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THE PERCEPTIONS OF COMMUNITY HEALTH CARE WORKERS REGARDING PRIMARY HEALTH CARE OUTREACH SERVICES IN THE TSHWANE SUB-DISTRICT, GAUTENG PROVINCE

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DECLARATION

I, **Sarah Mpshane**,

Student Number: 153 935 94,

declare that:

"THE PERCEPTIONS OF COMMUNITY HEALTH CARE WORKERS REGARDING PHC OUTREACH SERVICES IN THE TSHWANE SUB-DISTRICT, GAUTENG PROVINCE"

is my own work and that all sources that have been used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted for any other degree at any other institution.

_____ _____

Signed **Date**

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ABSTRACT

THE PERCEPTIONS OF COMMUNITY HEALTH CARE WORKERS REGARDING PHC OUTREACH SERVICES IN THE TSHWANE SUB-DISTRICT, GAUTENG PROVINCE

Introduction: The National Department of Health in South Africa piloted ward-based primary health care outreach services in 2011. The service is part of Primary Health care (PHC) re-engineering and it is provided by a team that includes community health care workers.

Aim: The aim of this study was to explore the perceptions of ward-based community health care workers (CHWs) regarding primary health care outreach services in Tshwane sub-district.

Research method: A qualitative ethnographic design was followed to explore the perceptions of CHWs. A purposive sampling method was used and data collected by means of interviews. Unstructured face to face interviews and reviews of site documents were used to generate data. Data was analysed using thematic analysis.

Findings: The four main themes were revealed as: household activities performed by CHWs, working conditions, benefits to the community, and acknowledgement by the Department of Health. The findings included dissatisfaction of the CHWs with their current working conditions, especially the need to be full-time workers, earning a living wage in the form of a salary, not a stipend, and the aspiration to development by furthering their

careers. Despite this dissatisfaction, the findings further revealed appreciation of the service by communities and reduction of the workload at clinics.

It was recommended that the Department of Health recognise the service of CHWs in the form of permanent employment and formalise the career paths of CHWs. Furthermore, it was recommended that clinic staff members begin to portray positive working relationships and attitudes towards CHWs.

Conclusion: Despite the dissatisfaction among the CHWs, the communities and health facilities are benefiting from this service.

Key words: Community health care workers, Primary Health Care Outreach Service, perceptions, focused ethnography.

LIST OF ABBREVIATIONS AND ACRONYMS

ABBREVIATION	MEANING
AIDS	Acquired Immunodeficiency Syndrome
CHWs	Community Health Care Workers
DoH	Department of Health
HIV	Human Immunodeficiency Virus
MDGs	Millennium Development Goals
NSDA	Negotiated Service Delivery Agreement
NGO	Non-Government Organisation
PHC	Primary Health Care
PCR	Polymerase Chain Reaction
UP	University of Pretoria
USA	United States of America
WBOT	Ward-Based Outreach Team
WHO	World Health Organisation

TABLE OF CONTENT

CHAPTER 2

PARADIGMATIC THEORETICAL PERSPECTIVES AND RESEARCH METODS

CHAPTER 5
SUMMARY OF THE STUDY

LIST OF REFERENCES

LIST OF ANNEXURES

LIST OF FIGURES

LIST OF TABLES

CHAPTER 1

ORIENTATION OF THE STUDY

1.1 **INTRODUCTION**

The study was conducted in Tshwane sub-district, Gauteng province to explore the perception of community health care workers regarding Primary health care (PHC) outreach services. In South Africa since 1994 the district health system was used as an approach to deliver PHC service (ANC 1994: 19). The PHC health care outreach service was provided at the facilities by nursing heath care professionals, whereby most clients were to visit the clinic for most of their health needs including collection of chronic medication and minor ailments. Despite programmes that were in place, the general health status of the population deteriorated. PHC experienced challenges of burden of chronic diseases. PHC outreach service was introduced in South Africa to control the burden of disease and accessibility of the health service to the entire population (Pillay & Barron 2011).

PHC outreach service is a National Health Strategy mandated by the Minister of Health Dr. A Motswaledi in 2011. The service is rendered in the communities for the uninsured population of South Africa to support the National Health Strategy of a “Long Healthy life for all South Africans”. Furthermore, to support the implementation of National Health Insurance (NHI) (NDoH 2010). In South Africa, PHC services are re-engineered to focus on health promotion and preventative care, whilst also ensuring that quality curative and rehabilitative services are provided (Fullman et al. 2016:2).

1.2 BACKGROUND

Primary health care (PHC) outreach services in Gauteng Province are highlighted in the 2011 ward-based PHC outreach team toolkit of services by the Department of Health (DoH). In the

toolkit, PHC re-engineering has shifted service delivery from curative services to stronger preventive, promotive and rehabilitative services that are to be provided by ward-based outreach teams (WBOTs) to communities at household level (Department of Health, 2011:6). The WBOTs consist of specialist primary health care nurses, community health care workers (CHWs), and environmental health and health promotion officers (see Figure 1.1). The roles and services that are rendered by WBOTs include conducting structured community household assessments and identifying health needs (Department of Health 2011:6-8). In addition, WBOTs screen families to prevent illnesses and provide health promotion through psycho-social support to the community (Department of Health 2011:6-8).

Figure 1.1 Source: Gauteng Provincial Guidelines for the implementation of the three mainstreams of PHC re-engineering.

Figure 1.1 indicates how CHWs are allocated households through several districts in Gauteng Province. Each community health care worker is allocated 270 families dependent on the distance and density of the location.

The World Health Organisation (WHO) defines a community health care worker as a person who is recruited from the community, and has a close link with the community and the health care system, enabling them to identify problems in that community (Ofosu-Amaah.1983:5; WHO 2006:8). Community health care workers are the frontline care providers of public health; they provide special basic health needs in their communities to address related Sustainable Developmental Goals (SDGs) (Fullman, Barber, Abajobir, Abate, Abbafati, Abbas, Abd-Allah, Abdulkader, Abdulle, Abera & Aboyans 2016:4). Community health care workers' training falls under the National Qualifications Framework as quality assurance and accreditation body. Both the Department of Health and Quality Council for Trades and Occupation (QCTO) are responsible for setting standards for the practice of community health care workers (Department of Health 2011:11).

Globally, the community health care worker concept was introduced after the ALMA ATA period around 1978 due to the emergence of non-communicable diseases and the HIV and AIDS epidemic which had an influence on the delivery of health care (Ofosu-Amaah 1983:5). In South Africa PHC engineering was initiated by the Department of Health (DOH) to address this emerging epidemic (Pillay & Barron 2011:3) through the endorsement of CHWs. Consequently, after the first democratic election in South Africa the government introduced the concept of CHWs to address the health-related SDGs during a PHC conference on revitalization which was supported by WHO in 2008. The African Health Ministers pledged to commit to the current health agenda and to update their national policies for the attainment of the Millennium Development Goals which expired in September 2015. In addition, further commitment was adopted by committing to the Sustainable Development Goal Agenda leading to 2030 (Fullman et al. 2016:2).

A change has been noted, especially in rural areas where the communities rely on the services of CHWs due to their socio-economic status and human resource constraints (Jaskiewics & Tulenko 2012:2). Community health care workers are expected to cover most of the essential services needed, including: maternal and child health, family planning, and communicable and non-communicable diseases with limited support (Jaskiewics & Tulenko 2012:2; Khanya & Zola 2013:4). This is confirmed by Khanya and Zola programme, who note that other tasks that

community health care workers have to do include the referral and accompaniment of clients to various social services and negotiating with service providers on behalf of clients (Nxumalo, Goudge & Thomas 2013:220).

A study conducted by Kok and Muula (2013:7) revealed challenges experienced by CHWs in Mwanza district in Malawi, especially regarding low salaries. The salaries of CHWs are not based on qualifications and there is no opportunity for promotion. In South Africa, the *Mail & Guardian* newspaper (2014) reported differences in the salaries of CHWs. The same report indicated that the implementation strategy on CHWs differs from province to province due to a lack of a National Policy on WBOTs. The current practice in South Africa is that CHWs undergo the same training and work the same hours although their monthly stipend differs from province to province (*Mail & Guardian*, 12 September 2014). Some of the provincial policy guidelines that support the work of CHWs focus on: population and household allocation, responsibility and function of outreach team members, community health care worker scope of work roles and competencies, and education and training of community health care workers (Department of Health 2011:15).

1.3 RATIONALE

As a strategy PHC re-engineering was initiated in South Africa in 2011. The intention of this strategic uptake was to address the burden of disease in the community by taking health care to the community (Pillay & Barron 2011:3). The ward-based PHC service has been implemented in all provinces from 2012; however, there are challenges that have been highlighted by various studies on ward-based PHC services (Nxumalo et al. 2013:22). The researcher developed an interest in exploring and describing the perceptions of community health care workers regarding their working conditions in PHC outreach services, and wanted to identify the challenges that they face in Tshwane sub-district, Gauteng Province.

1.4 PROBLEM STATEMENT

Ward-based PHC outreach service is a new concept in South Africa which has been piloted in all the provinces. CHWs were tasked to conduct structured community and household assessments including health promotion, prevention campaigns, early detection and interventions for health problems and illnesses, follow up, treatment support and basic health care support (Department of

Health 2011:6). Not much has been explored in terms of how the CHWs perceive this area of work (Department of Health 2011:8).

A study conducted in South Africa by Nxumalo et al. (2013:22) indicated that the working conditions of CHWs are challenging especially when coupled with a lack of support and coordination of the services that are provided. The researcher has worked in the community for more than fifteen years as PHC nurse working closely with CHWs however their scope of work was not at household level as the current ward based CHWs (ANC 1994: 19). The scope of work included: Going for home visits to directly supervise TB patients on taking TB treatment (DOT), tracing for TB patient defaulters and rendering basic nursing care to AIDS patient, bed ridden patient and maintenance of vegetable gardens in the clinic yards. Community health workers were allowed to take vegetables home for their families and the facilities would sell the rest to raise funds (ANC 1994: 19). Despite doing the great work for the community CHWs were not paid a salary or a stipend.

