretoria and the Nursing College assisted the researcher to navigate through the search for literature sources. Brink et al. (2018:62) stated that librarians can assist in indexes, reference materials as well as computer-assisted searches.

The following search terms were identified and used: Community Health Workers, Home Visits, and challenges in Home Visits, Perception or Perceive and Primary Health Care. Each of these concepts were searched individually then a Boolean operator 'and' or 'or' were used by combining the terms.

The search results were initially broad and were narrowed down with the use of more specific search topics. The researcher noted all journals and articles to avoid duplication of literature sources. The reference lists from retrieved studies that were manually searched were compiled. The reviewed literature comprised research conducted globally; in Europe, North and South America, Africa, Sub-Saharan Africa, West Africa, East Africa, Central Africa, Commonwealth countries, Asia and South Africa starting from 2013 to 2019. The introduction of rPHC in South Africa included CHWs in 2011 when they were absorbed as home-based cares the health care system from Non-Governmental Organisations (NGOs). Brink et al. (2018:61) also stated that the criteria which help to focus the search are: the period of interest, language preference, databases to use, types of studies and exclusion criteria. The criteria below assisted the researcher to identify the relevant literature sources for the study.

2.2.2 Inclusion criteria

In this literature review, the following inclusion and exclusion criteria were used:

- Articles on Community health workers, Home visits and Primary health care.
- Articles published in English.
- Articles published from 2013 to 2019.

2.2.3 Exclusion criteria

- Articles not on Community Health Workers, nor home visits or Primary Health Care.
- Articles not published in English.
- Articles not published from 2013 to 2019.
- Articles published in newspapers

After applying the above mentioned criteria, the articles were critically analyse appraisal model offered by Polit and Beck (2017; 395).

2.2.4 Data extraction

To discuss challenges Community Health workers perceived regarding home visits, more than thirty (30) articles, five (5) published theses, four (4) unpublished theses and three mixed method studies were reviewed globally. Two hundred and fifty (250) titles were identified, from which fourty two (42) abstracts were examined as they met the inclusion criteria. The fourty two (42) abstracts were further examined to verify if they address the research question: *What are challenges CHWs perceived regarding home visits in Tshwane district*? This question guided the literature search strategy adopted in this study.

2.3 DISCUSSION OF FINDINGS FROM LITERATURE REVIEW

The discussion included the following headings: home visits, Community health workers, Primary health care and challenges. The researcher used the six wise men, Kipling's conceptual framework to search for the meaning, purpose, origin or timeframe, for each term.

2.3.1 Home visits

The researcher searched globally for the origin of home visits. In the study by Finello et al. (2016:104) home visits were intended to improve health and hygiene in families with young children in the 1850's. A home visit is vital to reduce maternal and infant morbidity and mortality (Shaban, Al-Awamreh, Mohammad & Gharaibeh 2015:248). A health care project in Egypt recommends four home visits to women and their infants during the post-natal period commencing within 24 hours of delivery, on day 4 after birth, and on day 7 after birth, and a clinic visit on day 40 (WHO, 2014). American Indian and Alaska Native people have used informal home visits as a traditional cultural practice to take care of and attend to the needs of young children and families and improved outcomes in these areas (Novins, Meyer & Beltangady 2018:260). The researcher studied literature on home visits processes, the benefits, focus and the role of professional nurses and the employment of CHWs.

2.3.1.1 Preliminary health assessment

The role of conducting home visit as a task was shifted from professional nurses to the CHWs. Professional nurses conducted a preliminary health assessment of the client and the situation that existed, before conducting a home visit. The aspects of a client's life should be reviewed to detect strengths, existing problems and potential problems that may be addressed during the visit. The nurse utilised determinants of the health frame work to review the information on biological, psychological, environmental, socio-cultural, behavioral and health system factors that influence the clients' health status (Clark 2015:308-309) as depicted below:

- Biological determinants of health
  - the nurse considers effects of age and developmental level and also obtains information of pre-existing conditions
- Psychological determinants of health
  - nurses assess the existence of family stress and coping mechanisms
- Environmental determinants of health
  - The nurse obtains information about the home environment, safety needs, the client's and family's biographical data, infection control measures to plan effectively and to promote safety for the client and family.
- Socio-cultural determinants of health
  - The nurse obtains history on economic status occupation, cultural or religious factors of the client to assess the state of the social support system.
- Behavioural determinants of health
  - the nurse obtains information about nutritional needs and consumption patterns
- Health system determinants
  - The nurse obtains information of access to health services and the effects of the health system on the client

The preliminary data collected informed the CHW to plan effectively with relation to supplies needed during the home visit.

2.3.1.2 The benefits of home visits

Sitrin, Guenther, Waiswa, Namutamba, Namazzi, Sharma, Ashish, Rubayet, Bhadra, Ligowe, Chimbalanga, Sewell, Kerber & Moran (2015:2) further asserted that home visits by trained Community Health Workers can change practices regarding new born babies.

Ichikawa et al. (2015:13) confirmed that at least one visitation during pregnancy would reduce the risk of preterm births. In a study in Nigeria the health workers during their home visits were able to keep track of non-facility-based births, which were not recorded and affected the calculations of infant mortality (Salami & Brieger 2014:6).

Trainees in medicine can gain experience and confidence in making house calls by doing structured home visits (Magin, Catzikiris, Tapley, Morgan, Holliday, Ball, Henderson, Elliot, Regan & Spike 2018:82). Home visits are reported to improve adherence to medication, functional status and help keep people at home, improve quality of life, particularly at the end of life among the elderly (Clark 2015:314).

2.3.1.3 The focus of home visits

The focus of home visits expanded to other areas such as care of the elderly. Magin et al. (2018:78), reported that home visits are proposed to be an essential component of general practice care in the provision of comprehensive person centered care for the elderly. Voigt, Bojanowski, Taché, Voigt and Bergmann (2016:1) added that medical care of homebound patients is an integral part of primary care in Germany where most elderly patients live in private households, thus primary care services are offered by family physicians and medical assistants and not by communities. Preventative home visits may have positive effects on the health care costs by decreasing the nursing home admission, hospitalisations and the length of stay in hospitals (Liimatta, Lampela, Laitinen-Parkkonen & Pitkala 2016 :573). Home visiting services are part of the National Health Systems in most countries in Western Europe, where services are voluntary and free to all families (Finello et al., 2016:104).

2.3.1.4 The role of professional nurses in home visits

Grant, Wilford, Haskins, Phakathi, Mntambo and Horwood (2017:2) reported that health facilities faced a challenge of limited staffing and resources. The shortage of nurses at PHC clinics compromised their role to conduct home visits. Darikwa (2016:58) agreed that to prevent diseases and promote health, the role of community nurses was to conduct home visits irrespective of work overload.

However, it is important to recognise that the clinical proficiency of the nurses performing home visits are valuable due to their knowledge and experience which assist in discerning challenges and referring patients to relevant healthcare providers (Wells, O'Neill, Rogers, Blaine, Hoffman, McBride, Tschudy, Shumskiy, Mauskar & Berry 2017:15).

2.4 THE EMPLOYMENT OF CHWS TO DO HOME VISITS

The South African government introduced the strategy of employing CHWs to do home visits to promote health and prevent diseases by re-engineering PHC service through their employment. In the study by Bheekie and Bradley (2016:242) the establishment of District Management Teams (DMT) to improve the Primary Health System, increase life expectancy, decrease child and maternal mortality, combat HIV and AIDS and decrease the tuberculosis burden was utilised to address health problems.

The PHC outreach team consists of a senior professional nurse trained over three years, supported by a health promoter and environmental health officer, leading a team of six (6) CHWs within the geographic area of a municipal ward (Pillay 2012). The teams consist of general CHWs, led and supported by nurses and working in close collaboration with environmental health officers and health promoters (Schneider et al., 2018:60). The PHC outreach team is supposed to work with another professional nurse and an enrolled nurse at the clinic to provide comprehensive care to this population, from health promotion to treatment of minor ailments (Moosa, Derese and Peersman 2017:2).

2.4.1 Community Health Workers

According to Perry et al. (2014:400), more than five (5) million CHWs are active globally and known for their effectiveness and importance of providing services to communities. CHWs are trained government workers allocated to facilities and the community recognise them as health professionals and an extension of the formal health system (Sitrin et al, 2015:10). CHWs play a very important role in strengthening health care systems and increasing the availability of community level primary health care services while supporting the work of formal health professionals in many countries (Musoke, Ssemugabo, Ndejjo, Ekirapa-Kiracho & George 2018:2).

Mhlongo and Lutge (2019:2) stated that Community Health Workers had their origins in China in the 1920s and were precursors to the “barefoot doctor” movement in the 1950’s. They indicated that CHWs are groups of health workers who work outside the health facilities directly with people

in their homes, neighbourhoods, communities and other non-clinical spaces where health problems occur and diseases affect the communities.

Kok, Ormel, Broerse Kane, Namakhoma, Otiso, Sidat, Kea, Taegtmeyer, Theobald and Dieleman (2017:1405) regarded CHW's as health workers carrying out functions related to health care delivery; trained in some way in the context of the intervention, and having no formal professional or para-professional certificate or degree in tertiary education. The CHWs do mostly household profiling, screening and health education, with supervision by the professional nurse team leader (Moosa et al., 2017:2)

In South Africa CHWs are expected to assess health needs, facilitate service access, provide community-based information, education and psychosocial support, deliver basic health care and support community campaigns (Zulliger, Moshabela & Schneider 2013:1). The PHC training package, identifies 12 roles that are to be performed by the CHWs working in PHC which include home-based care, counselling, support and stress relief, health promotion and education at a household level, referral to relevant departments, initiative and support home-based projects, liaison between DOH and the community, mobilisation against diseases and poor health by means of campaigns, directly supervised treatment support (DOTS), screening of health-related clinic cards for compliance or default, assessment of health status for all family members while giving advice, weighing infants, recording in 'Road to Health' card and providing prevention of mother to child transmission of HIV/AIDS (White et al., 2017:5).

Le Roux et al. (2015:116) reported that the Department of Health was developing a policy framework to regulate the role of CHWs and their working conditions and further assert that shifting tasks and care responsibilities from professionals is necessary to meet the needs of the health care service. In Sierra Leone CHWs are trained to accompany HIV clients on ART and do routine home visits to monitor side effects and appointment reminders (Kelly, Frankfurter, Lurton, Conteh, Empson, Daboh, Kargbo, Giordano, Mukherjee & Barrie 2018:141). The role of CHWs known as Health Surveillance Assistants in Malawi is that, they work together with community leaders in providing basic health and environmental service in the rural areas, to create a link between the facility and the community and are paid salaries by the Ministry of Health (Nkosi-Gondwe, Robberstad, Blomberg, Phiri and Lange 2018 :2).
In the paper by Pillay (2012:3) the role of CHWs in many countries has contributed to better outcomes, however in South Africa the health outcomes are sub-optimal in areas of maternal and child health.

Home visits by CHWs during pregnancy can play a role in improving thermal care, early and exclusive breastfeeding, and hygienic core care practices in different settings (Sitrin et al., 2015:2).

2.4.2 Primary Health Care

At the international conference on Primary health care at Alma-Ata in 1978 where a declaration of "Health for All" by the year 2000 was made, CHWs' role in providing PHC was highlighted (Mhlongo & Lutge 2019:2). The World Health Organization (WHO), identified five key elements to achieving this goal: reducing exclusion and social disparities in health (Universal Coverage reforms); principles of equity, access, empowerment, community self-determination and inter-sectoral collaboration.

Universal Health Coverage (UHC) is defined in terms of rights to health care, financial protection and utilisation of healthcare services on an equitable basis. UHC thus implies equity of access and financial risk protection (WHO 2013). The UHC is aspired by most countries whereby community care is a crucial contribution and it is affordable with running costs of less than one US dollar per capita per year (Lawn, Bhutta, Wall, Peterson and Daviaud 2017:i4). The Astana Declaration (2018) had emphasised the critical role of PHC in advancing UHC and the potential contribution of CHWs supporting UHC in improving health care services (Agarwal, Anaba, Abuya, Kintu, Casseus, Hossain, Obadha & Warren 2019:2).

UHC means that all people receive the health services they need, including health initiatives designed to promote better health, prevent illness, and to provide treatment, rehabilitation and palliative care of sufficient quality, ensuring that the utilisation of the services does not expose the user to financial hardship (Fusheini & Eyles 2016:3).

The District Health System (DHS) is seen as the means of achieving an equitable, efficient and effective health system based on the principles of the Primary HealthCare (PHC) approach. This is because the main strength of the health district model is the combination of strong values of equity, efficacy, efficiency, autonomy and solidarity with conceptual neatness and operational relevance. (Fusheini & Eyles 2016:5).

The National Health Insurance (NHI) system and the DHS model are seen as key elements of UHC in South Africa. The DHS depicts a set of activities such as community involvement, integrated and holistic health care delivery, intersectoral collaboration and a strong "bottom-up" approach to planning, policy development and management. NHI is designed to pool funds to

provide access to quality, affordable personal health services for all South Africans based on their health needs, irrespective of their socio-economic status (Fusheini & Eyles 2016:5).

NHI in South Africa is an attempt to address this public-private inequity, mostly by funding changes which include service delivery reform, termed Primary Health Care (PHC) Re-engineering, as a shift towards more prevention. There are three streams in PHC re-engineering: municipal WBPHCOTs, school health teams and district-based clinical specialist teams (Moosa, Derese & Peersman 2017:2). In terms of cost, a preliminary policy paper issued by the Government estimated that NHI will cost R255 billion per year by 2025, if implemented as planned over a 15-year period (Fusheini & Eyles 2016:3). To achieve the principles of PHC, together with inclusion to the NHI and UHC, the employment of CHWs was instituted.

2.4.3 Challenges

The health services in which CHWs work often present with preconditions or limitations to function (Kok et al., 2015:2). The challenges found from the study of CHWs in Lesotho included demotivation because of inconsistent incentives, lack of supplies, community attitude, increase in workload, gaps in training and lack of a standardised reporting tool (Seutloali et al., 2018:4).

2.4.3.1 Breaking of trust and confidentiality

CHWs work in an environment where trust and confidentiality form a cornerstone in social relationships. Lack of confidentiality and trust was expressed as a major barrier to CHW acceptability, as the ethical standards of confidentiality were sometimes breached and were labelled as gossip (Grant et al., 2017:4). The authors further attested that CHWs' interaction during home visits could be challenging if family members were present during the visit and could lead to unwanted disclosure of sensitive information. Families failed to obtain medications due to transportation and financial problems (Wells et al, 2017:13).

2.4.3.2 Inconsistent incentives and conditions of services

Transport was reported to be a challenge in the study of workers in Malawi (Nkosi-Gondwe et al., 2018:8). Management apathy around allowances for CHWs in Kenya was a source of feelings of being undervalued and of not having control over one's work sphere (Kane et al., 2016:31).

Other barriers included the lack of career prospects for CHWs, lack of formal recognition as government employees of the health system even though they were paid through the governmental pay system, low incentives, delayed payments (De Neve, Garrison-Desany, Andrews, Sharara, Boudreaux, Gill, Geldsetzer, Vaikath, Baernighausen & Bossert 2017:16)

CHWs preferred better financial recognition for their work, increase in stipend, and confirmation of their work for future prospects, rain coats, Christmas hampers and tokens to help mitigate financial constraints (Busza, Dauya, Bandason, Simms, Chikwari, Makamba, McHugh, Munyati, Chonzi & Ferrand 2018:4). The CHWs mentioned their role in solving social issues in the community although remuneration was insufficient and working in the community allows opportunities to channel their values and beliefs into concrete actions with opportunities to self-actualisation (Kane et al., 2016:28).

The relationships between outreach teams and facility staff are often described as strained and unsupportive (Schneider et al., 2018:62). Nxumalo, Goudge and Manderson (2016:68) indicated that a key factor determining the success of a CHW programme is an established relationship with the formal health system which requires the involvement and coordination of multiple actors at the district level, such as community groups, health care providers, municipal level stakeholders and multiple sectors, social development, environmental services, and education.

2.4.3.3 Safety and security concerns

A perceived lack of personal safety was found to affect motivation to work at particular locations resulting to people resigning. Young female health workers felt unsafe, scared of substance abuse among young men, violent assaults, verbal abuse and accusations as well as fear of contracting infections (Sitrin et al, 2015:10). According to Clark (2015:305) professional nurses conducting home visits must be vigilant and should assess the environment at all times for potential safety risks.

Women in Jordan are traditionally not supposed to leave the house for 40 days post-delivery and mothers prefer that the home visit be done by a female CHW in the presence of a family member to enhance a sense of security (Shaban et al, 2015:251).

2.5 TOPOGRAPHICAL CHALLENGES

Climate, environmental challenges and the need to cover large distances hampered CHWs' performance of their duties. It was reported that the CHWs had difficulties in reaching communities because of flooding (Kok et al., 2015:7).

A study done in Uganda for visitation of mothers during pre-natal and post-natal periods by Village Health Teams proved that it was not possible for the teams to navigate large geographical areas while the low incentives they received to travel long distances added to the challenges (Ayiasi, Kolsteren, Batwala, Criel, & Orach 2016:14).

2.6 SUMMARY

This chapter focused on literature reviewed and the main points discussed were the introduction, methodology used, search strategy for peer-reviewed journals, the inclusion and exclusion criteria, data extraction, and discussion of findings from literature from the main themes of home visits, Community Health Workers, Primary Health Care And the challenges experienced. The next Chapter will discuss the research design and methodology.

CHAPTER 3
RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

The previous chapter outlined literature reviewed from peer-reviewed journals, the inclusion and exclusion criteria, data extraction and discussion of findings obtained in literature from the main themes of home visits, Community health workers and Primary health care. This chapter will discuss the research design and methodology.

3.2 OBJECTIVE OF THE STUDY

The study objective was to explore and describe the challenges CHWs perceived regarding home visits in the Tshwane district.

3.3 RESEARCH DESIGN AND METHODS

3.3.1 Research design

A research design is the overall plan for addressing a research question including specifications for enhancing the study‘s integrity (Polit & Beck 2017:743). Monette, Sullivan and De Jong (2008:9) in De Vos, Strydom, Fouche and Delport (2018:143) define research design as a plan outlining how observations will be made and how the researcher will carry out the project. According to Moule, Aveyard and Goodman (2017:151) the design is the plan of how the research aims, objectives, hypotheses and question(s) will be answered. In this study, a qualitative explorative, descriptive and contextual design was followed to explore and describe the challenges CHWs perceived regarding home visits in the Tshwane district and to capture the participants’ views.

3.3.2 Qualitative design

Qualitative design is a systematic approach used to describe the phenomenon and is rooted in the traditional disciplines of anthropology, sociology and psychology (Polit & Beck 2017:684).
The design focuses on qualitative aspects of meaning, experience and understanding and is used to study human experience from participants’ viewpoint in the context in which the action takes place (Brink et al., 2018:104). Qualitative research is the investigation of human experience in naturalistic settings, pursuing meanings that inform theory, practice, instrument development and further research (LoBiondo-Wood & Haber 2014:281). According to Moule et al., (2017:155) the

design is focused on understanding social settings, ward and community environment. In this study the participants are CHWs who are working in the community with whom the researcher conducted face to face interviews using open-ended questions to describe their challenges perceived regarding home visits in Tshwane district.

3.3.3 Explorative design

Explorative design shows the underlying processes as well as various ways in which a phenomenon is revealed (Polit & Beck 2017:15). In this study the challenges that CHWs perceived regarding home visits was explored with the use of open-ended questions in semi-structured interviews. The researcher allowed participants to talk freely through communication techniques of active listening and the use of non-verbal ques. Brink et al., (2018:11) state that the researcher is required to explore dimensions of the phenomenon, the manner in which it is manifested and other factors related to it. The researcher explored the challenges perceived by CHWs by conducting individual interviews.

3.3.4 Descriptive design

Descriptive design was used to observe, describe and document aspects of a situation as it naturally occurs (Polit & Beck 2017:15). The data that emerge from a qualitative study are descriptive and reported in words using the participants' words or pictures, rather than in numbers (Creswell 2013:255). In this study the participants described the challenges perceived regarding home visits during semi-structured interviews using their own words. The audio recorded questions were asked that allowed description of events as they occurred from the participants' point of view. Brink et al., (2018:11) state that the researcher is required to obtain complete and accurate new information about a phenomenon, utilising observation, description and classification. The participants described the challenges using their own words during the interviews and the researcher classified the data into themes and subthemes for further description of the phenomenon.

3.3.5 Contextual design

Contextual design is a study that is done in a specific area (Polit & Beck 2017:15). In this study challenges that the participants perceived regarding home visits was put in context, at three (3) PHC clinics where the CHWs were allocated and doing community work. The findings of this study will be limited to the three (3) clinics where the study was conducted.

3.4 RESEARCH METHODS

3.4.1 Setting / context

Research setting refers to the physical location in which data collection takes place in the study (Polit & Beck 2017:47). The study was conducted in the Tshwane district located in Gauteng Province of South Africa. Tshwane district is divided into seven sub-districts and three clinics was utilised from one sub-district. The researcher was granted access to the three clinics after communicating with the facility managers for data collection.

3.5 POPULATION

Population exists of an entire set of individuals or objects having some common characteristics (Polit & Beck 2017:56). The study population were CHWs who were allocated at PHC clinics in Tshwane district. The overall population of CHWs allocated at the three (3) Clinics were fourty six (46) CHWs by the time the study was conducted. The accessible population of fourteen (14) participants volunteered and consented which was 30% of the participants from the three sites who met the eligibility criteria. According to Moule, Aveyard and Goodman (2017:166) the researcher collected information or data from a particular population who met a specific criteria and set specific parameters before selecting a sample limiting the study population through eligibility criteria.

3.5.1 Inclusion criteria

Inclusion criteria or eligibility criteria, means the criteria specifying characteristics that a target population possesses (Polit & Beck 2017:250). The researcher included CHWs that were willing, volunteered, consented to be part of the study and have done home visits in the Tshwane district.

3.5.2 Exclusion criteria

Exclusion criteria means the criteria specifying characteristics that a target population does not have (Polit & Beck 2017:728). The study excluded CHWs who have not done home visits and not consented to participate in the study.

3.5.3 Sampling method

Sampling is a process of selecting a portion of the population to represent the entire population in order to obtain information regarding the phenomenon (Polit & Beck 2017:743; Brink et al., 2018:115). In this study the non-probability purposive sampling method was used to select participants who provided data on challenges perceived during home visits in Tshwane district.

Furthermore Polit and Beck (2017:743) describe purposive sampling as a non-probability sampling method in which the researcher selects the participants who have undergone the phenomenon and will be most informative.

3.5.4 Sample size

Sample size means the number of people who participate in a study, the number of participants was determined by data saturation (Polit & Beck 2017:497) that is sampling to the point at which no new information is obtained and redundancy is achieved. Fourteen (14) participants volunteered and consented to be part of the study. Furthermore Polit and Beck (2017:497) stated that there are no fixed rules for sample size in qualitative research but should be based on informational needs hence a guiding principle of data saturation.

A sample size should be large enough to sufficiently describe the phenomenon of interest, address the research question and a large sample size risks having repetitive data. The goal of qualitative research should be to attain saturation and that saturation of data is reached when there is no new relevant information that emerges from the information given by the participants (Polit & Beck 2017:499). The researcher interviewed the participants by the 12th participant data saturation was reached as information given by participants sounded the same and the researcher continued interviewing the last two (2) participants.

3.5.5 Preparatory phase

The researcher requested permission from Tshwane District Manager and Tshwane Research Committee to conduct research at the PHC clinics as research settings and also to interview CHWs. Permission was granted (see Annexure E). The dates and time were agreed upon by the researcher, respective OTLs and Facility managers.

3.5.6 Recruitment of participants

The participants were recruited from the PHC clinics where they are allocated and assistance was sought from facility managers and senior managers of WBPHCOT's in the Tshwane district. The researcher contacted the facility managers of the three clinics by email and telephone, proposed feasible dates to go to the facility. The facility managers introduced the researcher to Outreach Team Leaders (OTLs) on the day of recruitment when potential participants convened in one large venue. Initial contact involved clarification of the topic and the purpose of the study to gain trust. The date for the actual research was secured with participants who volunteered and signed the consent form after the information session.

3.5.7 Information session

Information session refers to the interaction between the researcher and the participants before the actual interview, when the researcher will explain the research topic and the aim of the study (Polit & Beck 2017:143).The researcher went to the clinics and the potential participants were given the information about the study. Information leaflets were distributed to the CHWs who attended the session. The potential participants were made aware of voluntary participation, anonymity and confidentiality related to the study. The potential participants were allowed to ask questions related to the information given and the contents of the consent form.

3.5.8 Pilot study

A pilot study is defined as a small scale version of a study done in preparation for the major study and is designed to assess the feasibility and support refineness, the protocols, methods, and procedures to be used in a larger scale study (Polit & Beck 2017:624). In this study the pilot study was done to investigate whether the research question asked: "what are the challenges perceived regarding home visits", was clear prior to the main study. Two participants were interviewed for the researcher to refine the interview skills, listen to the recordings and appraise them. The researcher found that the questions were relevant and that there was a need to explore more by means of silence and probing to obtain more information on the subject. The two interviews were not included in the study.

3.6 DATA COLLECTION

Data collection is the gathering of information to address the research problem (Polit & Beck 2017:725). Data collection provides an audit trail which includes a clear and specific explanation of how data were collected, how the findings were derived at and the reason for the method selected (Brink et al., 2018:134). In this study data were collected by the researcher by doing semi-structured interviews in English. Participants were allowed to use their own language when they struggled to further express themselves in English It was translated during transcribing of information, and thus allowed the participants to share information freely. The date, time and venue were chosen according to the participants' work schedule and appointments were secured. The interviews were conducted with participants at the clinics during the mornings before the participants went into the field to do community work. The researcher attended morning briefings by OTLs to get a clear picture of the reporting session.

The duration of interviews ranged between 30 to 50 minutes. The participants were asked the research question that guides the interviews: '*What are challenges that you perceive regarding home visits"*? Data recording was done by using an audio recorder with participants' permission and the consent form was signed, which allowed a much fuller record as notes were made after each interview (Polit & Beck 2017:508).The researcher followed the self- designed interview guide in Annexure B to explore and describe the challenges perceived by CHWs in the Tshwane district.

3.6.1 Individual interviews

An individual interview is defined as a method of gathering information in which the researcher asks questions face to face or by telephone (Polit & Beck 2017:732). The researcher was assisted by OTL's and facility managers to identify a room that was in a quiet area to conduct the interviews. According to Polit and Beck (2017:514) the researcher needs to select places that offer privacy with limited interruptions. A one-to-one individual semi-structured interview was conducted and audio recorded with the consent of each participant while various communication techniques were used to motivate participants to provide more information. In semi-structured interviews the researcher prepared a written topic guide with a list of matters to be covered during the interview (Polit & Beck 2017:510). The researcher developed an interview guide which covered the main question as well as follow-up questions with knowledge about home visits and the closing questions. The communication techniques of probing, paraphrasing, clarification and active listening were used to elicit more information. The researcher made notes after the interviews about experience and observations made during the interview. After completion of interviews the researcher acknowledged and thanked the participants for their involvement.

3.7 DATA ANALYSIS

Data analysis is the systematic organisation and synthesis of research data (Polit & Beck 2017:719). Data collected directly from participants were audio-recorded, organised in the form in which it was collected, without being coded or analysed (Polit & Beck 2017:508). It was done concurrent with data collection methods and involved an examination of text and the option to reflect on possible meanings and relationships of the data.

Data were analysed using Tesch's eight steps of analysing data collated by clustering together related types and narrative information into a coherent scheme of themes and subthemes, which are used to build a rich description of the phenomenon (Polit & Beck 2017:540). The researcher systematically analysed textual data using Tesch's eight steps as follows:

1. The researcher read all the printed transcripts of interviews word for word and wrote down impressions of every sentence to understand the essence of all data collected.
2. The researcher wrote down thoughts when reading the transcript from the shortest to longest interview to understand the underlying meaning.
3. Wrote down all thoughts from all participants' interviews, made a list of all the topics and clustered similar topics together. The researcher drew columns for all topics as major, unique and leftover topics.
4. Compared the list to the data, abbreviated the topics as codes and wrote down codes next to the appropriate segments of the text. The researcher tried the preliminary organising scheme to see if new categories and codes emerged.
5. The most descriptive wordings were turned into categories. Topics which had similar meanings were reduced and grouped together by indicating arrows to show that they were related.
6. The researcher made a final decision on abbreviations of each category and coded them alphabetically.
7. Data material belonging to each category were assembled in one column and analysed.
8. The researcher relooked at the data to recode if necessary and decided that it is possible.

Transcripts were filed, documents were labelled according to numbers and dates and ideas were written in field notes. A set of clean data transcripts were sent to an independent coder who is experienced in coding data. The researcher completed the analysis and compared it with that of the independent coder after which consensus was reached and agreed upon the findings. The analysed data were used to understand the challenges CHWs perceived regarding home visits and will be fully discussed in Chapter 4.

3.8 DATA INTERPRETATION

According to Green and Thorogood (2014:40) the researcher investigates a problem from a specific point of view and the reality is interpreted from the respondents' frame of reference. It is the process of making sense and meaning of the data which depends on the closeness and immersion of the researcher to the data (Polit & Beck 2017:530). In this study the researcher found meaning in each statement made by the participants, when audio recorded interviews were transcribed to themes and subthemes.

3.9 TRUSTWORTHINESS

Connelly (2016:436) defines trustworthiness or rigor of a study as the degree of confidence in data collected and the interpretation and methods used to ensure the quality of a study. Brink et al., (2018:110) referred to rigour in qualitative research that it reveals the openness, relevance of epistemological and methodological congruence of thoroughness in data collection and data analysis as well as the researcher's self-understanding. Researchers should establish the protocols and procedures necessary for a study to be considered worthy by readers (Boswell & Cannon 2018:200). Trustworthiness was ensured by using the framework as discussed by Lincoln and Guba cited in Polit & Beck (2017:559) of credibility, dependability, confirmability, transferability and authenticity.

3.9.1 Credibility

According to Polit and Beck (2017:559) credibility is achieved to the extent that the research methods engender in the truth of data and in the researcher's interpretations of the data. In this study the researcher ensured credibility through prolonged engagement, persistent observation, triangulation and member checking.

3.9.1.1 Prolonged engagement

Prolonged engagement means the investment of sufficient time by the researcher during data collection to have an in-depth understanding of the participants under study, thereby enhancing credibility (Polit & Beck 2017:740). According to Brink et al., (2018:158) the researcher gains in-depth understanding of the phenomenon, learns specific facts about participants and in turn promotes trust between the participants and the researcher by staying in the field. In this study the researcher spent time with the participants to establish rapport and to have a better understanding of the challenges they perceived regarding home visits. The researcher attended morning meetings at the clinics when the CHWs were reporting to the team and OTLs.