Irrespective of all the years CHWs been rendering service to the communities, they are still regarded as volunteers. Meanwhile, the researcher is still coming across CHWs at her area of work as a clinical community lecturer despite that she is not working directly with them as before. The researcher has also noted with concern that CHWs are still faced with issues such as long walking distances, sometimes in harsh weather conditions, to reach allocated households to render the PHC outreach services (Jaskiewics & Tulenko 2012: 9). Failure to address the identified challenges may lead to constraints on the improvement and optimisation of access to PHC services and the attainment of the SDGs (Fullman et al. 2016:4). Therefore, this study explored and described the perceptions of CHWs regarding the PHC outreach service in Tshwane sub-district, Gauteng Province.

1.5 SIGNIFICANCE OF THE STUDY

The significance of the study is part of the research problem that specifies the importance of the problem for health of individuals, families and communities (Burns & Grove 2011:709). The findings of the study have the potential to improve working conditions of CHWs and outreach services contributing to health promotion and the prevention of diseases in the community. The study will inform the DoH regarding the challenges CHWs are facing and improve their working

conditions. Currently, the PHC outreach services are guided by different provincial policies; this study might assist the national policy development regarding PHC outreach services. The study may further contribute to the body of nursing knowledge regarding PHC outreach services.

1.6 AIM

The aim of this study is to explore the perceptions of CHWs regarding PHC outreach services in Tshwane sub-district, to gain an understanding of how they execute their daily activities.

1.7 RESEARCH QUESTION(S)

A research question is the specific enquiry that needs to be conducted by the researcher with the aim of answering the research problem (Polit & Beck 2012:73). In this study, the research question is:

"What are the perceptions of CHWs regarding PHC outreach services in Tshwane sub-district?"

1.8 CONCEPT CLARIFICATION

1.8.1 Perception

A perception is the way in which a phenomenon is regarded, understood or interpreted (Bergin 1991:94). Perspective refers to viewpoints, or factual opinions based on points of view (Anderson, Bronskill, Mustard, Culyer, Alter & Manuel 2005:758). In this study, a perception is the way in which the CHWs view PHC outreach services in Tshwane sub-district.

1.8.2 Community health care worker

A community health care worker (CHW) is a person who is offering basic health care services in the community she/he resides in, who has completed 59 to 69 days of basic care training, and who works as a member of the ward-based PHC outreach team (Department of Health 2011:6-8). In

this study the CHWs are referred to as Ward-Based Community Health Care Workers who are responsible for household primary health care outreach services.

1.8.3 Primary health care outreach service

A primary health care outreach service is part of a series of strategies to strengthen primary health care to improve access and health outcomes by delivering health care to all communities at the household level (Department of Health 2011:6). In this study, PHC will mean preventative and promotive health care services that are rendered to the community at household level in a ward by Community Health Care Workers.

1.8.4 Ward-based PHC outreach team

The ward-based PHC outreach team is a designated team of health care workers which will provide services to communities, families and individuals at community-based institutions and at a household level (Department of Health 2011:6, 8). In this study the ward-based PHC outreach team means the team that is offering PHC services in Tshwane sub district in Gauteng Province. The ward-based PHC outreach team consists of specialist primary health care nurses, community health care workers, and environmental health and health promotion officers.

1.8.5 Ward

A ward is a political boundary that divides a community in urban, sub-urban areas and villages into regions for stratification purposes. In this study CHWs will be placed in households according to designated wards in the Tshwane sub-district Gauteng Province (Department of Health 2011:6).

1.9 RESEARCH DESIGN AND METHODOLOGY

Research methodology pertains to a detailed description of how research will be conducted, pertaining to the rules and procedures to be used when acquiring knowledge (Botma et al.

2010:136; Polit & Beck 2014: 385). A qualitative focused ethnography design was used in order to explore and describe the perspectives of CHWs regarding the PHC outreach service. The researcher used purposive sampling to select the participants. Ethnographic interviews were used by the researcher to obtain information from the participants. The researcher posed an open-ended question to participants so that they can share their views about the PHC outreach service. Thematic data analysis was used to analyse narrative data. See Chapter 2 for detailed research methods.

1.10 ETHICAL CONSIDERATIONS

Ethics is defined as a branch of philosophy that operates with certain principles and standards (Burns & Grove 2011:61). Ethics is further defined as 'the system or code of conduct and morals advocated by a particular individual or group' (Towsely-Cook & Young 2013:2). The researcher adhered to the following ethical considerations in this study:

1.10.1 PERMISSION TO CONDUCT THE STUDY

Permission to conduct the study was requested from the Ethics Committee of the University of Pretoria and Gauteng Department of Health (see Annexure D).

Permission was requested from the institution where research was conducted, which was the clinic where the participants work in Tshwane sub-district.

The following ethical principles: 1) beneficence (right to freedom from harm and protection from exploitation), 2) respect for human dignity (self-determination, right to full disclosure), and 3) justice (fair treatment and right to privacy) were adhered to (Polit & Beck 2012:152).

The researcher explained the purpose and extent of the study in the information leaflet to participants. Refer to Annexure C for the participation information leaflet and consent form Participants were given enough time and choice of whether to participate or not.

1.10.2 BENEFICENCE

1.10.2.1 Right to freedom from harm and discomfort

The researcher was obliged to prevent unnecessary harm or discomfort for the study participants in human studies (Polit & Beck 2012:152). In this study the researcher phrased questions carefully to avoid inflicting psychological harm on the participants. The participants were further assured that the researcher was prepared to terminate the interview in case the participants decided not to continue with the interview (Polit & Beck 2012:153).

1.10.2.2 Right to protection from exploitation

The study posed no danger of exploitation for the participants by maintaining privacy and the right not to be discriminated against according to class or categories (Creswell 2013:209). In this study, the participants' identity was protected by assigning them a code number. The participants were further assured that the information gathered during the interviews will not be used against them (Polit & Beck 2012:153).

1.10.2.3 Respect for human dignity

Human rights are 'claims and demands that have been justified in the eye of an individual or by a consensus of a group of individuals' (Burns & Grove 2011:189). The participants were given the right to make an informed voluntary decision to participate in or withdraw from the study (Polit & Beck 2012:154). In this study, all stated ethical principles and considerations were adhered to during the entire process of the study.

1.10.2.4 Right to self-determination

The right to self-determination implies that individuals have the right and competence to assess the given information, in order to come to a conclusion of accepting or rejecting the information given (De Vos et al. 2011:119). In this study the researcher informed the participants regarding the study objectives before they gave permission and signed the informed consent form. Furthermore, the

participants could withdraw from the study at any given time without any penalty (Polit & Beck 2012:154).

1.10.2.5 Right to full disclosure

Polit and Beck (2012:154) define the right to full disclosure as revealing information to participants regarding their rights and the benefits of the study. The nature of the study was fully described and explained to the participants. The participants were given an opportunity to decide whether to proceed with the study. In this study the participants' anonymity was respected by not disclosing their names during the study, and the clinic and community where the participants are working was kept anonymous.

1.10.3 JUSTICE

Justice is explained by Towsley-Cook and Young (2013:31) as a principle of fairness. This statement is supported by Polit and Beck (2012:155) who state that justice is viewed as a 'right to fair treatment and right to privacy'. In this study, the researcher made agreements with the participants regarding: appointment date, time, involvement of participants and the researcher during the study (Burns & Grove 2011:198).

1.10 4 INFORMED CONSENT

Consent is the permission or agreement to participate in a study after essential information is given to the participant and comprehension of the information by the participant (Burns & Grove 2011:201). The researcher provided information regarding: the aim of the study, the expected duration of the participants' involvement, data collection methods, the purpose of the study, the possible advantages and disadvantages of the study (De Vos et al. 2011:11).

The consent form for the participants was in accordance with common law and constitutional rights:

- *Privac*y was maintained by conducting the interviews in a private room at the clinic.

- *Self-determination and autonomy*. This was ensured through respect of the participants by informing them about the proposed study and allowing them to voluntarily participate. If they wanted to withdraw at any stage of the research this would not be used against them (Polit & Beck, 2012:173).
- *Confidentiality*. All the generated data was kept safe in a computer, and was only accessible to the researcher and supervisor. The researcher ensured that the recorded interviews did not contain personal identification information.

1.10.5 ORGANISATION OF THE STUDY

The study is structured as follows:

CHAPTER 1: **Orientation to the study**

This chapter provides an outline of the study where the background, purpose and objectives, research design and methodology, and a synopsis on ethical considerations are discussed.

CHAPTER 2: **Paradigmatic theoretical perspectives, research designs and methods**

The chapter provides a detailed description of the constructivist interpretive paradigm, while the focused ethnography design, conducting ethnographic interviews and measures of trustworthiness are discussed.

CHAPTER 3: **Data analysis and interpretation**

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

CHAPTER 4: **Discussions of the findings and literature control**

The chapter discusses the findings and support of such with relevant literature.

CHAPTER 5: **Conclusion, implications, recommendations and limitations**

The chapter provides a summary of the study in relation to research findings, implications, recommendations and study limitations.

1.11 SUMMARY

Chapter 1 provided an outline of the study. The paradigmatic and theoretical perspectives as well as the research methods will be discussed in Chapter 2.

CHAPTER 2

PARADIGMATIC THEORETICAL PERSPECTIVES AND RESEARCH METHODS

2.1 INTRODUCTION

Chapter 1 provided an overview of the study. This chapter will discuss paradigmatic and theoretical perspectives as well as the research methods that were used in this study.

2.2 RESEARCH PARADIGM

A research paradigm is a world view of reality influenced by an accepted set of beliefs or values that guides research (Polit & Beck 2014:385). Maree (2012:38) further states that a paradigm is a set of assumptions about basic aspects of reality which results in a world view. This study used a constructivist paradigm which originates in the phenomenology tradition, that recognises the impossibility of total objectivity; it appreciates the impediments of knowing reality with certainty, and therefore seeks probable evidence (Polit & Beck 2012:11-12).

The constructivist paradigm indicates that human beings construct meanings as they live in the world (Creswell 2007:16). During the collection of data, the researcher focused on various perspectives of the phenomenon given by participants in contrast to the single reality that positivists concentrate on (Babbie & Mouton 2014: 271). The researcher was able to listen to the various accounts that resulted in a deeper understanding of the entire phenomenon which was on the perceptions of CHWs regarding the PHC outreach service. The constructivist i paradigm will be further discussed under ontology, epistemology and methodological assumptions.