3.9.1.2 Persistent observation

Persistent observation refers to the researcher's intense focus on the aspects of a situation that are relevant to the phenomenon being studied (Polit & Beck 2017:738). In this study the researcher observed the participants and listened intensely during face to face individual semi-structured interviews to understand their views about the challenges they perceived regarding home visits.

3.9.1.3 Triangulation

Triangulation refers to the use of multiple methods to collect and interpret data about a phenomenon so as to converge on an accurate representation of reality (Polit & Beck 2017:747). Brink et al., (2018:84) state that triangulation is the use of multiple sources or referents to draw conclusions about what constitutes the truth, to bring clarity and understanding of the phenomenon. In this study, the researcher interviewed participants of different ages, different genders and from different economic backgrounds. The researcher conducted individual face to face audio-recorded semi-structured interviews, with the participants' permission, to ensure the accurate capturing of participants' narratives. The researcher made field notes after each interview to demonstrate a rich picture of participants' attitudes and behaviours to enhance the credibility of findings and in addition, an independent coder was used to assist with the coding of data.

3.9.1.4 Member check

Member check refers to a method of validating the credibility of data through debriefings and discussions with participants (Polit & Beck 2017:734). In this study the researcher summarised information collected, thereafter went back to participants at the clinics and presented the data for comments and confirmation to correct errors and for the participants to provide more information.

3.9.2 Dependability

Dependability refers to stability of data over time and for the evidence to be consistent and stable (Polit & Beck 2017:175). Brink et al. (2018:111) state that dependability refers to the provision of evidence so that, if repeated with the same participants in a similar context the findings will be the same. In this study the researcher developed a semi-structured interview guide, used an audiotape recorder for the interviews and stored the data safely and securely. Dependability was enhanced by checking the accuracy of transcripts, the research question and the data collected.

3.9.3 Confirmability

Confirmability means the objectivity or neutrality of the data and interpretations. (Polit & Beck 2017:559). It guarantees that the findings, conclusions and recommendations are supported by the data, that there is an internal agreement between the researcher's interpretation and the actual evidence (Brink, et al., 2018:111) while the findings of the study could also be confirmed by another (De Vos et al., 2018:421).

In this study the researcher did not invent her own interpretations of data or the findings represented by the participants' views. The researcher corroborated the findings by reading the transcripts over and over again in order to analyse the data. The independent coder affirmed the findings and agreement was reached confirming similar views of the findings.

3.9.4 Transferability

Transferability describes the extent to which findings can be transferred to or have applicability to other settings or groups (Polit & Beck 2017:560). It means the findings of the research can be transferred from a specific situation or case to another (De Vos, et al., 2018:420). According to Brink et al., (2018:159) transferability refers to the ability to apply findings in other contexts, orto other participants. In this study the researcher provided sufficient descriptive data in the report obtained from the chosen setting, context and participants to be transferred to other chosen settings.

3.9.5 Authenticity

Authenticity refers to the extent to which the researcher fairly and faithfully shows a range of realities, which emerge in a report when it conveys the tone of feeling of the participants (Polit & Beck 2017:560). According to Brink et al., (2018:160) the report must convey the emotions and experiences of participants as they occur. In this study the researcher reported all the participants' viewpoints and emotions as described during the face to face individual semi-structured interviews and findings were drawn from excerpts of the responses by participants.

3.10 FIELD NOTES

Field notes as a data collection tool are used to minimise data loss, the researcher looks at the sequence of events of what is happening in the settings and the clinic environment. The field notes were written after interviews to reflect what had happened. The researcher sat in a quiet place to write down the notes and the events as they occurred. In this study the field notes captured names of different areas in the community that the researcher was not familiar with to verify and to look for the correct spelling. The nonverbal responses, long silences, facial expressions and awkward looks from participants were noted in relation to some questions during data collection.

3.10.1 Descriptive notes /observational notes

Observational notes are objective descriptions of observed events and conversations, information about actions and dialogue documented as completely and objectively as possible (Polit and Beck, 2017: 521). Brink et al., (2018:136) described observation as a technique used for collecting descriptive data and allowing the researcher to observe behaviours as they occur. The participants showed the different types of emotions during interviews, of being fearful of the community environment and anger at working without prospects of promotion. The observations are depicted in table 3.10.1 below.

Table 3.1 DESCRIPTIVE NOTES

OBSERVATIONS / WHAT WAS OBSERVED	MEANING OF OBSERVATIONS
• The participant E smiled when talking about appreciation she received from previous employer. • The participant C frowned when a question was asked and did not understand it. • Sad face when talking about the environment where babies were neglected. • Anger was expressed towards clinic staff and managers when talking about challenges in remuneration of CHWs.	• The participant E showed happiness when appreciated. • Non-verbal communication asking for clarity. • The participant F was emotionally affected, apathetic by a non-verbal communication seeking comfort and acknowledgment of feelings. • The anger displayed feelings of hopelessness and worthlessness which seemed that the researcher was there to rescue the situation.

- **Personal notes**

Personal notes indicate that the researcher commented about own feelings in the field (Polit & Beck 2017: 522).The researcher reflected on the feelings evoked after interviewing one participant who narrated the home environment where elderly parents are left alone without care of next of kin. The researcher identified the feelings and worked on them daily while maintaining professionalism.

- **Theoretical notes/analytical notes**

Theoretical notes are made to document thoughts to make sense of what is going on (Polit & Beck 2017: 522). The researcher documented the thoughts of the day to make meaning of data collected.

- **Methodological notes**

Methodological notes are documented thoughts about new approaches and effective strategies utilised and serve as a reminder for subsequent observations to be made (Polit & Beck 2017:522). One participant during the interview reported incidences of other colleagues who were mugged and injured and the incidence was not treated as injury on duty.

3.11 SUMMARY

In this chapter the research design and methodology were discussed in order to explore and describe the challenges Community Health Workers perceived during home visits. An exploratory, descriptive and contextual qualitative research design was used. Data were collected and analysed and coded into themes and subthemes using the eight Tesch steps of data analysis and were afterwards coded by an independent coder. The research findings and literature controlled are discussed in Chapter 4.

CHAPTER 4
DATA ANALYSIS, FINDINGS AND LITERATURE CONTROL

4.1 INTRODUCTION

The previous chapter looked at research design and methodology. Data analysis, findings and literature control will be discussed in this chapter to answer the research question of what are the challenges Community Health Workers perceived during home visits in the Tshwane district.

4.2 DATA ANALYSIS

Data analysis is described as a systemic organisation and synthesis of research data such as transcripts and field notes until they are clear and meaningful (De Vos et al. 2011:337; Polit & Beck 2014:378). The process of data analysis involved a few steps of grouping together narrative information and making sense of the data.

4.3 DATA GENERATION PROCESS

4.3.1 Demographic data of participants

The demographic data includes information that describes important characteristics about the participants in the study (LoBiondo-Wood & Haber 2014:281). It is important to provide the demographic data for the readers to understand the participants' narrative and the sources of information. This demographic data is used in qualitative research to ensure transferability and to compare characteristics of participants in a similar setting of the one studied (Bryman, Bell, Hirschen, Dos Santos, Du Toit & Masenge 2014:45). Table 4.1 below indicates the characteristics of participants.

Table 4. 1: DEMOGRAPHIC CHARACTERISTICS OF THE PARTICIPANTS

PARTICIPANTS	GENDER	AGE RANGE		YEARS OF EXPERIENCE
14	Females:11 Males: 3	20- 30	1	2-14
		30-40	7	
		40-50	3	
		50-60	3	

Table 4.1 displayed the demographic data of participants. Data were collected from December 2019 to February 2020. The study comprised of fourteen (14) Community Health Workers from three (3) PHC clinics in Tshwane district who consented to be participants. There were eleven (11) females and three (3) males from all age groups with (2-14) two or fourteen years of experience in conducting home visits.

In this study all participants are Community Health Workers allocated and working in communities of Tshwane district. The participants were sampled from three PHC clinics in the district and volunteered to take part in the study. Each participant was allocated 250 households to map and register. The participants were allocated in pairs to reach the areas in the community around the clinics they report to.

4.3.2 Framework of themes and subthemes

The summary of findings presented in table 4.2 below displays the five themes and subthemes that emerged from data analysis of challenges CHWs perceived regarding home visits. The emergent themes were the challenges in Community, Logistical, Occupational, Human Resource, and Management.

Table 4. 2 THEMES AND SUBTHEMES

THEMES	SUBTHEME
Theme1: Community challenges	• Community access • Community animosity and distrust • Community non-compliance • Non-recognition in and acceptance from the community • Public environmental health problems • Social health challenges
Theme 2: Logistical challenges	• Ineffective planning and delegation • Lack of transport
Theme 3: Occupational challenges	• Exposure to ethical and legal risks • Exposure to safety risks in the community • Exposure to psychological risks • Insufficient equipment and resources • Working relationship problems with clinic staff
Theme 4: Human resource challenges	• Inadequate opportunities for personal development and promotion • Unconducive conditions of service • Inadequate training and education
Theme 5: Management challenges	• Inconsistent training • Lack of managerial support and recognition

4.4 FINDINGS

The above table represents the five main themes and subthemes the researcher identified as the challenges Community Health Workers perceived regarding home visits in the Tshwane district and will be discussed below. An italic font was used to support the direct quotations of themes and subthemes

4.4.1 Theme 1: Community challenges

Community challenges emerged as the first perceived challenge by the CHWs. Various challenges from the community posed a problem in accessing the community members during home visits. These included community access, animosity and mistrust, non-compliance to

treatment, non-recognition and acceptance, public environmental health and social health challenges.

- **Subtheme 1**: **Community access**

The CHWs were faced with difficulty in accessing members of the community during the day and the attitude they received from community members hampered access. Participants reported that when going to visit the clients they meet people in the street; some will call them names and swear at them and when they reach the designated homes some will chase them away or send dogs after them. The subtheme is supported by the next three quotations.

> '*The difficulties that we meet there, are that the people are working, we don't get a chance to meet them because most of them are only available during the weekend'. And said 'Sometimes we just pass the message around or leave a note in their flats and ask the neighbours*'. *Participant E*

> *Not finding people available at the households because they are at work and because we don't work on Saturday it becomes a challenge to access them*'. *Participant M*

> *"No sometimes I force it because my job stops when I find a house closed, people are at work and only available on weekends. I don't work on weekends'. Participant L*

The CHWs are required to map 250 household registrations as part of the workload for the area that is allocated to them. All the households should be captured and followed up in order to reach all members of the designated community linked to the PHC clinic. Grant et al., (2017:2) stated that the success of CHW interventions depends on high levels of community involvement and participation, as well as a positive relationship between the CHW programme and the formal health system.

- **Subtheme 2: Community animosity and mistrust**

Participants mentioned that data capturing included registration of the water meter reading which lead to the community members asking questions about the relation of meter checking towards health and illness. The subtheme is supported by the next four quotations.

'*The attitudes of other people on first contact to register the household, are that people treat us bad, especially because they don't know us, sometimes they will never open a gate for you or even listen to you'. Participant F*

Yes, the attitudes we get from the streets and homes when you can see the people asking us who we are every day, what are we doing there, it is not nice.' *Participant I*

The other challenge is with registration. There are some questions on the gadgets we are using to put in information that are irrelevant. For example questions about the meter numbers for water and proof of residence, so the community doesn't allow that. When we get there most of them say "no thank you because the Department of Health and the Department of Water don't mix together. So why do you need my meter reading"'. Participant C.

''Yes, they say that it's confidential, I can't just give you my meter number when you are working at the Department of Health. You are here for the sickness not for the water and electricity. Participant C.

CHWs were faced with mistrust and resentment from the community due to the belief that their roles were not in support of community needs. The lack of respect from the community has been seen to demotivate CHWs (Diomande 2019:7). Several factors that were undermining the work of CHWs as stated in the study by Mhlongo and Lutge (2019:3) were different perceptions of the CHW roles, lack of knowledge and skills and lack of stakeholders and community support.

Grant et al., (2017:2, 4) reported that lack of trust in the health system and between members of the health team also affects treatment, compliance and health outcomes and further stated another factor that influencing the development of a trusting relationship was the gender of the CHW, with women generally preferring female CHWs which impacted on relationships and influenced client confidences and trust. Furthermore state that the success of any health intervention relies on positive and trusting relationships at individual, patient-provider and systemic levels and the magnitude of the role trust plays in health systems is often underestimated.

- **Subtheme 3: Community non-compliance to treatment**

Participants mentioned that TB and HIV clients default treatment and are not compliant in taking the medication. Follow-up visits are done to monitor the compliance to treatment. The subtheme is supported by the next three quotations.

> *'HIV people who are defaulting, who are not coming to the clinic regularly, we go and look for them and then they must come back to the clinic'. Participant A*

> *'Yes, even now we don't know if she took the children to the clinic or what. We are even afraid to go and do the follow up and see if they got everything. We know that those children didn't get their immunisations, they didn't get deworming and they didn't get Vitamin A. So we were trying to help but because of Sporty we can't do a follow up'. Participant C.*

> *'The challenge we face is patients who don't take their medication as prescribed and not caring about their lives, so we have to regularly encourage them and ask the nurses to stress to them the importance of treatment'. Participant N.*

Home visits are done to follow up defaulters of treatment and to encourage compliance to treatment. The clients are traced back to their addresses to keep them on track and to comply with treatment prescribed. DiCarlo, Fayorsey, Syengo, Chege, Sirengo, Reidy, Otieno, Omoto, Hawken and Abrams (2018: 5) attest that home visits allowed time for education and counseling, and ensured individualised attention to address issues that had not emerged during clinic visits. A lack of trust in the health system and between members of the health team affects compliance to treatment and health outcomes (Clark 2015:4).

- **Subtheme 4: Non recognition and acceptance by the community**

The participants reported that the clinic does not provide uniforms but only name tags. The uniforms that they wear were provided by the NGO before being transferred to the clinics. The subtheme is supported by the next three quotations.

'The ones posing a big challenge for us is the community. We work with the whole community not only our assigned patients. The community doesn't recognise us, some are welcoming and others are not, especially when we were working without name tags but now the department gave us name tags'. Participant C

'Yes, we work in pairs but even so they can rob us. To be there as a man doesn't mean anything and some of them they recognise us late that we are CHWs because we don't have a proper uniform. We don't have a uniform for safety'. Participant E

'I suggest that the department provides us with a uniform, so that people can recognise us through it. The name tag is too small, they only see it when we are next to them but we need people to see us even when we are far'. Participant E

The lack of uniforms and name tags causes the community not to recognise and accept the workers as professionals and in some areas they are given a bad attitude**.** Busza, Dauya, Bandason, Simms, Chikwari, Makamba, McHugh, Munyati, Chonzi and Ferrand (2018:4) in the study about the role of CHWs the authors reported that the workers asked for 'branded' goods such as t-shirts, hats or ID cards to identify them as part of the health team. The provision of branded goods would prevent them from being viewed with suspicion by the community. The CHWs derive important motivation when provided with various non-financial incentives such as uniforms, nametags, and certificates (Austin-Evelyn et al., 2017:10)

- **Subtheme 5: Public Environmental Health**

The participants mentioned that they assist with cleaning of the home when dirty and open windows for fresh air before commencing with procedures. The subtheme is supported by the next three quotations.