2.2.1 Ontology assumptions

Ontological assumptions are concerned with the nature and structure of reality (Denzin & Lincon 2011:103). Creswell (2007:16) further explains ontology as the stand that the researcher adopts towards the nature of reality which is influenced by the philosophical assumption/ paradigm that the researcher used.

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 (Creswell 2007:17). These 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). Constructivist research assumes that reality is socially constructed; hence there is no single observable reality as assumed by positivists (Merriam 2009:8).

2.2.2 Epistemology assumptions

The epistemological assumptions are concerned with the nature of knowledge (Denzin & Lincon 2011:103). A constructivist epistemology assumes that meaning is constructed rather than discovered as positivists assume (Boadu & Higginbottom in de Chesney 2015:145). Constructivists emphasise what is called subjectivist epistemology (Denzin & Lincoln 2011:13). In subjectivist knowing, some people may have the same interpretation of a certain situation while others may have a different interpretation of the same situation. All of this according to the constructivist researcher is considered as part of knowledge.

Constructivist epistemology emphasises that knowledge is regarded as the meanings of the participants' perceptions (Lincoln & Guba in Chesney 2015:145). In this regard, the daily activities that CHWs offer in the PHC outreach service can be interpreted differently by them. One of the advantages of the constructivist epistemology is the recognition of different views regarding the same phenomenon, and acknowledging multiple realities and multiple truths (Boadu & Higginbottom in de Chesney 2015:145).

The researcher made sense of reality by interacting with those being researched and findings were determined by such interaction (Polit & Beck 2012:495). In this regard the benefit of interacting with participants gave the researcher the opportunity to know and understand the CHWs' daily activities, working conditions and adversities better (Babbie & Mouton 2014: 271).

The researcher's focus was to understand the perceptions of CHWs regarding PHC outreach services (Creswell 2007:18). Focused ethnographies gather multiple forms of data for example: interviews of participants and review of documents (Higginbottom, Pillay & Boadau 2013:3) such as job descriptions. The multiple forms of data enabled the researcher to understand the meanings people constructed by comparing the findings with the information from the site documents (Merriam 2009:11). Likewise, in this study, the researcher conducted ethnographic interviews and reviewed site documents that the CHWs use in their daily activities.

2.2.3 Methodological assumptions

Methodological assumptions are about the rules and procedures that direct how the researcher must study the phenomenon of interest (Bothma, Greef, Mulaudzi & Wright 2010:41). Methodological assumptions are concerned with the how of 'science'. The focus in this study was on the perceptions of CHWs regarding their daily work, so the researcher used focused ethnography as a research design to understand how the CHWs perceive their daily activities and the ways in which they structure such an experience (Polit & Beck 2012:495). In focused ethnography, the researcher was part of the research process and determines the definition of what is to be studied, questions to be asked, how the questions are to be asked, and rules to be followed in interpreting the answers obtained (Knoblauch 2005:34).

2.3 QUALITATIVE RESEARCH APPROACH

Qualitative research refers to a systematic subjective approach used which emphasises an understanding of people's lived experiences and the meanings individuals or groups give to a social or human problem (Polit & Beck 2012:741). In addition, Burns and Grove (2011:545) suggest that the understanding of meanings in qualitative research could be achieved by the researcher's interaction with the participants. Qualitative design is influenced by a constructivist interpretivist paradigm that indicates that human beings construct meanings as they live in the

world (Creswell 2007:16). In this study, the qualitative research approach of choice was focused ethnography. Focused ethnography was chosen to explore and understand the meanings associated with the perceptions of CHWs towards the PHC outreach service.

2.3.1 RESEARCH DESIGN

Polit and Beck (2012:741) describe the design as a plan for addressing the research questions. Furthermore, in a research design the process and decisions made throughout the entire study are included: methodology, data collection and analysis and ensuring maintenance of trustworthiness.

2.3.1.1 FOCUSED ETHNOGRAPHY DESIGN

This study used focused ethnography as one of the types of ethnographic studies. Ethnography is a type of qualitative research design which is associated with the discipline of social anthropology (Roper & Shapira 200:170). The early ethnographers were interested in studying the whole community or the entire culture (Cruz & Higginbottom 2013:170). People like Spradley (1979) are one of the earlier ethnographers who emphasised that ethnography is the work of describing culture. In later years focused ethnography emerged from classical anthropological ethnography whereby researchers focused on a specific problem within the specific context such as culture among a small group of people (sub-culture) (Higginbottom, Pillay & Boadau 2013:3).

Focused ethnography has currently gained popularity in nursing research and health (Cruz & Higginbottom 2013:36). Focused ethnographic studies research design focus on the exploration of cultures and subcultures within a specific context whereby the specific knowledge about the identified problem or phenomenon is investigated (Higginbottom, Pillay & Boadau 2013:3; Cruz & Higginbottom 2013:36). One of the strengths of focused ethnography is that it can elicit rich information within a specific context from a small group of people within a short space of time (Knoblauch 2005:8). This strength makes the research approach suitable for studying sub-cultural perspectives related to health care issues that will inform the policy for improvement (Higginbottom, Pillay & Boadau 2013:3). Focused ethnographic studies have proven to be effective in health care research in hospitals, communities and at primary level (Knoblauch 2005:8). Furthermore, effectiveness is accomplished by reaching health related decisions timeously within a short period rather than using traditional ethnography (Higginbottom, Pillay & Boadau 2013:3).

Observations are considered to be the signature of ethnographic designs, however, Higginbottom and Liamputtong (2015:170) state that it is not always necessary to do that. Focused ethnography in this study has been selected based on the following characteristics: (see Figure 2 for the characteristics of focused ethnography as outlined by Higginbottom, Pillay & Boadau 2013:4; Cruz & Higginbottom 2013:38):

- The target population have shared characteristics: CHWs share common experiences and perceptions regarding the PHC outreach service
- The researcher focused on the specific context: this is the PHC outreach service which is regarded as a sub-culture within the health system culture
- Limited number of participants: seventeen participants were interviewed until data saturation was reached
- A tape recorder and transcribed notes were used.
- Participants' knowledge is usually specific: the participants were knowledgeable regarding the PHC outreach service
- Used for development of health care service: the findings of the study aim to inform practice at the local level by way of feedback and to inform policy regarding CHWs' perception towards the PHC outreach service, that may contribute to the improvement of the service
- The role of the researcher in focused ethnography acted as a research instrument: who should eliminate personal biases and preconceptions prior to the study

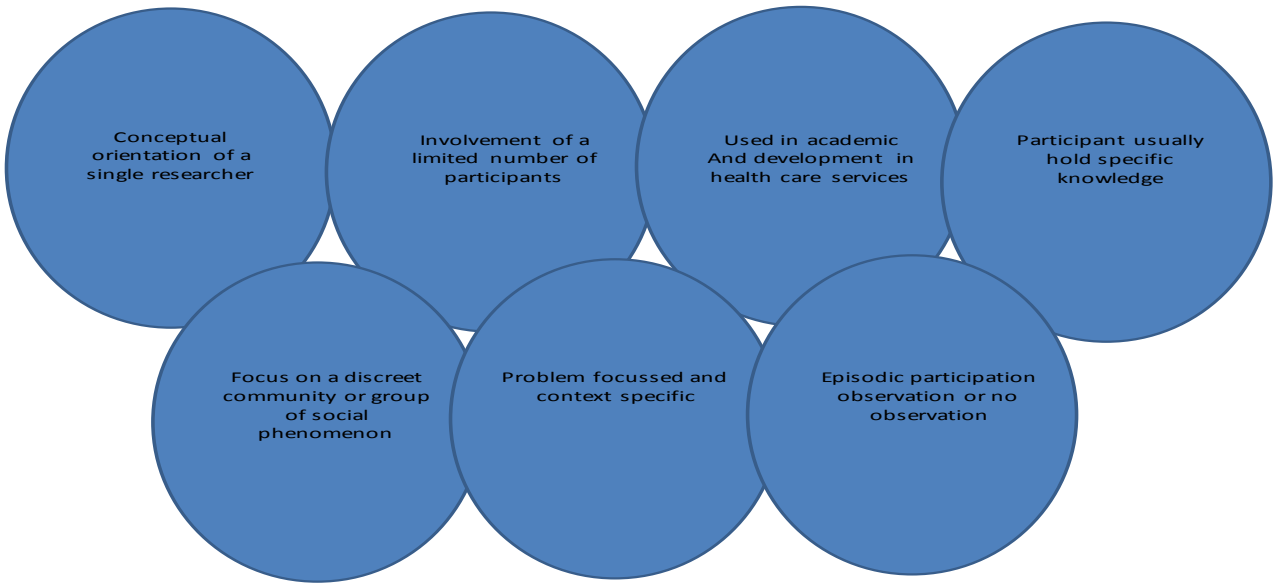

Figure 2. Characteristics of focused ethnography (Cruz & Higginbottom 2013:38).

2.4 RESEARCH METHODOLOGY

Research methodology pertains to a detailed description of how research will be conducted, pertaining to the rules and procedures to be used when acquiring knowledge (Botma et al 2010:136). Furthermore, Cresswell in de Chesnay (2015:147) describes the methodology as a strategy or plan of action in the process to address the research objectives and aims.

2.4.1 Population

The population is all elements that meet criteria for inclusion in the study in which the researcher is interested in (Burns & Grove 2011:703). The target population is the entire set of individuals who meet the inclusion criteria. In this study the target population was the CHWs rendering PHC outreach services in Tshwane sub-district in Gauteng Province. The researcher gained access to the population through negotiating with the PHC outreach team leader (Higginbottom. & Liamputtong 2015 in de Chesnay 2015:152). Population is the entire aggregation of cases in which a researcher is interested (Burns & Grove 2011:703). Accessible population is the aggregate of cases that conform to designated criteria (Burns & Grove 2011:703). In this study, the population involved two hundred and forty-four community health care workers working in thirteen clinics in Tshwane sub-district clinics

2.4.2 Sample

Sample is defined as a subset of the population that is selected for the study (Burns & Grove 2011:291; Polit & Beck 2014:391). The process of selecting subjects to be studied is referred as sampling. Non-probability sampling method was used to select the participants whereby the researcher could not estimate the number of participants to be included in the study. In this study the participants were purposely selected depending on the knowledge of the researcher regarding the participants experiences or perceptions of the phenomenon under study.