'The flat itself is not clean. The water that they are drinking there is from a tank called a Jojo tank which is on top of the flat. Sometimes birds die and fall in that water tank, when they the drink water they can see that the water is not clean'. Participant E

'I visit people for instance when we go to give them medication. We have chronic disease patients there. This is the kitchen here, a napkin/pampers there, toilet paper, dirty things... The municipality is trying by all means, that is why they employ some of them to clean the rubbish but those people are not in order. Sometimes when you enter their home there is a smoke of whatever they are smoking and we just try to cooperate with them'. Participant E

'The other challenge I have is people who have pets in their homes but they don't take the animals to get injected and on top of that they don't keep proper hygiene'. Participant K

The unsafe and unkempt environment in the community lead to CHWs to extend their scope of work by cleaning the household and referring the challenges to social development**.** The CHWs observed that households in informal settlements and peri-urban communities did not have house bins they used black garbage bags to dispose of waste and stored it outside the houses without proper protection or supervision, making it accessible to children who were seen scavenging for toys (Hangulu & Akintola 2017:5).The authors also stated that the CHWs were faced with challenges of washing clients' clothes in informal settlements where piped water supply and communal bathrooms were unavailable (Hangulu & Akintola 2017:6).

- **Subtheme 6: Social health problems**

The participants reported that they assist the clients with referrals to the social department and to home affairs to resolve issues with birth certificates and social grants. The subtheme is supported by the next three quotations.

'And remember generally the problems that they have, the majority of them are not working, they just take money and buy drugs.' Participant E

'*The kids mam, because most of the clients are on SASSA and have no money to hire people, their children live in their own houses and visit them or leave grandchildren to stay with them and the grandchildren will disappear for days.*' Participant I

'There was another incident where and old sick man was locked inside the house and kept away from the public by his children and relatives because it was like they wanted him to die so that they could inherit the house. So one of the neighbours gave us a tip on his condition, which led us to visit the house. There was a foul smell from the gate and one could tell that something is not right in this home. We entered and did the registration and asked if there was a sick person in the home, only then was the man able to get assistance from us and social workers. We provided nappies and helped to get rid of the foul smell, I would even go in the mornings to check if he had eaten. When he couldn't eat we'd use a syringe to feed him, eventually he looked better and by the time he died he could at least eat.' Participant N.

CHWs conduct door to door dissemination of information on prevalent infections and diseases, and refer the community to different government departments when they have challenges of housing, identity documents, birth certificates and water and sanitation (Nxumalo et al., 2016:64).

4.4.2 Theme 2: Logistical challenges

The participants report that the government should devise a means of providing the CHW programmes with transport and absorb them to be permanent employees with all benefits.

- **Subtheme 1: Ineffective planning and delegation**

The concept of walking the distance from house to house and to and fro to the clinic to report and clock out poses a challenge even though it is structured daily. The subtheme is supported by the next four quotations.

'I'm not sure but the least they can do is take us there, drop us at the places we work, leave us while we work then we can come back on our own. Because it's not right to arrive at a sick person's home looking sick and tired. There's nothing more you can do for the patient, you are also a patient'. Participant A.

'As you have mentioned if we can clock in and out on the gadget in our areas, it will save time and minimize the challenges'. Participant D.

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> *'As you have mentioned if we can clock in and out on the gadget in our areas, it will save time and minimize the challenges'. Participant D.*

> *'Or maybe they can drop us off in the morning and we can foot it going back to the clinic later in the day to sign off'. Participant I.*

> *'I started out by mapping Phase 1 which is a squatter camp but they often change us around so that we don't get used to one area. They even change partners so we don't work with the same person for too long.' Participant J.*

The CHW programme should be planned so that participants report weekly to the OTL's at a designated area in the clinic. The CHW should draw up a monthly schedule and submit it to the manager for approval. CHW programmes tend to be unsustainable at scale when there is poor planning, vague and/or extensive CHW scopes of work, lack of community and health system buy-in, resource scarcity, inadequate trainings, low incentives to the CHWs and poor supervision (Diomande 2019:8).

- **Subtheme 2: Lack of transport**

The participants reported that they walk long distances to homes after they have reported at the clinic and at the end of home visits go back to the clinic to clock out. The clinic does not provide transport for CHWs. They are not allowed in government vehicles as they do not have indemnity. The subtheme is supported by the next three quotations.

We are not feeling alright because sometimes the sun is very hot. So we feel if the department can allow one car to deliver those going there, so that they can provide services and then they can come back and take them. It will be better but because we are on contract we are always told we are not entitled to use the cars'. Participant D.

'As we are on contract we are not entitled to use the departments' car, so I and my colleagues have to walk very long distances under the hot sun'. Participant D.

'Weather conditions like we walk in the sun and it's very hot and sometimes when it rains and we have no umbrellas people don't let us in because we are wet'. Participant L.

Weather conditions and the fact that the CHWs are contract workers also aggravate the challenge of transport. Some CHWs did not access formal modes of transport and instead walked to and from their allocated area of work. The lack of transportation posed two barriers for CHWs, limiting the ability of outreach teams to access communities, while also making it difficult for them to effectively refer patients to health facilities (Austin-Evelyn et al., 2017: 9). The common barriers are of lack of transportation, lack of official support, poor capacity of CHWs, lack of training for CHWs, incentives for CHWs were supported by (Huang, Long, Li, Tao, Zheng, Tang & Abdullah 2018:16)

4.4.3 Theme 3: Occupational challenges

The participants mentioned that the clients ask questions about dealing with mental health and to confront abusers which are beyond their scope of practice. The CHWs refer the matters beyond their control to the police and social workers because it was not covered in their course.

- **Subtheme 1: Exposure to ethical – legal risks**

The participants gave information about this insufficient training and it was evident that it causes distress when they were talking about it. Some health topics were not covered in their training which frustrated them. The subtheme is supported by the next three quotations.

'I feel good that I have learned it from my OTL but then I asked myself if the daughter of that ouma (grandmother) was a nurse and found the wound of her mother dressed that way, what was going to happen to me? Who was going to be there to talk for me because I'm just a CHW. Participant C.

'But most want me to talk to their abusers but it is a difficult challenge I'm not trained to do that'. Participant F.

'We also had a bedridden patient who was being nursed by her mother till the patient died and the mother was not aware what has killed her daughter. After the funeral they'd call you and demand answers to what caused her death. I tell them I don't know because I have to protect confidentiality, what led her to not divulge her status while she was alive I cannot break'. Participant H.

The insufficient training given to CHWs could lead them to be involved in legal cases and they can be found to have violated ethical issues. Confidentiality is an important part in interaction within the health system, CHWs are challenged with maintaining confidentiality because their training is less extensive compared to that of nurses and doctors and cannot rely on aspects of the healthcare facility infrastructure (e.g. private consultation rooms) that promote confidentiality (De Neve, et al 2017:883).

- **Subtheme 2: Exposure to psychological risks**

The participants reported that they experience difficulty in dealing with emotions and would be brave in front of clients not to expose their sadness in seeing children with terminal conditions. They cry privately and when they reach their homes. They pray daily not to meet dangerous individuals in the community. The subtheme is supported by the next three quotations.

'The other challenge I mentioned is that it's very traumatizing when we find sick children, so we need counselling'. Participant B

'The other challenges about testing, is that is it very traumatizing because sometimes we go to households and we find children who are under the age of five years. So it's very sad to see children being sick because of the parent's defaulted treatment, so it's really stressing us'. Participant B

'We are working as Community Health Workers, we are always scared of getting robbed of our money, and our cellphones are stolen every now and then'. Participant D.

The CHWs experience emotional stress of coping with difficult circumstances of being scared to venture into the community. Exposure to very sick individuals causes emotional distress and frustration. CHWs risk taking on their clients' psychological distress or becoming demoralised when they confront difficult circumstances and are unable to effect positive change (Busza et al., 2018:2), the authors further asserted that in addition, poor remuneration, lack of opportunities for career advancement, and potential exploitation of predominantly poor and female volunteers further increase burnout.

- **Subtheme 3: Exposure to safety risks in the community**

The participants mentioned that the nurses at the clinic will give referrals to trace clients who defaulted treatment of TB, some are XDR or MDR clients and the participants end up being exposed to health risks of contracting diseases because of insufficient information given to them about the client's status. The subtheme is supported by the next three quotations.

> *'The challenges we get in the homes vary, like you can find a wounded woman in a closed window house that is smelling, which in turn makes you sick. You must not react near the patient, you must just be strong, tend to her wound and finish even though you are not alright inside'. Participant A.*

> *'I don't know, they just give us the letters to go there and trace patients and some of them are coughing, they have TB and they don't supply us with masks to protect ourselves'. Participant C.*

> *'When you find a house with more than three men in a room, usually they* are *smoking something. In that state they will just allow you to come in and for women it is very dangerous because those men can even rape or rob some of our CHWs'. Participant E.*

The lack of face masks when visiting homes can lead to the workers contracting airborne diseases. There were concerns about CHWs safety, identification, debriefing and risk for contracting diseases (Moosa, Derese and Peersman (2017:5).

- **Subtheme 4: Insufficient equipment and resources**

The CHWs reported challenges of limited resources of having to carry blood pressure machines to different homes on certain days. Lack of data on cell phones to call the OTLs' or to summon the ambulance when faced with emergency situations during home visits. The cell phones issued had a short lifespan. The subtheme is supported by the next four quotations.

> *'For now we are using papers to register because most of our gadgets are broken'. Participant C.*

> *'I do, but even in the area I do not have resources for monitoring blood pressure and diabetes, the machines are few and the one we have at the clinic we use it on rotation bases. When a client tells you can you check my blood pressure I'm not feeling well it is a problem when you don't have a device or a phone to call an ambulance when needed? You ask the client's phone and afterwards you feel embarrassed when you tell them you did not have data or airtime'. Participant F.*

> *'We can do a household, we can put information of a patient but because of the phone it's not a quality it freezes'. Participant G.*

> *'They try to get us materials but it is not enough'. Participant M.*

The lack of material resources create a challenge and financial burden to community workers which can lead to feelings of frustration and spending their own money to counter the limited resources (Josephson, Guerrero, and Coddington 2017:37). The workers in India expressed a need for timely payment of incentives and suggested that higher incentives or a fixed salary would increase their motivation. In addition they also felt travel and mobile phone allowances would facilitate their work (Sarin et al., 2016: 178). CHWs should be given more training and tools to be able to do their work well when they are visiting communities and treat people in their homes, [such as] skills and equipment for emergency treatment in the field (Austin-Evelyn et al., 2017: 5) and the fact that they were less well-resourced than other disease focused CHW programs was a challenge.

- **Subtheme 5: Working relationship problems with clinic staff**

The lack of medical aid to consult when ill, poses a challenge to the participants and this is seen by the clinic staff, as CHWs are forced to queue like any other client visiting the facility. The subtheme is supported by the next four quotations.

> *'The other challenge that we face here in the clinic is the staff don't treat us well. When I'm sick and have to consult with one of our sisters, I have to queue like everyone else. Participant B*

> *What also bothers me is that the government gives us a job but not the materials and tools to do the job. Participant K.*

> *'Yes but there's nothing, but even here at the clinic every Wednesday they have a meeting that they call in-service meeting but they say the Community Health Workers are not included'. Participant D.*

> *'I don't get respect from nurses at the clinic and if I become sick with TB and HIV what will happen to me, I volunteered to do this job but I need assistance if something goes wrong while I'm busy in the community'. Participant F.*

The lack of support by clinic staff lead to stress and frustration. In the article by Moosa, Derese and Peersman (2017:7) managers felt that the CHW workload was very heavy and their working conditions difficult, citing the lack of space, stationery and equipment. Ndaba et al., (2019:407) stated that CHWs' potential is hampered by the lack of integration and conflict with health professionals, insufficient recognition and community support, knowledge retention problems and inadequate supervision. When clinic staff publicly undermine CHWs, this lack of respect and trust can strongly influence community perceptions of the CHW's role. If nurses do not trust CHWs, this attitude may extend to the community, leading to CHWs' competency being questioned and reducing acceptance of CHW services (Grant et al., 2017:6)

4.5.4.Theme 4: Human resources challenges

The human resource department in the clinics does not include CHWs in the skills professional development plan. The participants reported no opportunities to improve their skills and see growth in their chosen job and the reluctance of the clinic to include them during in-service trainings.

Subtheme 1: Inadequate opportunities for personal development and promotion

The participants have no opportunities of promotion from one level to the other, they remain in one category. The subtheme is supported by the next three quotations.

> *'They don't take us to school so that they can promote us... I have been here from 2013'. Participant A.*

> *'Yes! At least it will be better than walking in the streets for five years, it's too much'. Participant A.*

> *'No, not to say my job is okay, I want to upgrade to have more information and knowledge so that I can help people'. Participant H.*

There should be a growth pathway for CHWs, to ensure that the persons with experience can achieve higher levels of employment and mentor the newer applicants in the programme (White, Govender & Lister 2017:7). It was found in a Master's research study that in South Africa, the HRH Strategy for Health estimates that in 2020 the critical need gap will persist with a shortage of over 3000 formally qualified CHWs and over 2000 qualified Home-based Caregivers (Diomande 2019:57).

Subtheme 2: Inadequate training and education

The participants reported inadequate training when they observed other CHWs performing the same procedure in a different way. Peer training seemed to be encouraged in areas which were not covered in the CHW course. The subtheme is supported by the next three quotations.

> *'We were just dressing it our own way until the other day when I was supervised by my OTL, I saw the difference because I was just dressing as I would dress myself. When he was doing the dressing I realised that I was not doing everything right'. Participant C.*

> *'I just counsel based on what I've seen my partner do, she has a certificate for counselling. I learned from her, I never went to a course or training even for HIV Testing'. Participant C.*

'Yes. If I can be trained to do counselling to the person reporting the abuse it will be better, but we were trained to do health promotion and prevent illnesses it does not include these other areas of life'. Participant F.

Conducting more in-service education will make sure that the acquired skills and knowledge are not lost forever (Nkosi-Gondwe et al., 2017:12). Formalisation of CHWs' training in relation to procedures done during home visits will bring job satisfaction.

In a study in KZN it was recommended that the training of the CHWs should be incorporated into the Expanded Public Works Programme (EPWP) training strategy which will enable the CHWs to obtain a formal qualification which is aligned to national standards (White, Govender & Lister 2017:7). The lack of care for the carer is symptomatic of the entire public service and creates the impression that CHWs are readily disposable (Moosa, Derese and Peersman (2017:7).

It has been shown that while the standardised training of CHWs as generalist health workers is ideal, program-specific training is much more effective as it ensures that core knowledge and skills are effectively relayed (Ndaba, Taylor & Mabaso 2019:411).

Subtheme 3: Unconducive conditions of service

The CHWS sign a contract every year and they have been in temporary positions for many years. The participants expressed anger and frustration when narrating the aspect of stipend and of signing contracts of employments every year. Occasional gifts, such as rain jackets and Christmas hampers proved popular as tokens and helped mitigate financial requests (Busza et al., 2018:4). The subtheme is supported by the next four quotations.

'My main problem is the stipend and we've been working for more than 7 years with no pension fund. The only thing we do is sign contracts every year'. Participant A.

'No, we are not permanent. We sign a contract every year. The union has been discussing the conditions to make us permanent with the department. So it looks like the conditions do not suit the people representing us'. Participant A.

'We are just working for the department getting a stipend and we don't even have medical aid to protect us'. Participant C.

'We don't have enough uniforms and were given uniforms a long time ago. And the stipend we receive is too little to buy more'. Participant M.