2.4.3 Purposive sampling

Purposive sampling is referred as judgemental sampling whereby the researcher selects the participants who can give most of the best information about the topic (Botma et al, 2010:199). The

sample was not selected randomly like in quantitative studies. In this study the participants were chosen according to the features of interest or possess knowledge or experience for a study. (Botma et al, 2010:199). Participants who met the criteria of the study volunteered to be included in the study (De Vos et al 2011: 344) This study used purposive sampling as is common practice in ethnographic studies in which criteria are based on the participants belonging to the sub-culture being investigated (Cruz & Higginbottom 2013:38; Burns & Grove 2007:344). In purposive sampling, the researcher identifies participants who have knowledge that may address the aim and objective of the study to be part of the study (Botma et al. 2010:201). In ethnographic research key informants are utilised to assist in gaining access to the population. The researcher was assisted by the PHC outreach team leader to gain access to CHWs (Higginbottom in de Chesnay 2015:152). The sample in this study was selected from the entire CHWs who are rendering PHC outreach in Tshwane sub district in Gauteng Province.

2.4.4 The sample size

The sample size is the portion of the population that is used to obtain the information during the study (Polit & Beck 2014:391). In purposive sampling /ethnographic studies the sample size is determined by the quality of data and saturation. Saturation of data is reached when there is no new relevant information that emerges from the information given by the participants. The number of participants is not often predetermined as data saturation indicates the sample size (Higginbottom, Pillay & Boadau 2013:4; Cruz & Higginbottom 2013:38). In this study the researcher obtained rich data from seventeen CHWs. Interviews were conducted until data saturation.

2.4.5 Information sharing

The researcher provided information on the study to CHWs regarding the purpose and benefits of the research through a research briefing meeting before the commencement of the study. The meeting was held at the place where the participants report every day before going to their assigned households. Issues of confidentiality, anonymity and feedback as part of the ethical measures were also outlined during the session. The researcher indicated to the potential participants that she would be using a tape recorder during data gathering. Most importantly, in every individual interview the researcher was reiterating the above-mentioned information, throughout the duration of the study.

2.4.6 Context of the Study Setting

Context is a physical location and the conditions in which data collection takes place in the study (Polit & Beck 2012:745). There are three hundred and twenty (320) CHWs working in communities in clinics in the sub-district. One designated clinic was chosen for this study under which thirty-one (31) CHWs are affiliated, and seventeen of these CHWs were recruited. The findings will be used to inform the policy and feedback given to the local health facilities for improvement and development of the PHC outreach services (Boadau & Higginbottom in de-Chesnay 2015:147).

The study was conducted in Tshwane sub-district, Gauteng province. Tshwane district is demarcated into sub-districts according to the district health systems in the Gauteng Department of Health. One sub-district was selected for the study. This sub-district is demarcated in wards, some are rural and others peri urban. These wards are allocated a team offering PHC outreach services including CHWs. Community health care workers are allocated each two hundred and fifty (250) households according to the geographic area they live in .

2.4.7 Inclusion criteria

Inclusion criteria are the specific characteristics that the participants should possess to be part of the target population (Grove et al. 2013: 353). In this study the following inclusion criteria were used. Community health care workers:

- Rendering PHC outreach services in a selected clinic in Tshwane sub-district,
- Who have undergone PHC outreach programme training for 56-69 days;
- With one year or more experience working in the programme;
- Who consented to take part in the study.

2.4.8 Exclusion criteria

Exclusion criteria refer to characteristics that the person does not possess to qualify to be included in the study. (Grove et al. 2013: 353). In this study the following exclusion criteria were used: Community health care workers:

- Not rendering PHC outreach service in one of the communities in Tshwane sub-district,

- Who did not undergo PHC outreach programme training for 56-69 days;
- With less than one year working in the programme;
- Who did not consent to take part in the study.

2.4.9 Access to participants

Access to participants in research is defined as obtaining permission from individuals to conduct a study (Creswell 2007:9). In this regard, the researcher requested permission to gain access to CHWs through the PHC outreach Chief Executive Officer of Tshwane sub-district, and the facility operational managers. Permission was further requested from the team leader of the PHC outreach teams. The team leader was the one who provided the 'hands-on' permission to contact CHWs who fell under her line of work. The researcher held a briefing meeting with the CHWs at the place where they reported every day. This meeting provided the researcher with an opportunity to explain the purpose and benefits of the study to CHWs. Community health care workers who were interested after the meeting provided their contact details to the researcher for her to set up appointments with them (Burns & Grove 2011: 84).

2.5 DATA COLLECTION PROCESS

Data collection is explained as a precise and systematic gathering of information to seek to understand and explore the research problem (Botma et al. 2010:131). In addition, data collection involves activities directed towards answering the research question (Polit & Beck 2012:537). In ethnographic research data collection is done through social interaction during interviews (Maree 2013:5). In this study, the researcher used two phases to collect data: Phase 1: Ethnographic interviews were conducted with the participants, and in Phase 2: relevant site documents were reviewed. An audio tape recorder was used to support the data collection process.

2.5.1 PHASE 1: ETHNOGRAPHIC INTERVIEWS

Ethnographic interviews are described as a series of friendly conversations through which the researcher introduces new issues as they emerge in the conversation in order to assist the informants to respond as the reservoirs of knowledge (Spradley 1993:464). Accordingly, the ethnographic interviews have three main elements: explicit purpose, ethnographic explanations, and ethnographic questions (Spradley 1993:464). The core of ethnographic interviews is to have

an insight into how the participants execute their daily activities as part of their lives (de Vos et al. 2011:348). In some cases, an ethnographic interview might be combined with observations and one-on-one interviews (Robbins in de Chesnay 2015:239). Ethnographic interviews involve a mixture of descriptive and structural questions. In a descriptive question a broad question is asked and in this regard the question was: *What are your perceptions as a community health care worker regarding primary health care outreach services that you render*? Through the descriptive question the researcher encouraged the participants to describe what they do on daily basis as part of their work.

Subsequently, structural questions in ethnographic interviews are more specific and they explore the responses to the descriptive questions (Robbins in de Chesnay 2015:239). The structural questions allowed the researcher to find out from the participants how they organised the knowledge they had regarding the household primary health care outreach services they are providing. In normal qualitative interviews the structural questions are considered to be the probes that are used for clarity, details and examples to obtain an in-depth description of data. (Babbie & Mouton 2001:289). Some of the structural questions in this regard were: *How and where were you trained as a CHW? What guides your daily work as a CHW?*

2.5.1.1 Conducting the interviews

The researcher conducted face to face interview to CHWs in the designated facility in Tshwane sub-district. The interviews were conducted in a private room that was used as an office. Both verbal and written consent were obtained from the participants (Polit & Beck 2012:159) before the commencement of the interviews. The researcher requested permission from the participants to use a voice recorder for data gathering. The interviews were recorded for data analysis and quality control purposes (Cruz & Higginbottom 2013:380). The researcher initiated conversation by asking the descriptive question which was: “What are your perceptions as a community health care worker regarding PHC outreach services in Tshwane sub-district?” (de Vos et al 2011:349). The interview was interactive, as structural questions followed the descriptive question. These were for clarity and to provide details in the pursuit of in-depth description (Babbie & Mouton 2001:289). The participants were keen to provide detailed information regarding their perceptions towards PHC outreach services.

The researcher documented her field notes and kept a reflective journal throughout the research process (Cruz & Higginbottom 2013:38). Every procedure was explained to the participants to allay anxiety and to gain cooperation. The researcher wrote notes of what was going on during the whole process: comments, gestures, emotions (de Vos et al 2011:359). In research, field notes are important to document the accurate practical details of what the researcher saw, heard and thought has happened during the interview (Babbie in de Vos et al 2011:359). The interviews took twenty-five to forty-five minutes. Effective communication techniques were applied during the interview process. The researcher commenced the interview by establishing rapport with participants including reminding the CHWs that the English language will be used, and to allay anxiety participants were assured that English is not our first language but will be used to the maximum of our capabilities, the researcher was not going to judge them according to the way they would be speaking the language. The researcher used positive body language by maintaining eye contact, active listening, depicting empathy and concern throughout the interview. In addition, the participants were encouraged to elaborate further on any statement made and paraphrasing was used by the researcher to obtain a common understanding of what the participants were saying.

2.5.2 Phase 2: Review of relevant documents on site

The researcher reviewed site documents relevant to the work of community health care workers. The documents provided clarity on what the CHWs are mandated to do when offering PHC outreach services. The documents reviewed were: the household registration form, maternal and child health record, individual adult health record, referral form as well as the job description of the CHWs.

The *household registration form* is used to document all the information about all the household members. The form indicates the number of people in the house, their employment status as well as the learners. The form provides a section where the household members are screened for communicable diseases such as TB and HIV, the use of family planning methods, and pregnancy.

*Maternal and child health record***:** This form is used for antenatal care, postnatal cases and the care of children under five. The form is for recording the health promotion activities, delivery plan and danger signs during pregnancy, feeding, counselling, family planning, checking of the road to

health book, health and growth screening tests, home-based treatment given and support, and counselling and referral.

Individual adult health record: This form is used for the capturing of care given during visits regarding the screening conducted, health status and monitoring, health promotion, treatment adherence and support given.

Referral form: The form is used to refer all household members for related health and social problems including immunisation and the PCR test for infants. The same referral form is used for feedback to refer patients back to the PHC outreach team.

Job description: The daily activities that are to be performed by the CHWs are outlined in the job description.

All these documents were from the Department of Health and created to be used by the CHWs when offering household health services.

2.6 MEASURES OF TRUSTWORTHINESS

Trustworthiness in research is the extent of trust that the researcher has in the data, based on the assessment conducted through the criteria of credibility, dependability, conformability and authenticity (Polit & Beck 2012:745) as well as reflexivity.

2.6.1 Reflexivity

As this study was an ethnographic study, 'reflexivity underscores other trustworthiness criteria. Reflexivity is described as a researcher's continuous process of reflecting on how his or her personal behaviour, values or interaction with participants can affect the interpretation of participants' responses' (Doyle 2013 in Higginbottom 2015:159). The researcher is a clinical

facilitator at a selected Higher Nursing Education Institution in the area. On a daily basis the researcher accompanies students for service learning in various clinics in the sub-district. From the clinical accompaniment the researcher developed an interest in the PHC outreach programme. Most importantly, the researcher noted with concern that the working conditions of CHWs were not up to standard. This prompted a need to explore this. During the study researcher continued with personal scrutiny and internal dialogue in order to avoid personal bias when coming to know about the working conditions of the CHWs. Continuously the researcher was compiling *a reflective journal and field notes* (Doyle 2013 in Higginbottom 2015:159) where she was revealing her feelings about the study. Furthermore, the researcher was having debriefing meetings with the supervisory team on what was happening in the field.

2.6.2 Credibility

Credibility refers to the faith that can be put in the researcher as a data collection instrument, based on qualifications, experience and training (Polit & Beck 2012:585; Creswell 2014:2013). In addition, it ‘‘refers to the confidence in the truth value of data and interpretation’’ (Polit & Beck 2014:323).

Credibility was achieved through the following criteria:

- *Prolonged engagement:* The researcher stayed in the field for sufficient time. The interview process took twenty-five to forty-five minutes per participant so as to develop an in-depth understanding of the phenomenon.
- *Triangulation:* Unstructured interviews and review of relevant site documents were used to collect data.
- *Peer debriefing*: Colleagues who have an understanding of the nature of the study were invited to review the study in regard to perceptions, insights and analyses. The peer debriefing contributed to the researcher’s honesty.
- *Member checks*: The researcher went back to participants to confirm the data collected and interpretation for the participants’ input. The taped interviews were played back to the participants for comments. A member check was performed to ensure accuracy in the interpretation of data.

2.6.3 Dependability

Lincoln and Guba's (in Polit & Beck 2012:585) framework refers to dependability as reliability of data over time and over conditions. The findings of the study will be consistent if an independent researcher replicates the study with the same participants and in a similar context to meet the dependability criteria (Polit & Beck 2012:585). Dependability was ensured by the following:

- *Peer debriefing*: Colleagues who have an understanding of the nature of the study were invited to review the study in regard to perceptions, insights and analyses.
- *Member checks:* The researcher conducted a follow up with participants to confirm the data collected and interpreted.

2.6.4 Confirmability

Confirmability is defined as the degree to which the findings are the creation of the focal point of the study, not of the biases of the researcher (Babbie & Mouton 2014:278; Polit & Beck 2014:323; Knoblauch 2005:3). In this study confirmability was achieved by:

- *Confirmability audit*: copies of the interview transcripts, field notes and protocols were send to an independent objective auditor. The auditor had expertise and qualifications in nursing and qualitative research. The results of the study reflected the responses and perceptions that the participants revealed during the interview. The interviews were recorded with the permission of the participants. The researcher transcribed the verbatim data, and later analysed and coded the data. The researcher ensured that feedback was given to participants regarding emerging interpretations and participant reactions were obtained (Knoblauch 2005:3).

2.6.5 Transferability

Transferability refers to external validity, which is defined as the degree to which the results of the study may be applied in another context or with other participants or groups (Babbie & Mouton 2014:277). The aim of the study was to understand the perceptions of CHWs regarding the PHC outreach service to improve service delivery. In this study transferability was achieved by:

- *Purposive sample*: Participants had to meet certain criteria, such as working for a year or more and having undergone the required training.

- *Thick description:* A detailed description of data was collected until saturation was reached to allow for judgement in specific settings.

2.6.6 Authenticity

Authenticity is explained by Polit and Beck (2014: 323) as the degree to which the researcher truthfully and justly displays various ranges of reality. In this study, the researcher wrote reports of interviews and observations in a manner that portrays the real perceptions of participants.

2.7 SUMMARY

Chapter 2 discussed the paradigmatic, theoretical perspectives and the research methods that were used in this study. The chapter started with explaining the constructivist interpretivist paradigm that underpinned the study. A focused ethnographic design guided the research method and the process. The next chapter will discuss data analysis and the interpretation thereof.

CHAPTER 3

DATA ANALYSIS AND INTERPRETATION

3.1 INTRODUCTION

The previous chapter discussed the paradigmatic and theoretical perspectives as well as the research methods that were used in this study. This chapter will discuss the analysis and interpretation of the data together with a discussion of the main themes and sub-themes emerging in relation to the quotes from the participants as well as the excerpts from the reviewed site documents. The themes, sub-themes and codes reflect the perceptions of community health care workers regarding the PHC outreach service in Tshwane sub-district.

3.2 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 that involve the grouping together of narrative information and making sense of the data. The steps serve as guidelines (De Vos et al. 2011:336). In this study, the researcher used Braun and Clark's (2006) six phases of thematic analysis:

1. *Familiarisation with the data:*

   The researcher familiarised herself with the collected data by listening to audiotapes of the interview process. Further reading, revising and internalising the data from audiotape and the reviewed documents led to transcribing of the audiotapes word for word. This process of transcription is called verbatim transcription. One transcribed interview was 7–8 pages of data. The transcribed interviews were then arranged to note the words /concepts that came up frequently. The words/concepts that emerged repeatedly were listed as: household activities, personal development, acknowledgement, further training, recognition, benefits, working conditions, and challenges.

2. *Coding, to establish patterns and labels:*

   The researcher coded the data to establish patterns and labels for important characters of data. Coding was also used as an analysis process as it captures the semantic and conceptual meaning of the data. All transcripts were printed as

   hard copies and then the researcher read through the data to identify sentences that were similar in meaning and appearing more often than others. The common sentences were identified as patterns and highlighted with different colours. The pattern that was listed first was household activities, which was highlighted in green. Personal development was highlighted in a peach colour and working conditions in red. In addition to attaching meanings and ideas to the coded data, the researcher developed sub-themes. The sub-themes generated from the codes were: household activities for children under five, household activities for adults, identification of social problems, lack of resources, poor relationship with clinic staff members, appreciation of the PHC outreach services, reduction of waiting periods at the clinic, permanent employment, remuneration and career development

3. *Searching for themes:*

   Classic ethnographers like Spradley and Aronson argue that in searching for themes, the researcher combines all the coded data into a catalogue of related patterns and sub-themes. In this step, all data related to the already classified patterns were grouped together. From the sub-themes, themes were identified by 'linking' components or fragments of ideas in a meaningful way (Aronson 1992:2; Spradley 1979:100).

4. *Reviewing themes:*

   The researcher confirmed whether the themes identified could make sense in relation to the coded extracts. This step aimed to identify if each theme was relevant to each other and to the full data.

5. *Defining and naming themes*:

   In defining and naming themes Aronson states that the identified themes should be compared to the literature for verification purposes. In step five the researcher had to reflect on whether the themes were telling a corresponding story about the perceptions of community health care workers regarding PHC outreach services by comparing these with the literature (Aronson 1992:2).

6. *Writing up*:

   Ethnographic studies demand a thick description of the phenomenon through the last step. The writing process is an integral part of the analytic process. The researcher provided a thick description of perceptions of CHWs towards PHC outreach services, through condensing the data extracts to inform the reader. The researcher provided a coherent and persuasive story about the phenomenon.

3.3 DATA GENERATION PROCESS

TYPE	FORMAT	TOTAL
Individual Interviews	**Audios**	17
Site Documents	**Text:**	
	-Household Registration form	1
	-Community Health Worker Household Visit Tick Sheet	1
	Individual Adult Health Record.	1
	-Community Health Worker's Job Description.	1
	-Department of Health Provincial Guidelines for the Implementation of the three streams of PHC re- engineering.	1
	-Annexure A of National Health Insurance Policy on an ideal Clinic realization and Maintenance the Primary Health Care Package	

The data generation processes yielded seventeen audios from the interviews with the community healthcare workers' perceptions on regarding PHC Outreach services in the Tshwane Sub-district, Gauteng Province Five main site documents were reviewed as : Household Registration for Community Health Worker, Household Visit Tick Sheet, Individual Adult Health Record, Community Health Worker's Job Description Annexure IV, Department of Health Provincial Guidelines for the Implementation of the three streams of PHC re- engineering and ANNEXURE A National Health Insurance on an Ideal Clinic Realization and Maintenance of the Primary Health Care Package.

3.3.1 DEMOGRAPHIC DATA OF PARTICIPANTS

		NUMBER OF PARTICIPANTS
Gender	Male	3
	Female	14
Age	20-30	5
	>30	12
Highest Grade Passed	< Grade 12	6
	Grade 12	11
Years of experience	< 5	0
	5-10	17

3.4 FRAMEWORK OF THEMES AND SUB-THEMES

The following table highlights the themes and sub- themes identified during the data analysis. The themes identified are: household activities performed by CHWs, working conditions of CHWs, benefits to the community, and acknowledgement by the Department of Health. There are also sub-themes that emerged from the themes.

TABLE 3.4.1 SUMMARY OF THEMES AND SUB-THEMES

THEMES	SUB-THEMES
Theme 1: Household activities performed by community health care workers	• Household activities for children under five • Household activities for adults • Identification of social problems and economic problems
Theme 2: Working conditions for CHWs	• Lack of resources • Poor relationship with clinic staff members
Theme 3: Benefits to the community	• Appreciation of the PHC outreach services • Reduction of waiting periods at the clinic
Theme 4: Recognition by the Department of Health	• Permanent employment • Remuneration • Need for career development

3.5 FINDINGS

The above table describes the identified themes, sub themes and quotes from the analysed data. The researcher identified four main themes and nine sub-themes on the perceptions of CHWs regarding the PHC outreach services in Tshwane sub-district. These themes and sub-themes will be discussed below.

3.5.1 THEME 1: HOUSEHOLD ACTIVITIES PERFORMED BY COMMUNITY HEALTH CARE WORKERS

Household activities performed by community health care workers emerged as the first theme. The following sub-themes were identified: household activities for children under five, household activities for adults, and identification of social problems.

- **Sub-theme 1: Household activities for children under five**

The household activities for children under five are tasks that are geared for preventative promotive health care services for children. These tasks are performed by CHWs at household level during the household visits.