In a study in KZN CHWs reflected negatively on the fact that they earned a meagre stipend whilst they needed to cover their own transport to and from their allocated area of work and that they worked a normal work day of eight hours duration (White, Govender & Lister 2017:5 & 7) and the study further asserted to the review of the remuneration package to be aligned to South African labour law. Poor remuneration incentives and the lack of a suitable professional promotion system were the most common reasons for community health worker dissatisfaction in urban China, furthermore financial rewards and career development had been problematic barriers to work motivation (Zhang et al., 2016:20). Elaborate with sources, TheWBPHCOT Policy Framework is silent on the issue of remuneration and working conditions of CHWs (Schneider 2018:63).

4.5.5.Theme 5: Management challenges

The participants mentioned that managers are not supporting in terms of training, shortage of resources and for engaging with the department to transfer their posts to be permanent employees**.**

Subtheme 1: Inconsistent training

Training of CHWs is not the same, some participants have done a ten (10) days course and others fifty nine (59) or sixty nine (69) day courses which included HIV counseling. The courses were offered by different organisations in the district. The subtheme is supported by the next three quotations.

'No they taught that here in the office, just to check the Road to Health cards. We didn't train very well'. Participant B.

'Yes, it is a guideline in what I do but things are always changing and there are some members in the communities who might know more than me and I am using the old syllabus. Some will let you introduce yourself and explain your services and then pose a question like "I heard that TB is no longer screened with a bottle but by swabbing? So I prefer you test me with a swab" then I have to explain that the reason I don't have a swab test is because of lack of resources in the government clinic'. Participant J.

'I just counsel based on what I've seen my partner do, she has a certificate fo
I learned from her, I never went to a course or training even for HIV Testing'. Participant C.

Irregular one-off training sessions without opportunities to refresh knowledge has been reported to demotivate and reduce CHW performance in other LMICs (Ozano et al., 2018:8). In Malawi, CHWs refused to conduct certain tasks when they had not been invited to be trained because the training was given to those who were favoured and was attached to financial gain (Kok et al., 2017: 1422).

Subtheme 2: Lack of managerial support and recognition

The participants report challenges of being contract workers, not having enough resources annually for managers which seems to be not attended to. The need for appreciation by forms of tokens was eluded. The subtheme is supported by the next four quotations.

'Yes, it's still a challenge because we've only heard rumours that we might be permanent next year. Last year the Minister took us to Nasreq and told us we are going to be permanent 2019 April and nothing happened. Even now they are still preaching the same song but we will see next year when we sign another contract if the numbers have changed or what'. Participant A.

'I usually tell them each and every time. I say I have a medal that says you are doing a good job. So I have been here since last year and I don't see somebody appreciating me with 'you are doing a good job'. Participant G.

'No we don't have masks, we have asked for it several times and they said they did not have them'. Participant D.

'They can't help because we are all looking for assistance from the government. Last year a CHW got attacked on the job and no assistance was provided by the government'. Participant K.

Managers felt that the community viewed CHWs as professional and favoured CHWs being developed as professionals; they questioned CHWs as professionals, largely with their limited training and wanted a planned strategy for CHWs, including career progression and professional regulation. Security risk, space and logistical support was a concern and questioned the selection criteria (Moosa, Derese and Peersman 2017:5). The lack of infrastructure, medical supplies, unfriendly and abusive supervisors and difficult physical work environments contributed towards systemic factors experienced by the workers (Sarin et al., 2016:174).

In South Africa, the district health system remains poorly structured and unintegrated, and is characterised by lack of resources, health worker shortages and weak managerial capacity, these all continue to limit the efficacy of CHW programmes (Nxumalo et al., 2016:61).

4.5.DISCUSSION OF FIELD NOTES

Field notes as a data collection tool are used to minimise data loss. The researcher looks at the sequence of events of what is happening in the settings and the clinic environment. The field notes were written after interviews to reflect what had happened. The researcher sat in a quiet place, to write the notes and the events as they occurred.
In this study the field notes captured names of different areas in the community that the researcher was not familiar with to verify and to look for the correct spelling. The non-verbal responses, long silences, facial expressions and awkward looks from participants were noted in relation to some questions during data collection.

4.5.1.Descriptive notes /Observational notes

Observational notes are objective descriptions of observed events and conversations, information about actions, dialogue and documented as completely and objectively as possible (Polit and Beck, 2017: 521). Brink, van der Walt and van Rensburg et al., (2018:136) describe observation as a technique used for collecting descriptive data as it allows the researcher to observe behaviours as they occur. The participants showed the different types of emotions of being fearful of the environment and anger at working without prospects of promotion during interviews that.

4.5.2.Reflective notes

According to Polit and Beck (2017:522) the reflective notes document the researcher's personal experience, reflections and progress during field work. The researcher had made personal, theoretical and methodological notes.

- **Personal notes**

Personal notes indicate that the researcher commented about his or her own feelings in the field (Polit & Beck 2017: 522).The researcher reflected on the feelings evoked after interviewing one participant who narrated the home environment where elderly parents were left alone without care of next of kin. The researcher identified the feelings and worked on them daily while maintaining professionalism.

- **Theoretical notes/analytical notes**

Theoretical notes are made to document thoughts to make sense of what is going on (Polit & Beck 2017: 522). The researcher documented the thoughts of the day to rationalise data collected.

Methodological notes are documented thoughts about new approaches and effective strategies utilised and serve as a reminder for subsequent observations to be made (Polit & Beck 2017:522). During the individual interviews one of the participants reported incidences of other colleagues involved in muggings, who were injured and were not treated as injury on duty.

4.6 SUMMARY

This chapter discussed the findings of the study that emanated from fourteen participants. The purpose of the study was to explore the challenges perceived by CHW'S regarding home visits in the Tshwane district. Data collection methods were used to explore the CHW's challenges, digitally recorded semi-structured interviews and field notes.

Out of the data collected five themes emerged and sub-themes were developed which were discussed while a literature review was conducted to verify the facts and findings of this study. In the next chapter, the study will discuss the conclusions, implications, recommendations and limitations of the study.

CHAPTER 5
DISCUSSIONS, RECOMMENDATIONS, LIMITATIONS AND CONCLUSION

5.1 INTRODUCTION

The purpose of this chapter is to provide conclusion of the study on Challenges Community Health Workers perceived regarding home visits in the Tshwane district; the discussions, recommendations, limitations and conclusion are discussed in detail in order to ensure trustworthiness. The conclusion of this study was informed by the five main themes and subthemes that emanated from data analysis as discussed in chapter 4.

5.2 RESEARCH OBJECTIVES

The current study intended to explore and describe the challenges CHW's perceived regarding home visits in the Tshwane district.

5.3 RESEARCH QUESTION

The research question was: "W*hat are the challenges CHW's perceived regarding home visits in the Tshwane district"*

5.4 RESEARCH DESIGN AND METHODOLOGY

A qualitative research design was used to explore, describe and put in context the challenges CHWs' perceived regarding home visits in the Tshwane district. The researcher used self-developed semi-structured research questions and interviewed fourteen participants who were chosen using non-probability purposive sampling to collect data. This sampling technique is based on the researcher's judgment regarding participants of the study phenomenon (Brink et al., 2018:126).

The interviews commenced with creating rapport to help the participants to relax, explaining the duration of the interview, confidentiality and consent to continue with the interview. The first question '*what are the challenges perceived regarding home visits'* was asked, follow-up questions were asked on the resolution strategies, support and how the community received the

participants. The other questions were about knowledge with reference to training, the role of the CHW before, during and after conducting the home visit and the referrals done, the closing questions were of clarity seeking and conclusion of the interview. Communication techniques used were active listening. The use of non-verbal cues, paraphrasing, clarifying and summarising.

The interviews were digitally recorded after participants had given informed consent, interviews were transcribed and analysed using the eight Tesch data analysis techniques and coded by an independent coder. The researcher and independent coder compared and agreed with all themes and subthemes that emerged from data analysis and thus trustworthiness was maintained.

5.5 OVERVIEW OF RESEARCH FINDINGS

The research findings from data analysis and interpretation reflected the challenges CHWs perceived regarding home visits in the Tshwane district and were divided into the following themes:

- Theme 1: Community challenges
- Theme 2: Logistics challenges
- Theme 3: Occupational challenges
- Theme 4: Human resources challenges
- Theme 5: Managerial challenges.

5.5.1 Summary of findings

5.5.1.1 Theme 1: Community challenges

The community challenges emerged as the first theme with subthemes of community access, community animosity and distrust, non-compliance to treatment, public environmental health and non-recognition in and acceptance from the community. The role of CHWs is to do door to door household visits to register and trace defaulters of treatment. The participants could not access some clients who defaulted treatment because they worked during the week. The participants left notes for the clients with neighbours to indicate follow-up dates and to make appointments at the clinic. The participants were resilient, would revisit the clients after two to three days to complete the registrations and follow up. The participants noticed that the community did not recognize and accept them and they were viewed with suspicion and disrespect, some were chased away and not allowed access to some households.

The attitude of other family members during home visits contributed to the CHWs' feelings of being inadequate and disrespected. CHWS are not given proper uniforms to wear for all weather conditions and that led to the community being suspicious of the workers. This attitude of mistrust by the community lead to self-esteem issues.

5.5.1.2 Theme 2: logistic challenges

The logistic challenges that emerged were ineffective planning, delegation and lack of transport. The rotation schedule was haphazard and done randomly where one area were allocated five CHWs to map 250 households. The participants observed that the leaders and managers utilised an unplanned strategy of allocation of CHWS to areas without material resources. The lack of vehicles to navigate the treacherous roads in the community increases the challenges of walking long distances to do home visits and go back to the clinic to sign off. The strategy of clocking in and out is a challenge when workers have to report to the clinic at 08:00 and return back to the clinic at 14:00 to clock out, it posed a challenge in planning. Sarin, Sooden, Kole, and Lunsford (2016:179) agreed that transportation and clock-outs have been noted as significant challenges faced by CHWs in other countries.

5.5.1.3 Theme 3: Occupational challenges

The occupational challenges were exposure to ethical and legal risks, psychological risks and safety risks, inconsiderate and disrespectful treatment from clinic staff, and insufficient equipment and material resources. The participants alluded to the fact that they attended to some issues which were beyond their scope of work. The clients expected the participants to intervene in cases of abuse which left the CHW in a dilemma because it was beyond their scope of practice. The community did not consider confidentiality as important, the participants reported that the clients asked them to disclose what was happening at other homes.

The perceived lack of personal safety challenged the CHWs' to pursue other sections of the community. The female CHWs felt unsafe when entering homes which were occupied by a group of men who were involved in substance abuse. The home environment was dangerous and caused anxiety and stress. The participants acknowledge that even though they are stressed they appreciated the job. The findings reveal poor working relationships with clinic staff. According to Sarin et al., (2016:174) rude behavior of facility-based health professionals can make CHWs

reluctant to refer clients to the facility. CHWs are not considered as part of the health force and are not included in monthly meetings and in-service education. The participants did not have a sense of belonging to the health system.

The findings revealed the lack of equipment and resources, shortage of bandages, masks, Baumanometers, umbrellas, raincoats, backpacks and broken gadgets and phones, no airtime and data to call ambulances in an emergency. Insufficient supplies and materials affect CHWs' functionality and credibility in the community (Sarin et al., 2016: 179). The participants mentioned that the lack of resources, transport and harsh weather conditions are stressful and demotivating. The participants commented about the unkempt and dirty environment which posed a risk of contracting communicable diseases.

5.5.1.4 Theme 4: Human resource challenges

The human resources challenges included inadequate opportunities for personal development, unconducive conditions of service, inadequate and inconsistent training and education. The participants viewed that the training was not sufficient to cover aspects of abuse and mental health challenges. The participants wanted formal training in counselling, wound dressing and being promoted to another level and provided with certificates after training. Lack of proper training, skill development, supportive supervision, heavy workload and the changing scope of work was among the systematic challenges experienced by CHWs (Sarin et al., 2016:174). The CHW training curriculum consisting of modules on community mapping and mobilisation would be supportive in collaboration with environmental health practitioners and facility clinic committees (Schneider et al., 2018:61). Knowledge deficits related to activities during home visits add to CHWs' psychological risks.

The participants reported that they have been signing contracts annually for several years and there were less opportunities for development or to be absorbed as permanent employees. They report to the clinic and clock out like all permanent staff but when faced with illness they have no medical aid and are not assisted like any of the other staff members. CHW wages fell within the lowest four deciles of the South African labour market, which had declined in real wages over the last two decades and low remuneration for CHWs incited both high attrition and moonlighting (Van de Ruit 2019:1539). According to Sarin et al., (2016:174), that, although CHWs were motivated by altruism, social recognition, knowledge gain and career development, they were dissatisfied with the pay levels and the authors further stated that The WBPHCOT Policy Framework is silent on the issue of remuneration and working conditions of CHWs.

5.5.1.5 Theme 5: Managerial challenges

The findings indicate a lack of support from management, they consider CHWs not permanent staff members of the facility. Attaching the WBPHCOTs to clinics added extra managerial and service responsibilities onto a strained, overstretched, under resourced and underperforming clinic (Schneider, Besada, Sanders, Daviaud & Rohde 2018: 62).

The participants reported that the managers lacked appreciation in regard to arranging resources and training in skills needed to do home visits. In the study of supervisors in Zimbabwe the authors found that the participants felt demotivated by having to deal with the shortage of materials and unfavourable work conditions of the CHWs and to advocate for CHWs at the management level (Akintola and Chikoko 2016:12). In this study the participants reported shortage of masks and bandages to OTLs and relayed the challenge to managers who responded that there were insufficient resources at the clinics.

5.6 IMPLICATIONS OF THE STUDY

The study revealed challenges perceived regarding home visits which might implicate the Primary Health Care Service, policy making and the implementation of the WBPHCOT Strategy. The participants mentioned the challenges which affect their role of conducting home visits.

5.6.1 Primary Health Care services

The research has highlighted responsibilities and supervision of CHWs. The role of CHWs and lay counsellors need to be revisited. According to Schneider et al., (2018:62) in some areas of the country, this has been compounded by initiatives to do away with lay counsellors, support facility-based HIV testing, counselling and ART treatment. The participants reported that in addition to other activities, they perform testing for HIV at homes, in the community and then refer patients to the clinic for further management.

5.6.2. Policy Implications

The participants cited challenges of community, logistics, human resource, managerial which need to be supported and restructured related to working conditions. The researcher suggests the outlined recommendations in relation to the findings and implications.

5.7 RECOMMENDATIONS

Home visits remains the most important part of the job description of CHWs. The role of CHWs end up in appraisal of the home environment.

5.7.1 Recommendations for the Department of Health

5.7.1.1 Debriefing and counselling for CHWs

Participants during interviews appreciated that debriefing and counselling would be beneficial in the course of their work in the community. Debriefing and counselling should be arranged for the workers periodically to deal with psychological effects after home visiting. The department can allocate members of the multidisciplinary health team to deal with issues of emotional and psychological nature encountered by CHWs.

5.7.1.2 Improved conditions of service and recognition

It is noted that the Department of Health is handling the remuneration of CHWs and the phases of training be streamlined and completed before allocation to conduct home visits. The standards of education, recruitment and selection must be clearly established when recruiting the Community Health Workers. The selection criteria should be revisited. Collaboration with Municipal councilors and clinic committees for acknowledging the presence and availability of CHWs as part of the community and PHC clinics.

5.7.1.3 Planning and provision of equipment and resources

The Situational analysis and planning of routes, transport, in-service training should be done well in advance before allocation of CHWs to do home visits. Equipment and gadgets used to capture data should be of a reputable standard and reliable in all-weather conditions.

5.7.1.4 Recommendations for clinical practice

- Continual support by the Department of Health, all managers of the programme, OTL's and facility managers in relation to career progression, remuneration, resources and training.
- The environmental health department in the district to link with the facility to follow up the environmental challenges reported in the community.
- Social workers be involved in resolving social issues reported by CHWs during home visits.

5.7.1.5 Recommendations for nursing research

- Further research is needed for formalisation of the course, with duration and scope of practice career progression and safety guidelines during home visits.
- Preventative and promotive aspects of PHC model to be studied or incorporated or specialised into groups.
- Other sub-districts can be studied to get a comprehensive picture of the whole Tshwane district because it is a diverse area with different kinds of populations and social ills.

5.8 LIMITATIONS OF THE STUDY

This study was limited to three clinics in the Tshwane district, which explored and described challenges CHWs perceived regarding home visits. The focus of this study was on home visits and whereas other settings can be investigated, generisabilility will be limited even though trustworthiness was ensured. The participants were given information using information leaflets and consent forms were signed.

The interviews were conducted with CHWs who could have an unequal power relationship when they view the researcher. Potential power issues can affect data collection and should be reviewed to ensure ethical principles and remove coercion and manipulation (Moule et al., 2018:315). The qualitative research is grounded on the real life experiences of people with first-hand information on the phenomenon (Polit & Beck 2017:17) and the approach can yield subjective data from participants. The authors further stated that the naturalistic studies involve a small group of people thus generalisability of findings can be questioned. The study sample was limited to fourteen participants.

5.9 CONTRIBUTION TO THE BODY OF KNOWLEDGE OF NURSING

The study findings may contribute to the body of knowledge on home visits during training of CHWs and nurses. The curricula of training include the rationale of conducting home visits, logistics involved and resources needed. The training needs and improvement of skills for those already in the system should be planned and staggered in the district. The attitude of the community and other members of the profession towards CHWs need to be improved through stakeholders' consultation.

5.10 FINAL CONCLUSION OF THE STUDY

The purpose of the study was to describe and explore the challenges perceived by CHWs regarding home visits in the Tshwane district. The participants gave a detailed picture of the different challenges perceived and the researcher categorised the challenges into themes of community, logistical, occupational, human resource and managerial. The recommendations to the Department of Health, clinical practice and research related to training and education of Community Health Workers on home visits were outlined. The roles of the Community Health Workers', scope of practice, recruitment, selection, training and policies to be reviewed and restructured were mentioned. Ozano et al., (2018: 4) agreed that the challenges participants perceived hinder them to practice optimally. Recommendations were made to Policy makers and partners to improve the working conditions of CHWs that could lead to improved health care during home visits.

LIST OF REFERENCES

Akintola, O., Chikoko, G. 2016. Factors influencing motivation and job satisfaction among supervisors of community health workers in marginalized communities in South Africa. *Human Resource for Health,* 14**,** 54 https://doi.org/10.1186/s12960-016-0151-6

Austin-Evelyn, K., Rabkin, M., Mutiti, A., Mwansa, J., Macheka, T., El-Sadr, W.M. 2017. Community health worker perspectives on a new Primary Health Care initiative in the Eastern Cape of South Africa. *PLoS ONE,* 12(3): e0173863.https://doi.org/10.1371/ journal.pone.0173863.

Backes, D.S., Haeffner, L., Dorin, L., et al., 2017. Meaning of home visits to Brazilian health students. Nurse Care. *Open Access Journal;* 4(1):358–363.DOI:10.15406/ncoaj.

Bheekie, A., Bradley, H. 2016. Re-engineering of South Africa's primary health care system: where is the pharmacist?. *South African Family Practice*, 58:6, 242-248, DOI:10.1080/20786190.2016.1186365

Boswell, C., Cannon, S. 2018. *Introduction to nursing research incorporating evidence based practice.* 5th ed. Jones and Bartlett Learning.

Brink, H., Van Der Walt, C., Van Rensburg, G. 2018. *Fundamental of Research Methodology for Health care Professionals.* 3rd ed. Cape Town, South Africa.

Bryman, A., Bell, E., Hirschen, P., Dos Santos, A., Du Toit, J. & Masenge, A. 2014. *Research Methodology: Business and Management Contexts* (1st adapted ed.). Cape Town, South Africa: Oxford University Press.

Brownsword, R., Scotford, E., Yeung, K. 2017.*Oxford Handbook of Law, Regulation, and technology.* 1st ed. Oxford University Press.

Busza, J., Dauya, E., Bandason, T., Simms, V., Chikwari, C.D., Makamba, M., Mchugh, G., Munyati S, Chonzi P, Ferrand, R.A. 2018. The role of community health workers in improving HIV treatment outcomes in children: lessons learned from the ZENITH trial in Zimbabwe. *Health Policy and Planning*, (33) 3, https://doi.org/10.1093/heapol/czx187

Clark, M.J.D. 2015*. Population and community health nursing.* 6th edition. Hoboken, New Jersey: Pearson Education.

Connelly, L.M. 2016. "Trustworthiness in qualitative research." *MedSurg Nursing*, Nov.-Dec. 2016, p. 435+. Academic OneFile, Accessed 2 May 2018

Creswell, J.W. 2013. *Research design: Qualitative, quantitative, and mixed methods approaches.* London: Sage Publications.

Darikwa, P. 2016. *An exploration of the perceptions of Community Health Workers on the enablers and barriers to providing services in Nyanga District, Zimbabwe.* Master thesis. Johannesburg: University of Witwatersrand.

De Neve, J.W., Garrison-Desany, H., Andrews, K.G., Sharara, N., Boudreaux, C., Gill, R., Geldsetzer, P., Vaikath, M., Bärninghausen, T., Bosset, T.J. 2017. Harmonization of community health worker programs for HIV: A four-country qualitative study in Southern Africa. *PLoS Med* 14(8): e1002374. https://doi.org/10.1371/journal.pmed.1002374

De Vos, A.S., Strydom, H. Delport, C.L.S. 2011. *Research at grass roots: for the social sciences and human service professions.* 4th ed. Cape Town: Creda Communications.

Demaio, A.R., Nielsen, K.K., Tersbøl, B.P., Kallestrup, P. Meyrowitsch, D.W. 2014. Primary Health Care: a strategic framework for the prevention and control of chronic non-communicable disease. *Global Health Action*, 7:1, 24504, DOI: 10.3402/gha.v7.24504 Columbia. Edu /catalog /ac: 192781.

Dennill, K., Rendall-Mkosi, K., King, L. 2013. *Primary Health Care in South Africa*, 3rd ed doi: 10.1371 /journal.pone.0105934.

DiCarlo, A., Fayorsey, R., Syengo, M. Chege, D., Sirengo, M., Reidy, W., Otieno, J., Omoto, J., Hawken, M.P., Abrams, E.J. 2018. Lay health worker experiences administering a multi-level combination intervention to improve PMTCT retention*. BMC Health Serv Res,* 18, 17 (2018). https://doi.org/10.1186/s12913-017-2825-8

Finello, K.M., Terteryan, A., Riewerts, R.J. 2016. Home Visiting Programs: What the Primary Care Clinician Should Know. *Current Problems in Pediatric and Adolescent Health Care*, (46), 4:101–125.

Fusheini, A., Eyles, J. 2016. *Achieving universal health coverage in South Africa through a district health system approach: conflicting ideologies of health care provision*. *BMC Health Serv Res* (16):558. https://doi.org/10.1186/s12913-016-1797-4

Gondwe, T., Robberstad, B., Mukaka, M., Lange, S., Blomberg, B. Phiri, K. 2018. Delivery strategies for malaria chemoprevention with monthly dihydroartemisinin-piperaquine for the post-discharge managerial of severe anaemia in children aged less than 5 years old in Malawi: a protocol for a cluster randomized trial. *BMC Pediatric* (18):238. https://doi.org/10.1186/s12887-018-1199-3

Grant, M., Wilford, A., Haskins, L., Phakathi, S., Mntambo, N., Horwood, C.M. 2017. Trust of community health workers influences the acceptance of community-based maternal and child health services. *African Journal of Primary Health Care and Family Medicine*, a1281. https://doi.org/10.4102/phcfm.v9i1.1281

Green, J., Thorogood, N. 2014. *Beginning data analysis. In: Qualitative Methods for Health Research*. 3rd ed. London: Sage Publications.

Grove, S.K., Burns, N. Gray, J. 2013. *The practice of nursing research: appraisal, synthesis, and generation of evidence*. 7th ed. St. Louis, Mo.: Elsevier/Saunders.

Hall, J.J., Taylor, R. 2003. Health for all beyond 2000: the demise of Alma-Ata Declaration and primary health care in developing countries. *Medical Journal of Australia.* Volume 178 issue 1.

Hangulu, L., Akintola, O. 2017. Health care waste management in community-based care: experiences of community health workers in low resource communities in South Africa. *BMC Public Health,* 17. https://doi.org/10.1186/s12889-017-4378-5

Huang, W., Long, H., Li, J. et al. 2018. Delivery of public health services by community health workers (CHWs) in primary health care settings in China: a systematic review (1996–2016). *Glob Health Res Policy,* 3. https://doi.org/10.1186/s41256-018-0072-0

Ichikawa, K., Fujiwara, T., Nakayama, T. 2015. Effectiveness of Home Visits in Pregnancy as a Public Health Measure to Improve Birth Outcomes. *PLoS ONE,* 10(9): e0137307. https://doi.org/10.1371/journal.pone.0137307

Ichikawa, K., Fujiwara, T., Nakayama, T. 2016. Correction: Effectiveness of Home Visits in Pregnancy as a Public Health Measure to Improve Birth Outcomes. *PLoS ONE,* 11(3): e0152354. https://doi.org/10.1371/journal.pone.0152354

Josephson, K., Guerrero, G., Coddington, C. 2017. *Supporting the Early Childhood Workforce at Scale: The Cuna Más home visiting program in Peru.* Washington, D.C:Juta & Company Ltd

Kane, S., Kok, M., Ormel, H., Otiso, L., Sidat, M., Namakhoma, I., Nasir, S., Gemechu, D., Rashid,S., Taegtmeyer, M., Theobald, S., de Koning, K. 2016. Limits and opportunities to community health worker empowerment: a multi-country comparative study. *Soc Sci Med*. doi: 10.1016/j.socscimed.2016.07.019. Epub 2016 Jul 20. PMID: 27459022.

Kelly, J.D., Frankfurter, R., Lurton, G., Conteh, S., Empson, S.F., Daboh, F., Barrie, M.B. 2018. Evaluation of a community-based ART programme after tapering home visits in rural Sierra Leone: a 24-month retrospective study. SAHARA-J: *Journal of Social Aspects of HIV/AIDS*, doi:10.1080/17290376.2018.1527244.

Kok, M., Muula, S. 2013. Motivation and job satisfaction of health surveillance assistants in Mwanza, Malawi: An explorative study. *Malawi Medical Journal*, 25 (1), 5-11.

Kok, M..C, Kane, S.S., Tulloch, O., Ormel, H., Theobald, S., Dieleman, M., et al. 2015*. How does context influence performance of community health workers in low- and middle-income countries? Evidence from the literature. Health Research Policy and Systems. Methodology for Health care Professionals.* 3rd Ed. Cape Town, South Africa.

Kok, M.C., Taegtmeyer, M., Broerse, J.E.W., Kane, S.S., Ormel, H., Namakhoma, I., Otiso, L., Sidat, M., Kea, A.Z., Theobald, S., Dieleman, M. 2017. Optimising the benefits of community health workers' unique position between communities and the health sector: A comparative analysis of factors shaping relationships in four countries. *Global Public Health*, 12:11, 1404-1432, DOI:10.1080/17441692.2016.1174722

Lawn, J.E., Bhutta, Z.A., Wall, S.N., Peterson, S., Daviaud E. 2017. Cadres, content and costs for community based care for mothers and newborns from seven countries: implications for universal health coverage. *Health Policy Plan,* 32:i1–5.

Le Roux, K., Le Roux, I., Mbewu, N., Davis, E. 2015. The role of community health workers in the re-engineering of primary health care in rural Eastern Cape. *South African Family Practice,* (57): 2. http://doi:org/10.1080/20786190.2014.977063.

Lincoln, Y.S. & Guba, E.G. 1985. *Naturalistic enquiry*. Beverly Hills, C A: Sage.

LoBiondo-Wood, G., Haber, J. 2014. *Nursing research, methods and critical appraisal for evidence-based practice*. 8th ed. St. Louis, MI: Mosby.

Mangwi Ayiasi, R., Kolsteren, P., Batwala, V., Criel B, Orach, C.G. 2016. Effect of Village Health Team Home Visits and Mobile Phone Consultations on Maternal and Newborn Care Practices in Masindi and Kiryandongo, Uganda: A Community-Intervention Trial. *PLoS ONE*, 11(4): e0153051. https://doi.org/10.1371/journal.pone.0153051

Mascarenas, D.N., Wurzburger, R., Garcia, B.N., Tomedi, A., Mwanthi, M.A. 2015. The promise of home visitation by community health workers in rural Kenya: A protective effect that reduces neonatal illness. *Education for Health*, 28:181-6.

Mayo-Wilson, E., Grant, S., Burton, J., Parsons, A., Underhill, K., Montgomery, P. 2014. Preventive Home Visits for Mortality, Morbidity, and Institutionalization in Older Adults: A Systematic Review and Meta-Analysis. *PLoS ONE* 9(3): e89257. doi:10.1371/journal.pone.0089257.

Mhlongo, E.M., Lutge, E. 2019. The roles, responsibilities and perceptions of community health workers and ward-based primary health care outreach teams (WBPHCOTs) in South Africa: a scoping review protocol. *Systemic Reviews,* 8. https://doi.org/10.1186/s13643-019-1114-5

Monette, D.R., Sullivan, T.J. De Jong, C.R. 2008. *Applied social research: A tool for the human services.* Belmont, CA: Brooks/Cole, Cengage Learning.

Moosa, S., Derese, A., Peersman, W. 2017. Insights of health district managers on the implementation of primary health care outreach teams in Johannesburg, South Africa: a descriptive study with focus group discussions. *Human Resources for Health*, 15(1), 7.

Mottiar, S., Lodge, T. 2017. The role of community health workers in supporting South Africa's HIV/ AIDS treatment programme. *African Journal of AIDS Research*, 17:1, DOI: 10.2989/16085906.1402793

Moule, P., Aveyard, H., Goodman, M. 2017. *Nursing Research an Introduction.* 3rd ed. London: Sage Publications Ltd.

Musoke, D., Ssemugabo, C., Ndejjo, R. et al. 2018.Reflecting strategic and conforming gendered experiences of community health workers using photovoice in rural Wakiso district, Uganda. *Human Resource for Health,* (16): 41. https://doi.org/10.1186/s12960-018-0306-8

National Department of Health. 2010. Re-engineering primary health care in South Africa: *Discussion document*. Pretoria: Department of Health.

Ndaba, T., Taylor, M., Mabaso, M. 2019. Training and evaluation of community health workers (CHWs): towards improving maternal and newborn survival in an urban setting in KwaZulu-Natal, South Africa. *The Open Public Health Journal*. 12:406-413.