This household activities are stated in the Provincial Health Department document on the Health Provincial Guidelines for the Implementation of the Three streams of PHC re-engineering which is the **job description of the CHWs which outlines key performance areas such as:**

"*-Provide information, education & support for healthy behaviours and appropriate home care.*

-Carry out a Community Assessment

-Conduct household assessments & identify those at risk and high risk

-Identify and manage minor health problems

-Support screening and other programmes

-Support continuum of care"

The activities supporting the KPA are outlined as:

-"Support immunisation, vitamin A and de-worming campaigns

-Identify households with children under 5 and women of reproductive age

-Assess need for and facilitate access to key preventive and care services: early ANC, immunisation, growth and development, HIV screening and care in pregnancy and childhood"

The following view was expressed:

"If I find children under five years I used to ask for the card to check for vaccination they go to the clinic properly neh, they don't short [not up to date] of this immunisation, if they are short I refer them to the clinic. We normally have in our kit vitamin A and deworming, if they are short [not up to date] we give vitamin A and deworming. We check after six months,

then we give it to them, we [even] encourage the mother. On that card I will also check if the child is HIV positive or maybe the mother." [P 9]

Another participant said:

"We are also trace [tracing] malnutrition [malnourished] children whereby we can be able to assess [by] looking at them whether the child is malnutritious [malnourished] or normal. We also have tapes to measure the child's arm [MUAC, or mid upper arm circumference]. We have tapes whereby we can measure the children's arms to see [assess]. We are looking for a child who has been taken to clinic for Immunisation. We check at the card (coughing) if the check-up is (coughing) ok or not. If the child has never been taken to immunisation, we write a referral letter so that the child can be taken to the clinic. If it concerns vitamin A and deworming we give." [P 2].

Another participant said:

"We also trace the children defaulters for PCR [polymerase chain reaction], they give us names at the baby clinic so that we can trace the PCR children they also train us how to prevent PMTCT [prevention of mother to child transmission of HIV]." [P 1]

In addition, one participant added:

"Maybe the mother does not know how to clean the umbilical cord of the child, we do help with that, we do it for her, show her, next time she can do it herself." [P 6]

CHWs, when visiting the assigned household, CHWs are required to check the health card of all the children who are under five years of age. This is to determine if the child is fully immunised, has received their vitamin A and deworming and is up to date. The important activity which CHWs are supposed to be cognisant of is to determine the HIV status of the child, monitor the polymerase chain reaction (PCR) blood test, and determine if the child is not defaulting. In addition, CHWs perform health promotion by educating mothers on topics such as: prevention and treatment of diarrhoea, good nutrition, exclusive breastfeeding, and the prevention of mother to child HIV transmission. If it is found that immunisation, vitamin A, or deworming is not up to date, the CHWs provide an on the spot service, or refer the child to the clinic for immunisation.

- **Sub-theme 2: Household activities for adults**

Household activities for adults emerged as the second sub-theme. The activities performed by CHWs during assessment amongst others are aimed at screening for communicable and non-communicable diseases as well as preventative and promotive care to household members.

Individual Adult Health Records that are used indicate various categories of Care Codes the CHWs are to assess and refer if need be: This document indicates Individual record of care that the CHWs are to provide when visiting households on daily basis. The document outline*: Date*, *time of visit, health screen conducted, health status monitoring, adherence support the care and intervention that the CHW provided and most importantly if the patient requires referral*. As a monitoring mechanism this document provide *for patient signature as well as the team leader's signature.*

This household activities are stated in the Provincial Health Department document on the Health Provincial Guidelines for the Implementation of the Three streams of PHC re-engineering which is the **job description of the CHWs which outlines key performance areas for adult activities such as:**

"*-Promote voluntary counselling and testing for HIV*

-Distribute condoms

-Advise on TB infection control in the home

-Provide information on risk factors for chronic diseases

-Provide information and motivational interviewing on substance abuse

-Provide information on prevention of injuries in homes and Antenatal and postnatal care for women

These activities were confirmed by one participant who said:

"If I find someone with signs and symptoms of TB, I have to take [collect] sputum. The sputum taken [collected] is taken to the clinic, then the patient will be given the date to go to the clinic for the results if not seriously ill". [P.6]

"Some of the community members especially [with] some of the things they are not aware [of], if you teach them of some of the things, if you go to household you advise them to eat healthy or must they take their medications as the doctor prescribed. I think it is good. If you visit the family often, if a person was about to give up in taking their medicines, if you encourage the person [will] end up taking medications and they become healthy". [P 4]

And:

"We ask questions [such as] if you are sweating at night like the symptoms sweating or losing weight, if there is someone having the symptoms [of TB] we have to write a referral form [to the clinic]. And sometimes if we have material to collect the sputum and bring them to the clinic. If there is someone coughing we collect the sputum." [P 3]

In addition to the activities another participant stated that:

"I check the card first to see the TCB [return date]. And if maybe the TCB [return date] is for 3 months, I check if they are drinking normally [taking medication as prescribed]. If maybe she or he have more tablets I have to know how because normally they give for 3 months, some they don't know how to drink, maybe they are taking overdose, I have to teach them how they should adhere [to medication]." [P 9]

Participants mentioned that pregnant women are screened and they monitor their clinic visits:

"We teach – like people don't know if you don't get your periods you might be pregnant. We explain that even if you are preventing [on contraceptives] you may still be pregnant. They appreciate because sometimes they just sit at home and something bad happen and we teach the pregnant women to go to their homes until they give birth, after that we monitor them with the new-born." [P 3]

And:

"*If someone is pregnant we are going to make sure that she does not skip the clinic there is first visit, second visit. We write the other form which is called tick sheet for appointment for that person and maternal [form]. After you came we record all visits, first and second, after*

giving birth we check if the mother and the child are going to the clinic, also the umbilical cord is taken care [of].'' [P 17]

And:

"When you find someone who is pregnant, you refer them to go to the clinic and book at least they get tested for HIV then they know their status earlier, they prevent transmitting the disease to the baby." [P 18]

One participant added by stating:

"We also do follow ups of the PNC just immediately after delivery, within 24 hours. Iif delivery is today, I have to go to the households the following day. I ask the mother if she is still bleeding, how painful is her vagina [from an episiotomy] or operation [and] I also teach on how to care for the baby." [P 6]

And

"If I find out there is someone who is bedridden, I bath her, make food for her if staying alone, if living with the family I will [be] educating the family how to take care of the patients. If staying alone, I will give care." [P 17]

The CHWs perform activities such as assessment and screening of all adults in the household. The assessment and screening and other activities include the following: 1) communicable diseases such as HIV and AIDS and tuberculosis; 2) non-communicable diseases such as hypertension, diabetes, cardiovascular diseases and problems with bedridden patients; 3) supplying of chronic medication to elderly members of the family; 4) health promotion; 5) monitoring compliance with medication; 6) screening for pregnancy and antenatal care by monitoring clinic attendance and referrals to clinics; 7) post-natal care to mothers and monitoring clinic attendance and referrals; and 8) rendering basic nursing care to bedridden patients.

- **Sub-theme 3: Identification of social problems and economic problems**

Identification and screening of social problems emerged as the third sub-theme. During household visits CHWs come across social problems.

Annexure A of National Health Insurance Policy on an ideal Clinic realization and Maintenance the Primary Health Care Package outlines the referral process that CHWs are to follow when referring the patients for further management: In most cases the families are referred for social and health problems as indicated in this **excerpt.** In the referral pathway that quality care should be of an accepted standard. "*The Municipal Ward Based PHC Outreach Teams, through the **referral process**, will enable community members, especially vulnerable populations within communities, to access formal healthcare services, community-based services and social agencies as part of their daily activities*."

Identification of social and economic problems are highlighted in the Provincial Health Department document on the Health Provincial Guidelines for the Implementation of the Three streams of PHC re-engineering which is the **job description of the CHWs which outlines key performance areas such as:**

> "*-Conduct household assessments & identify those at risk and high risk*
> *-Conduct structured household visits*
> *-Assess biographical profile of household Information on health status.*
> *-Level of health and social risk facing households and individuals.*
> *-Need for services ease of access to health and social services.*
> *-Identify vulnerable households."*

Some of these social and economic problems were confirmed by participants who said:

> "*When I assess the household and I can see that there is a problem here, I have to come back to the clinic to talk to my leader and talk to them to go to the social worker, maybe social worker can do something – maybe there is no food, not enough house to stay [poor housing*]." [P 9]

In addition, one participant reiterated:

> *"We have helped many people in applying for social grant, foster care grant and also for those who do not have IDs [identity documents], those applying for foster grant those who don't have IDs.*" [P 2]

One participant added:

> *"There are some household who don't have electricity for basic needs like electricity in case they need refrigerator, so that they can store the medication. There are some people who have been diagnosed with diabetes, [they] can store their medications in the refrigerator. [In addition, there are] challenges of not having toilets with running water, if no toilet we take it as a complaint, we address it to our leader and refer the problem to the environmental affairs. We work it out so as the household to have proper sanitation."* [P 8]

And:

> "*Sometimes we find social problems. Maybe there are orphans, they don't know how to register for foster grant. I will tell someone older to go and register to the social services or whoever*". [P 17]

And:

> "*Like maybe there is no one working, if there is no one working I refer them to the social services.*" [P 11]

The screening process that CHWs perform is not only a physical assessment, whereby a health inspection and history from household members is collected, it also entails mental, social and economic factors that influence the household members and their health status. The most common social problems that are identified during screening of households amongst others are: poverty, not being in possession of identity documents to access social grants, and factors that expose people to malnutrition and diseases. These social problems in most instances emanate from poverty. The interventions from the screening process include referrals to various stakeholders such as social services, Home Affairs, Environmental Affairs, etc.

3.5.2 THEME 2: WORKING CONDITIONS FOR CHWS

Working conditions of CHWs emerged as the second theme. The following sub-themes were identified: lack of resources, and poor relationships with clinic staff members.