Ndlovu, G.P., Sokhela, D.G., Sibiya, M.N. 2018. Experiences of community caregivers in the assessment of malnutrition using mid-upper arm circumference measurement in children under 5 years old. *African Journal of Primary Health Care and Family Medicine,* 10(1), a1743. https://doi.org/10.4102

Ngan, D., 2018. Verbal Paraphrasing Technique: A Case of University English-Major Students' Perceptions and Implementation. *Kasem Bundit Journal*, 19 (May-June), pp.449-465

Nkosi-Gondwe, T., Robberstad, B., Blomberg, B., Phiri, K.S., Lange, S. 2018. Introducing post-discharge malaria chemoprevention (PMC) for managerial of severe anemia in Malawian children: a qualitative study of community health workers' perceptions and motivation. *BMC Health Serv Res*. doi: 10.1186/s12913-018-3791-5.

Novins, D., Meyer, A., Beltangady, M. Contextual Issues for Implementation and Evaluation of Home-Visitation Programs for American Indian and Alaska Native Communities: An Introduction to the tribal maternal, infant, and early childhood home visiting program. *Infant Mental Health Journal*, 10.1002/imhj.21705, 39, 3, (259-264), (2018).

Nxumalo, N., Goudge, J., Lenore Manderson, L. 2016. Community health workers, recipients' experiences and constraints to care in South Africa – a pathway to trust. *AIDS Care*, (28:Suppl 4) 61-71, DOI: 10.1080/09540121.2016.1195484

Olaniran, A., Smith, H., Unkels, R., Bar-Zeev, S., van den Broek, N. 2017. Who is a community health worker? – A systematic review of definitions. *Global Health Action*, 10(1), 1272223. http://doi.org/10.1080/16549716.2017.1272223

Ozano, K., Simkhada, P., Thann, K. et al. 2018. Improving local health through community health workers in Cambodia: challenges and solutions. *Human Resource for Health* 16, 2. https://doi.org/10.1186/s12960-017-0262-8

Paintain, L.S., Willey, B., Kedenge, S., Sharkey, A., Kim, J., Buj, V., Webster, J., Schellenberg, D., Ngongo, N. 2014. Community Health Workers and Stand-Alone or Integrated Case Management of Malaria: A Systematic Literature Review*. American Journal of Tropical Medicine Hygiene,* doi: 10.4269/ajtmh.14-0094 Period, 2014/15:q1 2014/15 to q2.

Perry, H.B., Zulliger, R., Rogers, M.M. 2014. Community health workers in low-, middle-, and high-income countries: an overview of their history, recent evolution, and current effectiveness. *Annual Review of Public Health*. Vol. 35:399-421 https://doi.org/10.1146/annurev-publhealth-032013-182354

Pillay, Y., Barron, P. 2011.The implementation of PHC re-engineering in South Africa*. Public Health Association of South Africa*; Available: http://www.phasa.org.za/the-implementation-of-phc-reengineering- in-South-Africa

Polit, D.F., Beck, C.T. 2017. *Nursing Research: Generating and assessing evidence for nursing practice.* 10th edn. Philadelphia: Lippincott, Williams and Wilkins.

Rotheram-Borus, M.J., Tomlinson, M., Le Roux, I.M., Harwood, J.M., Comulada, S., et al. 2014. A Cluster Randomised Controlled Effectiveness Trial Evaluating Perinatal Home Visiting among South African Mothers/Infants*. PLoS ONE* 9(10): e105934.

Sarin, E., Sooden, A., Kole, S.K., Lunsford, S.S. 2016. Identification of Challenges and Needs to improve Community Health Workers Performance: Narratives of Accredited Social Health Activists (ASHA) from Two Indian Districts. *Journal of Public Health in Developing Countries,* 173-182.

Schoen, J., Mallet, M.W., Grossman-Kahn, R., Brentani, A., Kaselitz, E., Heisler, M. 2017. Perspectives and experiences of community health workers in Brazilian primary care Centres

using m-health tools in home visits with community members. *Human Resource for Health* 15(71). https://doi.org/10.1186/s12960-017-0245-9

Seutloali, T., Napoles, L., Bam, N. 2018. Community health workers in Lesotho: Experiences of health promotion activities. *African Journal of Primary Health Care & Family Medicine*, [S.l.], v. 10, n. 1, p. 8 pages, ISSN 2071-2936.

Shaban, I.A., Al-Awamreh, K., Mohammad, K., Gharaibeh, H. 2018. Postnatal women's perspectives on the feasibility of introducing postpartum home visits: a Jordanian study. *Home Health Care Services Quarterly*, 37:3, DOI: 10.1080/01621424.2018.1454865

Shihundla, R.C., Lebese, R.T, Maputle, M.S. 2016. Effects of increased nurses' workload on quality documentation of patient information at selected Primary Health Care facilities in Vhembe District, Limpopo Province. *Curationis* 39(1), a1545. http://dx.doi. org/10.4102/curationis. v39i1.1545

Sitrin, D., Guenther, T., Waiswa, P., Namutamba, S., Namazzi, G., Sharma, S., Ashish, K.C., Rubayet, S., Bhadra, S., Ligowe, R., Chimbalanga, E., Sewell, E., Kerber, K., Moran, A. 2015. Improving newborn care practices through home visits: lessons from Malawi, Nepal, Bangladesh, and Uganda, *Global Health Action*, 8:1, DOI: 10.3402/gha.v8.23963

Stansert Katzen, L., Tomlinson, M., Christodoulou, J. Laurenzi, C., Le Roux, I., Baker, V., Mbewu, N., Le Roux, K.W., Rotheram Borus, M.R. 2020. Home visits by community health workers in rural South Africa have a limited, but important impact on maternal and child health in the first two years of life. *BMC Health Serv Res* 20, 594. https://doi.org/10.1186/s12913-020-05436-7

Tsolekile, L.P., Schneider, H., Puoane, T. 2018, The roles, training and knowledge of community health workers about diabetes and hypertension in Khayelitsha, Cape Town. *Curationis* 41(1), a1815. https://doi.org/10.4102/curationis.v41i1.1815

Weger, H., Castle,G.R., Emmett, M.C. 2010. Active Listening in *Peer Interviews:* The Influence of Message Paraphrasing on Perceptions of Listening Skill. *The Intl. Journal of listening*, 24: 34–49, 2010.copyright © Taylor & Francis Group, llc.issn: 1090-4018 print / 1932-586x onlinedoi: 10.1080/10904010903466311

Wells, S., O'Neill, M., Rogers, J., Blaine, K., Hoffman, A., McBride, S., Tschudy, M.M., Berry, J.G. 2017. Nursing-led home visits posthospitalization for children with medical complexity. *Journal of Pediatric Nursing*, 34. 10-16

White, M.S., Govender, P., Lister, H.E. 2017. Community health workers lensed through a South African backdrop of two peri-urban communities in KwaZulu-Natal. *African Journal of Disability* 6(0), a294. https://doi.org/ 10.4102/ajod.v6i0.29

WHO. The World Health Report 2008. Primary Health Care - now more than ever, vol. 26. Geneva: *World Health Organization*. Available from: http://www.who.int/whr/2008/whr08_en.pdf

World Health Organization (2011*). Declaration of the first global ministerial conference on healthy lifestyles and noncommunicable disease control.* Moscow: World Health Organization.

You, H., Chen, J., Bogg, L., Wu, Y., Duan, S., Ye, C., Liu, X., Yu, H., Diwan, V., Dong, H. 2013. Study on the Factors Associated with Postpartum Visits in Rural China. *PLoS ONE* 8(2):e55955. https://doi.org/10.1371/journal.pone.0055955

Zulliger, R., Moshabela, M. Schneider, H. 2014*.* She is my teacher and if it was not for her I would be dead: Exploration of rural South African community health workers' information, education and communication activities. *AIDS Care,* 26(5), 626-632.

ANNEXURE A

DECLARATION OF ORIGINALITY: UNIVERSITY OF PRETORIA

ANNEXURE A: DECLARATION OF ORIGINALITY: UNIVERSITY OF PRETORIA

Full names of student: Hilda Kawaya

Student number: u18371028

Topic of work:
"CHALLENGES COMMUNITY HEALTH WORKERS PERCEIVED REGARDING HOME VISITS IN THE TSHWANE DISTRICT"

Declaration:

1. I understand what plagiarism is and am aware of the University's policy in this regard.

2. I declare that this proposal is my own original work. Where other people's work has been used (either from a printed source, Internet or any other source), this has been properly acknowledged and referenced in accordance with departmental requirements.

3. I have not used work previously produced by another student or any other person to hand in as my own.

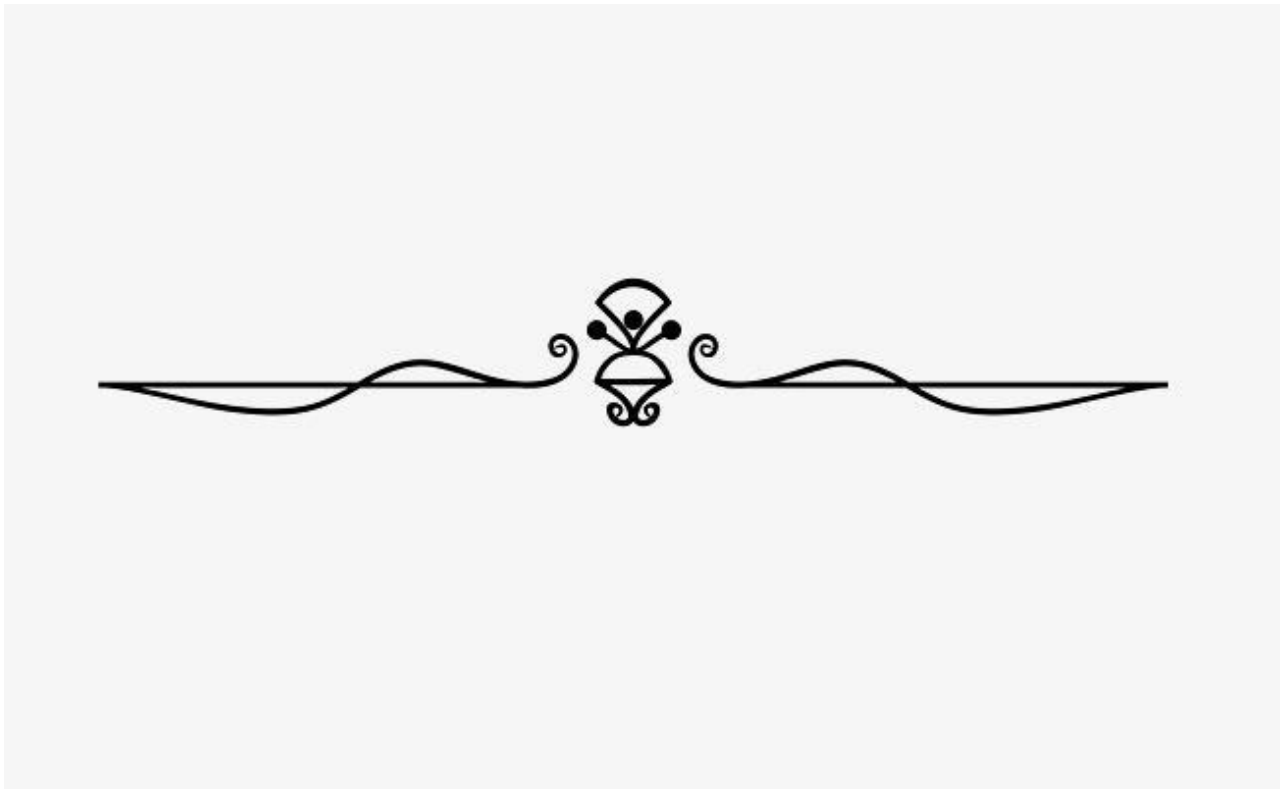
4. I have not allowed, and will not allow, anyone to copy my work with the intention of passing it off as his or her own work.

_____ _____

SIGNATURE **DATE**

ANNEXURE B

INTERVIEW GUIDE



ANNEXURE B: INTERVIEW GUIDE

Self-designed questions by the researcher

Main Question

- What are the challenges that you perceive regarding home visits?

Follow up questions

- How can these challenges be resolved?
- Which strategies did you use to resolve these challenges?
- How are you supported when you meet these challenges?
- How do the individuals/families and community receive you during the home visit?

Knowledge about home visits

- What training did you receive related to home visits?
- What do you prepare before going to do home visits?
- What is your role during home visits?
- What is your role after the home visit?
- When do you refer clients to the clinic?

Closing questions

- Is there any information you would like to share related to challenges regarding home visits?
- Are there any other questions that you think I should have asked related to the challenges regarding home visits?

N.B Probing will be done in between questions

ANNEXURE C

INFORMATION LEAFLET AND INFORMED CONSENT

ANNEXURE C: INFORMATION LEAFLET

Dear Participant

Thank you for taking time to read this information letter. I am a Master's Degree student at University of Pretoria and in order to qualify, I am required to complete a research proposal. The details are outlined below:

Brief Introduction and Purpose of the Study:

Re-engineering of Primary Health Care System brought in a different way of delivery of service to the community by employing the CHWs, to bridge the gap of shortage of staff and to access those clients who are at hard to reach areas. The CHWs are allocated to different clinics and NGO's to render service to the community. One of their roles is to do follow-up of clients who have defaulted treatment. They form part of a team of WBOTS and have a supervisor whom they report to. The Community Environment may confront the CHWs with challenges during home visits. During these home visits the CHWs are exposed to different situations. Therefore, this study aims to explore and describe the perception of CHWs regarding home visits in the Tshwane district.

Research Design: I am requesting that you allow me to interview you for approximately thirty (30) minutes to sixty (60) minutes. I request permission to record the interview and the recordings will be kept in a safe place and will be destroyed after a period of 5 years. Please note that the interviews will be recorded for the purposes of later transcription.

Risks or Discomforts to the Subject: You will not be subjected to any risk or discomfort.

Benefits: This study seeks to explore and describe your perception regarding home visits. This would show the researcher how the CHW's when allocated at Primary Health Care services are doing home visits. The findings of this study will be shared with you for verification purposes and thereafter will be published in journals.

Remuneration: There is no remuneration for participating in this study.

Costs of the Study: None

Confidentiality: All data collected will be strictly private and confidential and will only be used for the purpose of the study. No information will be linked to your identity.

Research-related Injury: You will not be subjected to any risk or discomfort.

Persons to Contact in the event of any problems or queries:

Ms H Kawaya: 0741317748 mobile and 0123195655, Supervisor: Dr MM Moagi: 0766754266

Co – Supervisor: Prof MD Peu: 0825344245

CONSENT TO PARTICIPATE IN THE STUDY

I confirm that the person asking my consent to participate in the study has explained to me about the nature, the process, risks, discomforts and benefits of the study. I also received the information leaflet about the study, have read and understood the contents. I am aware that the results of the study including personal details will be anonymously processed into research reports. I am participating willingly. I have had time to ask questions and have no objection to participate in the study. I understand that there is no penalty should I choose to withdraw or discontinue to participate in the study.

Participant's name:_____(Please Print)

Participant's signature:_____Date: _____

Investigator's name:_____(Please Print)

Investigator's signature:_____Date:_____

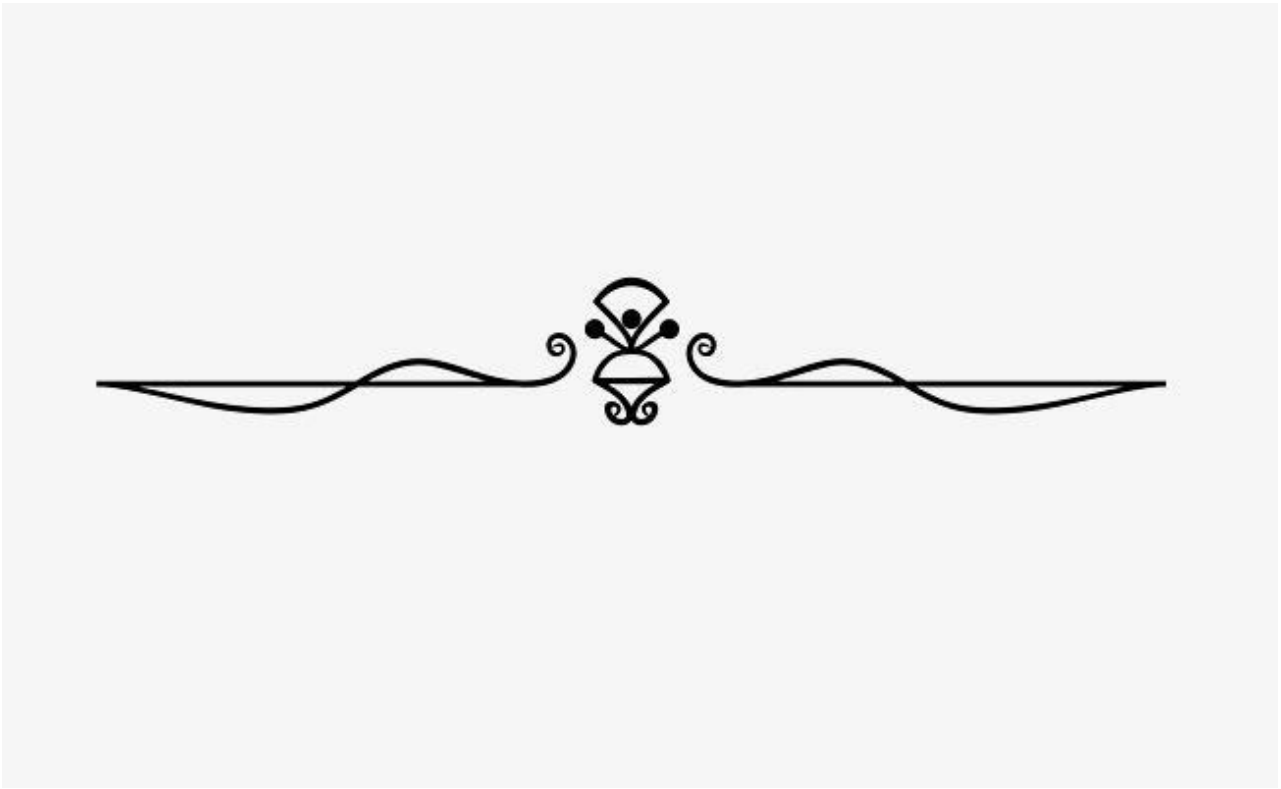
Witness's name:_____(Please Print)

Witness's signature:_____Date:_____

ANNEXURE D

LETTERS OF APPROVAL:

UNIVERSITY OF PRETORIA



UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences

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

- FWA 00002567, Approved on 22 May 2002 and Expires 03/20/2022.
- IRB 0000 3235 IORG0001762 Approved on 22/01/2014 and Expires 01/14/2020

18 June 2019

Approval Certificate
New Application

Ethics Reference No.: 288/2019
Title: Challenges community health workers perceived regarding home visits in the Tshwane District

Dear Ms H Kawaya

The **New Application** as supported by documents received between 2019-05-03 and 2019-06-12 for your research, was approved by the Faculty of Health Sciences Research Ethics Committee on its quorate meeting of 2019-06-12.

Please note the following about your ethics approval:

- Ethics Approval is valid for 1 year and needs to be renewed annually by 2020-06-18.
- Please remember to use your protocol number (288/2019) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, monitor the conduct of your research, or suspend or withdraw ethics approval.

Ethics approval is subject to the following:

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

We wish you the best with your research.

Yours sincerely

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

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

Research Ethics Committee
Room 4.20, Level 4, Tswelopele Building
University of Pretoria, Private Bag X323
Arcadia 0007, South Africa
Tel +27 (0)12 356 3084
Email deepeka.behari@up.ac.za
www.up.ac.za

Fakulteit Gesondheidswetenskappe
Lefapha la Disaense tša Maphelo

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences

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

- FWA 00002567, Approved dd 22 May 2002 and Expires 03/20/2022.
- IORG #: IORG0001762 OMB No. 0990-0279 Approved for use through February 28, 2022 and Expires: 03/04/2023.

27 August 2020

Approval Certificate
Annual Renewal

Ethics Reference No.: 288/2019
Title: Challenges community health workers perceived regarding home visits in the Tshwane District

Dear Ms H Kawaya

The **Annual Renewal** as supported by documents received between 2020-07-13 and 2020-08-26 for your research, was approved by the Faculty of Health Sciences Research Ethics Committee on 2020-08-26 as resolved by its quorate meeting.

Please note the following about your ethics approval:

- Renewal of ethics approval is valid for 1 year, subsequent annual renewal will become due on 2021-08-27.
- Please remember to use your protocol number (288/2019) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, monitor the conduct of your research, or suspend or withdraw ethics approval.

Ethics approval is subject to the following:

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

We wish you the best with your research.

Yours sincerely

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

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Email: deepeka.behari@up.ac.za
www.up.ac.za

Fakulteit Gesondheidswetenskappe
Lefapha la Disaense Tša Maphelo

ANNEXURE E

TSHWANE RESEARCH COMMITTEE:

CLEARANCE CERTIFICATE

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Enquiries: Mpho Moshime-Shabagu
Tel: +27 12 451 9036
E-mail: Mpho.Moshime@gauteng.gov.za

TSHWANE RESEARCH COMMITTEE: CLEARANCE CERTIFICATE

DATE ISSUED: 08/08/2019
PROJECT NUMBER: 44/2019
NHRD REFERENCE NUMBER: GP_201907_015

TOPIC: Challenges Community Health Workers Perceived Regarding Home Visits in the Tshwane District

Name of the Researcher:	Ms Hilda Kawaya
Name of the Supervisor:	Dr MM Moagi Prof M D Peu
Facility:	Stanza Bopape CHC Skinner Street Clinic Laudium CHC Holani Clinic Eersterust CHC Bophelong Clinic
Name of the Department:	University of Pretoria

NB: THIS OFFICE REQUEST A FULL REPORT ON THE OUTCOME OF THE RESEARCH DONE AND

NOTE THAT RESUBMISSION OF THE PROTOCOL BY RESEARCHER(S) IS REQUIRED IF THERE IS DEPARTURE FROM THE PROTOCOL PROCEDURES AS APPROVED BY THE COMMITTEE.

DECISION OF THE COMMITTEE: APPROVED

.....
Dr. Mpho Moshime-Shabangu
Acting Chairperson: Tshwane Research Committee

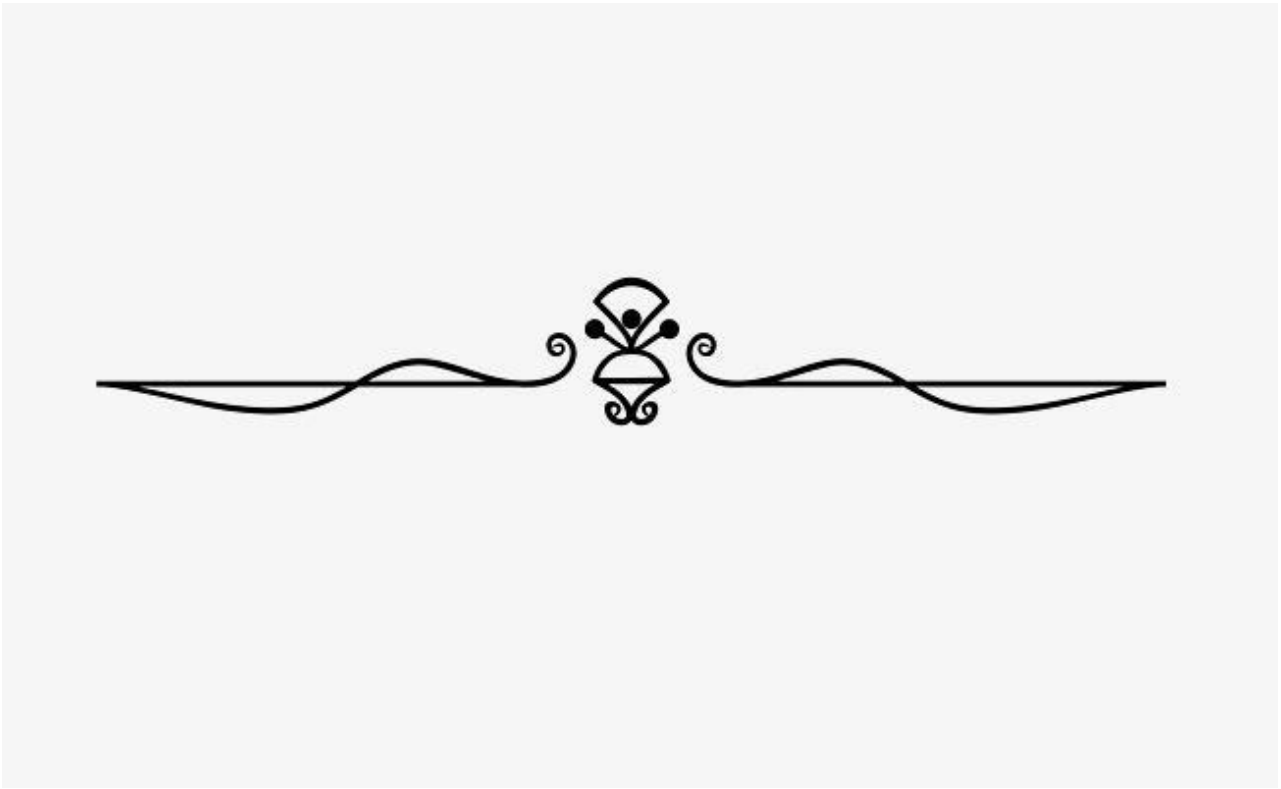
Date....14|08|2019....

.....
Mr. Mothomone Pitsi
Chief Director: Tshwane District Health

Date: 2019.08.14

ANNEXURE F

PERMISSION TO CONDUCT A STUDY AT TSHWANE DISTRICT HEALTH CARE SERVICES



PERMISSION TO CONDUCT A STUDY AT TSHWANE DISTRICT HEALTH CARE SERVICES PRIMARY HEALTH CARE CLINICS.

No 1 Litroos place
Lindo Park
Pretoria
0186
18 September 2019

Facility manager

Re: Permission to do access Community Health Workers allocated to the clinic/ CHC

TITLE OF STUDY: Challenges Community Health Workers perceived regarding home visits in the Tshwane district.

I am a Masters student at the Department of Health Sciences at the University of Pretoria. I am working at SG Lourens Nursing College; I herewith request permission to conduct a study on the above topic on clinic grounds. This study does not involve access to patient records. This study involves clinical research.

The researcher request access to the Community Health workers allocated to do home visits around the community attached to Primary Health Care Clinics.

We intend to publish the findings of the study in a professional journal and/ or to present them at Professional meetings and the personal identity of the Community health workers will be protected.

We undertake not to proceed with the study until we have received approval from the Faculty of Health Sciences Research Ethics Committee, University of Pretoria.

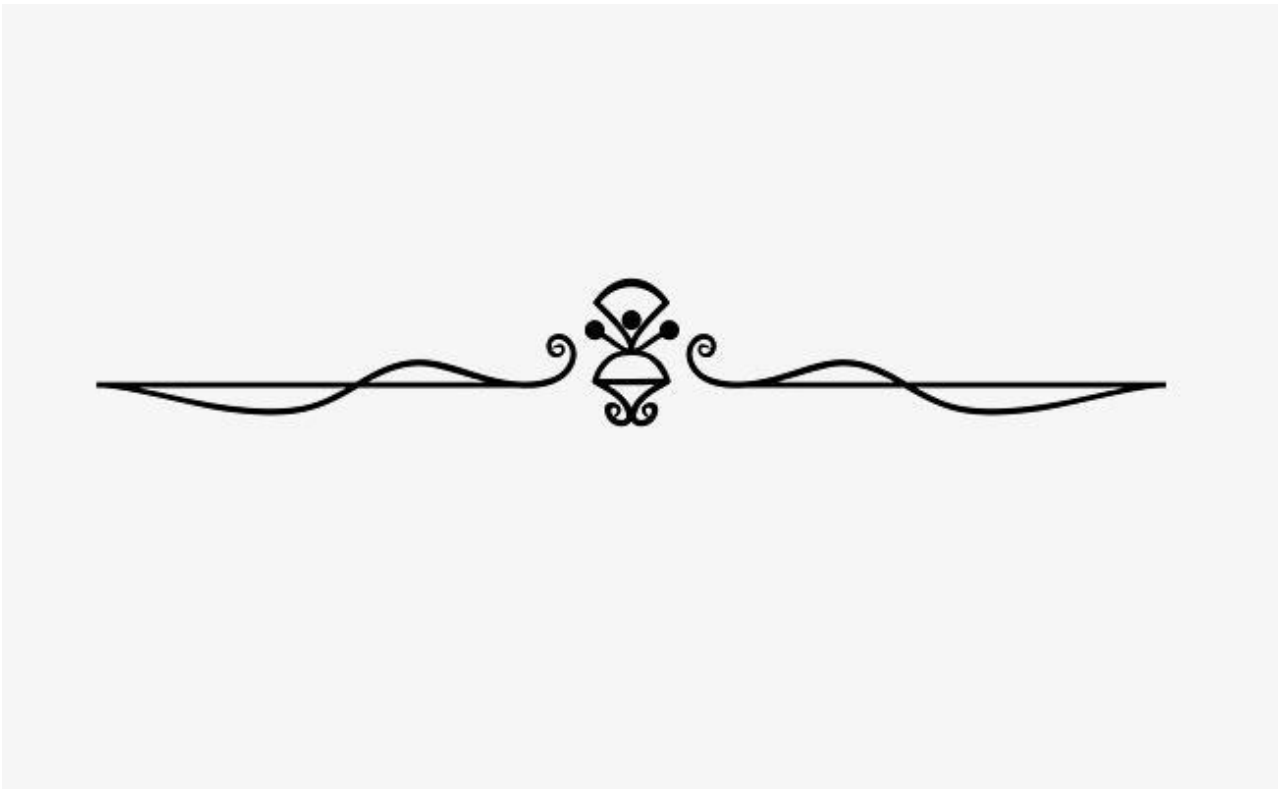
I appreciate time and attention to my request and look forward to the reply. My contact information is 0741317748 mobile and office (012)3195655 and email is hkawaya@gmail.com for further correspondence. My supervisor Dr MM Moagi can be contacted at mobile 0766754266 University of Pretoria.

Yours Sincerely
Hilda Kawaya
Principal Investigator

Signature: H Kawaya 2019/09/18

ANNEXURE G

QUALITATIVE DATA ANALYSIS



Dr Annatjie van der Wath (M Cur, Ph D)

Qualitative Data Analysis

This serves to confirm that Annatjie van der Wath has co-coded the following qualitative data: 14 interviews for the study:

CHALLENGES COMMUNITY HEALTH WORKERS PERCEIVED REGARDING HOME VISITS IN THE TSHWANE DISTRICT

I declare that the candidate and I have reached consensus on the major themes and sub/ categories as reflected in the findings during a consensus discussion.

Annatjie van der Wath (M Cur, Ph D)