- **Sub-theme 2: Lack of resources**

Challenges regarding resources emerged as the first sub-theme under working conditions. Lack of and insufficient resources pose a challenge in the provision of services. The lack of resources was affirmed by participants:

> "*Baumanometer, that we are using they are not working most of them won't read the BP. It's difficult, we need [it] because we need to take medication to the patient." [P 2]*

In addition, one participant felt that:

> *"Even at higher authority they know especially issue of lack of space, we tell task team that we don't have space, sometimes you need to write standing when you are given lectures [attending in service training], it's difficult to write." [P 17]*

And:

> "*We are walking in the sun for a very long day [due to lack of transport], we are telling people to stay away from the sun but we are doing it." [P 6]*

Community health care workers are expected to provide effective primary care in households. However, their effectiveness relies on the resources available. Participants indicated that they walk long distance, sometimes in the sun, to households, which poses a challenge. Walking to households in harsh weather makes working conditions unfavourable to CHWs. The resources used by CHWs also determine the effectiveness of the service. If equipment like baumanometers are not in good working order, they will give the wrong readings, and this is detrimental to the community that they are attempting to assist. The challenge of resources hampers the service as they have to share the equipment they have. Furthermore, they are supposed to measure blood pressure before issuing medication to clients.

- **Sub-theme 2: Poor relationships with clinic staff members**

Poor relationships with clinic staff members emerged as the second sub-theme under working conditions. The poor relationship with staff members was described by participants:

> *"Sometimes it's not good we feel like even the clinic they don't treat us well. Let us say today I have to deliver medication and I have to wait on the queue just like other patient to get the file before I can go to collect medications. They will treat you like you are nobody because you are CHW, sometimes you feel like you are nobody (sad)."* [P 4].

And:

> "*That is why I told you some of the community they don't take us serious because sometimes the sister will shout [at] us in front in front of the patient. Especially at the filling room if you can take the file they will shout you and say (showing with hands) no no you must be on the row (eish!) [exclamation], they don't treat us well (sad face and frustration)."* [P 11]

The poor relationship was further attested to:

> *"Because we deliver medication for the elderly at home, maybe for example today is the date for [issuing chronic medication] then I will go to the filling room, issue them the number of the patient, the file number. Because sisters are not the same they differ in their ranks, I have to find the professional nurse who can prescribe medication for the patient. If I go to that nurse, [she] will say I'm not your OTL [operational team leader]. The patient will default because our team leader is not there, I can't prescribe even staff nurse don't do that. They want to help but because of their rank they can't. Some they call us nurse makaka [faeces]."* [P 17]

Community health care workers are providing integral care to the community and are regarded as members of the health care system according to PHC engineering. Despite CHWs being members of the health care system, they are still experiencing discrimination and lack of support from some members of the clinic staff. The findings revealed that some clinic staff members are reluctant to assist with the dispatching of medication and client files, amongst others. The poor assistance results in CHWs arriving at households late, and this impacts on their service to patients.

3.5.3 THEME 3: BENEFITS OF PHC OUTREACH SERVICE TO THE COMMUNITY

Benefits of PHC outreach service to the community were identified as a third theme. The following sub-themes emerged under benefits to the community: appreciation of the PHC outreach service by the community, and reduction of waiting time at the facilities.

- **Sub-theme 1: Appreciation of the PHC outreach service**

Appreciation of the service emerged as the first sub-theme under benefits of PHC outreach service to the community.

This sub-theme is **tapped from** the Provincial Health Department document on the Health Provincial Guidelines for the Implementation of the Three streams of PHC Annexure 1 on the Summary of the Scope of Community Health Worker in providing Ward based Outreach PHC services which outline the positive outcomes of PHC outreach as:

> "*Improve the quality of life of community members by mobilizing for improved access to and delivery of primary health care at local level within the context of an inter-sectoral*
>
> *environment.*
>
> *1. Promote health and prevent illnesses*
>
> *2. Conduct community assessments & mobilise around community needs*
>
> *3. Conduct structured household assessment to identify their health needs*
>
> *4. Provide psychosocial support to community members*
>
> *5. Identify and manage minor health problems*
>
> *6. Support screening and health promotion programmes in schools and ECD centres*
>
> *7. Promote and work with other sectors & undertake collaborative community-based interventions. Support continuum of care through service co-ordination with other relevant service providers*"

The community appreciation of the service was indicated by their positive comments. Participants repeated positive responses from the community members by stating:

> "*I perceive the services to be like, maybe...what, how can I put it, maybe as CHWs see it as an upgrading for health care services, it is an upgrading, they call it health reengineering (thlabologo in Setswana) [re-engineering of the service]." [P 2]*

One participant voiced the appreciation of the PHC outreach service by the community by affirming:

> *"The community appreciate the care. Since WABOT [ward based outreach team] was introduced, [the] community was so silent. The WABOT is the mouth and ears of the community. There were many challenges before, but since the intervention of CHWs there is minimal flow of people to clinics. There is decreased flow to the clinic; there is control of flow of people, there is no longer overflow to the clinic." [P 8]*

CHWs regard the service as reengineering of the old PHC because it can reach the community at their household level, and they do not have to visit the clinics as often. CHWs expressed that the community appreciates the PHC outreach service. The community appreciation of the service was indicated by their positive comments and the application of a healthier lifestyle in the community's daily life. Furthermore, the findings revealed the service rendered by CHWs assist the community in social issues. This means that, if there is a concern in the community, the CHWs will be informed first by the community members and the concern will be taken to the relevant channels. The social issues addressed by CHWs amongst others are poor families being referred to apply for social grants and Home Affairs to apply for identity documents.

- **Sub-theme 2: Reduction of waiting period at the clinics**

Reduction of waiting period in the facilities emerged as the second sub-theme under the theme of benefits to the community and the clinics. Participants confirmed the reduction of waiting times by stating that:

> '*We feel the community itself appreciate us, they see the work that we are doing. Every time they don't have to come to the clinic just to collect medication and sometimes we*

check their BP [blood pressure], test blood sugar and there is no need to come to the clinic. We do that at home, they don't have to come to the clinic, only if they feel like they are sick, then they will come to the clinic. We also help the clinic there is no longer queues, people waiting for [long] to get help, sometimes they just queue to collect medications with CHWs. The clinic refers them back to us, we collect their medication and we bring them back to their homes." [P 3]

And:

"*They appreciate that, they even say yooo! (exclamation), they are happy, we no longer stay a long time at the clinic without food, without nothing.*" [P 11]

And:

The queue is heh!!!...(exclamation) short at the clinics, there is decreased overcrowding at the clinic. WABOT [ward based outreach teams] is the mouth and ears of the community, [being a CHW] it's like being an advocate, sort of negotiator of the community." [P 8]

The facilities also benefit service delivery, as the queues at facilities were shorter, as most of the chronic patients are visited in their households. The community as well appreciates the reduction of the waiting period at the clinics.

3.5.4 Theme 4: Recognition by the Department of Health (DoH)

Recognition of CHWs by the DoH emerged as the fourth theme. The following sub-themes emerged from recognition by the Department of Health: permanent employment, remuneration, and the need for career development.

- **Sub-theme 1: Permanent employment**

Permanent employment emerged as the first sub-theme under recognition by the DoH. CHWs are regarded as being recognised by the DOH, despite being regarded as volunteers. Participants stated that they need to be registered as permanent members.

Seeking permanent employment was voiced by participants as follows:

> "*We are surprised why the DOH don't take from us, to understand our situation, they don't want to give us permanent [employment]. They say to us we are many, they don't have money. Maybe if they take from us the shortage of staff they can manage, do you understand."* [P 9]

Community health workers seek permanent employment from the DOH. Despite being key players in the PHC outreach service and recognised by as volunteers, they do not have permanent work. The impact and the service provided by CHWs is acknowledged, despite the fact that CHW are not permanent members of the health care system.

Sub-theme 2: Remuneration

Remuneration emerged as the second sub-theme under recognition by the Department of Health. Community health care workers are recognised by the DoH, however, their stipend is not regular. The participants voiced their dissatisfaction regarding remuneration as follows:

> "*We want salary, not stipend, because the government said CHWs you are so many, we can't afford you and then they issue application forms. They said everyone, even people at home, must apply and they hired them. Even now we are under the contract of (Smart Purse)* [a service provider]*."* [P 11]

Another participant described the remuneration challenges as follows:

> *" We did not receive stipend starting from May [2017], that's where we started having problems with the salary. Service provider Smart Purse gave us a contract which start[ed]*

> *1st August [2017], end next year July 2018. The DOH gave us a one-month contract ended up 30 April 2017. Starting from May 2017, we never got paid. We don't know who owes us that's why we wanted to ask the DoH who owes us [should pay our outstanding stipend]. Last time they took our register to say after assessing it they will pay us up; until now we were not paid.*" [P 2]

And:

> "*Those who signed the 'Smart Purse' contracts are going to be paid by Smart Purse, but now we are still waiting for the outstanding money for 3 months. When we ask if Smart Purse is going to give us that money, DoH says we must ask Smart Purse.*" [P17]

The findings revealed that participants were dissatisfied about the stipend they are earning, as they indicated that the DoH is using them to meet their objective of PHC outreach service. The participants were not paid regularly and were concerned about their outstanding salaries as they had not paid since May 2017. Furthermore, they were not certain whether the new service provider, Smart Purse, or the DoH itself would pay their outstanding salary. According to the findings, participants were not certain if the new service provider would take responsibility for paying them the outstanding money, which they find distressing.

- **Sub-theme 3: The need for career development**

The need for career development emerged as the third sub-theme under acknowledgement by the DOH. Most of the CHWs have been working for more than five years but they cannot progress in their career.

The need for career development was expressed as follows:

> "*I want to see myself as a nurse. Ok my challenges before we go to the other ones we are surprised, instead of the DOH if they need the nurses, why don't they take from us, [or] they hire from us. They hire outside, they don't take from care [CHWs], the DOH they don't take us serious." (emphasis)* [P 9]

"We do have training [as CHWs] but we don't know [the outcome of the training]. my wish is if the department can absorb us and hire us permanently or take us to school to the colleges to nursing colleges for being trained as nurses." [P 4]

"I want to see myself as a nurse with epaulettes on my shoulder." [P 11]

"I can be happier if the department can assist me maybe by going to school to learn more." [P 4]

The findings indicated that CHWs need to further their careers as many of them have been working in this field for many years. Some have been CHWs for more than five years, but they cannot progress. Most of them have Grade Twelve certificates and aspire to be trained further to become nurses. The CHWs indicated that they need to be given priority to train as nurses, as they are already recognised as members of the health care team.

3.6 SUMMARY

Chapter 3 discussed the analysis and interpretation of data together with discussion of the themes and sub-themes in relation to quotes from the participants. The findings revealed the perceptions of CHWs towards the PHC outreach service they provide. The perceptions of CHWs revealed activities performed at households, which include activities for children under five and adults, as well as the identification of social problems. In addition, the working conditions of CHWs highlighted a lack of resources and poor relationships with clinic staff members, which hinder effectiveness of the service. The findings further revealed the benefits of the service to the community, which is evidenced by the community's appreciation of the service and a reduction in the waiting period at the clinics. The community health workers further expressed the need to be acknowledged by the Department of Health, given the outcome of the service. They cite the need for permanent employment, regular remuneration and career development. Chapter 4 will discuss the findings and literature that support the findings.

CHAPTER 4

DISCUSSION OF THE FINDINGS AND LITERATURE CONTROL

4.1 INTRODUCTION OF THE FINDINGS

The previous chapter discussed the analysis and interpretation of the data, and specifically the themes and sub-themes in relation to quotes from the participants. This chapter will discuss the findings in relation to the literature and field notes. The discussion in this chapter reflects the aim of the study, the perceptions of community health workers regarding the PHC outreach service in Tshwane sub-district.

4.2 DISCUSSION

The results are discussed according to the themes and in relation to the relevant literature

4.2.1 Household activities performed by community health care workers

The identified themes were household activities performed by CHWs, working conditions of CHWs, benefits to the community, and recognition by the Department of Health, and each of these was further divided into sub-themes. The household activities performed by CHWs emerged as the first theme, with the following sub–themes: household activities for children under five, household activities for adults, and the identification of social problems.

The National Department of Health (NDoH) allocates CHWs according to population density, geographical and catchment areas. The current trend is that approximately 270 households are allocated per one CHW (Department of Health, 2011:6; Kawasaki et al. 2015:19). Household activities that are performed by CHWs amongst others are: 1) household assessments and screening, 2) health promotion and prevention (including maternal and child health, HIV, TB, and

chronic diseases), 3) health promotion regarding immunisation, and the 4) provision of support, counselling and referrals.

According to the Policy Document of the Department of Health (2011:6), household activities that are supposed to be performed by CHWs for children under five include: screening of all children in the household, and providing preventive and promotive health service. During household visits CHWs assess the health cards of all children who are under five years of age in that specific household. This is to determine if all the children are fully immunised, were given vitamin A and deworming. If it is found that immunisation, vitamin A, or deworming was not up to date, the CHWs provide on the spot service, or refer the child to the clinic for immunisation. Findings revealed that for the entire process to be effective, cooperation of the clinic staff members is essential, as they are expected to attend to the client and complete the back-referral letter, that should be taken back to the CHWs for feedback and the completion of records.

Findings further revealed one of the important activities which CHWs are supposed to be cognisant of is to determine the HIV status of the children. In South Africa, the programs provided by CHWs are: prevention of mother to child transmission (PMTCT), encouraging mothers to adhere to treatment, and practising exclusive breast feeding (Nxumalo et al, 2016: 68). These aspects of health care have revolutionised the PHC service in South Africa since their inception in 2011, according to the findings.

Community health care workers are health promoters as well, in addition to the household activities outlined. Community health care workers give health education on topics such as: prevention and treatment of diarrhoea, good nutrition, exclusive breastfeeding, and the prevention of mother to child HIV transmission. The findings revealed the communities are aware of the services offered at local clinics and the measures needed for maintaining a good lifestyle.

According to the following studies, immunisation and health promotion are amongst the most common household activities that are performed by CHWs (Nsibande et al 2013:47; Ingram et al. 2012:259; Callaghan-Koru et al. 2012:7). The community members regard CHWs as their main source of health education. Amongst the health education topics that are usually covered by CHWs, are: basic nutrition, hygiene and the prevention of childhood illnesses (Kawasaki et al.

2015:9; Callaghan-Koru et al. 2012:7). However, Ingram et al. (2012:259) state that CHWs even go to the extent of accompanying sick children to health care facilities, despite the attitude portrayed by health care staff members of not accepting them as members of the health care system. Of importance, the findings revealed CHWs are often the first health care staff members to come into contact with mothers once they have been discharged from hospital after giving birth, for continuity of care. Nsibande et al. (2013:47) affirm that in South Africa new mothers take instructions regarding care of their new-born babies from CHWs as they are hands-on in the care of the families.

The household activities that the CHWs are doing for adults include assessment and screening of communicable and non-communicable diseases. Amongst the diseases screened are tuberculosis, hypertension, diabetes, CVS, and HIV and AIDS. According to the findings, CHWs also render basic nursing care to bedridden patients. The basic care includes activities such as cleaning the house, cooking, feeding, bathing and giving medication in case there is no one in the family to give such care. In addition, the findings indicated that CHWs supply chronic medication to elderly members of the family, provide health promotion, and monitor compliance with chronic medication. The findings further indicated that amongst screenings conducted by CHWs, pregnancy is included and monitoring for antenatal care, checking clinic attendance and also referral to clinics. Additionally, the CHWs provide postnatal care to mothers and monitor their clinic attendance and referrals (Department of Health, 2011:6).

Community health care workers are primary care givers in both developing and developed countries. CHWs play a major role in combating communicable diseases such as TB by visiting households to detect symptomatic patients and collection of sputum on the spot for early diagnosis. The sputum collected is taken immediately to the facility to be send to the laboratory for testing. Furthermore, they help to ensure treatment compliance by implementing direct observation of patients taking treatment (Puett, Alderman, Sadler & Coates 2015:1019; Kawasaki et al. 2015:19; Department of Health 2011:6; (Nxumalo et al, 2016: 68). Studies in Haiti and Uganda affirm that CHWs offer several programs that include adherence and treatment success as indicated in the findings (Perry, Zullinger & Rogers 2014:404).

The findings revealed that the communities benefit and acknowledge the household health care provided by CHWs. These cadres render the care that was previously provided by the clinics to the

household level. The primary health care outreach service amongst others reaches the poor communities who cannot afford transport to visit a clinic to collect chronic medication or to measure their blood pressure. The Affordable Care Act of 2010, known as 'Obama Care' in the USA, integrated CHWs into the primary setting in 2014, and was intended to intervene in the reduction of chronic diseases among the lower socio-economic population in the USA, just like the PHC outreach service used in South Africa (Perry, Zullinger & Rogers 2014:413).

The CHWs indicated that they do not only perform physical assessments, but they also screen for mental, social and economic factors that make the household members more susceptible to diseases and social ills (Mlotshwa, Harris, Schneder & Moshabela 2015:6). The outcomes of these screening processes determine the interventions that the CHWs are able to implement. For example, interventions from the screening of social problems amongst others will include liaising with other stakeholders such as the social welfare service, Home Affairs and others. Hence, CHWs are regarded as a link from the community to other stakeholders (Tsolekile, Puoane, Schneider, Levitt & Steyn 2014:7).

Though the training of CHWs does not go beyond identification and screening, their interventions have been noticed to be in the areas of social and health issues, which are mostly referral and advice on health matters (Nxumalo et al, 2016: 61). It is essential to note that CHWs are not social workers but the findings revealed that they assist the community to access social services (Mlotshwa, Harris, Schneder & Moshabela 2015:6). The findings indicate that the social issues that the CHWs come across in their daily work during household visits include: not having a stable income, unemployment, and poverty (Tsolekile, Puoane, Schneider, Levitt & Steyn 2014:7; (Nxumalo et al, 2016: 71). One of the activities performed by CHWs is referring the household members to relevant services such as Home Affairs and social welfare (Mlotshwa, Harris, Schneider & Moshabela 2015:2).

4.2.2 Working conditions

Working conditions of CHWs emerged as the second theme. The following sub-themes emerged from the theme: lack of resources, and poor relationships with clinic staff members.

The findings revealed dissatisfaction amongst CHWs regarding the attitudes of health care staff members. According to the findings, the attitudes displayed by clinic staff members towards CHWs instil feelings of not belonging to the health care system and of being discriminated against. However, the CHWs are regarded as key players in the implementation of the PHC outreach programme in South Africa. Despite this important function, the working condition of CHWs are rarely considered by the government (Turinawe et al. 2016:86).

Community health care workers also experience discrimination and lack of support from some members of the clinic staff. The findings described the activities performed by CHWs and the impact of the PHC outreach service on the communities. However, there are still some health care staff members who disregard CHWs. In addition, the findings revealed that some health care members are reluctant to assist with the dispatching of medication and client files, amongst others. The poor assistance results in CHWs arriving at households late, which impacts on the effectiveness of the service (Nxumalo, Goudge & Manderson 2016:71).

The poor relationship and the lack of co-operation of the staff members in the local health facilities to CHWs is regarded by Mampe, Schneider and Reagon (2016:33) as detrimental. In addition, in the real situation PHC outreach teams are linked to the local health facility, where CHWs are expected to report and send referrals. However, CHWs experience challenges when coming to the coordination of reporting and referral services in these local health care facilities. Of importance is that CHWs require resources such as patient files and medication from these facilities. However, according to the findings several staff members in these health facilities are reluctant to assist the CHWs (Puett, Alderman, Sadler & Coates 2015:101; Mampe, Schneider & Reagon 2016:33). In addition, it was noted that the staff members in the local health facilities do not comply with the back-referral procedures for the patients to the CHWs despite these forms being needed by the CHWs for completion of the household records. Turinawe et al. (2016:85) affirm that other health care staff members pass comments that are demeaning to the CHWs, which is very discouraging.

In order for CHWs to provide effective primary health care at household level, there is a need for resources to be able to function properly. The findings further revealed a lack of resources among CHWs. Despite CHWs being an important concept in SA, the CHWs still experience a lack of resources, which ranges from transportation to households, to the equipment to be used,

infrastructure, and medication for chronic patients. Such a lack or insufficient resources pose a challenge in the provision of the PHC outreach service by CHWs.

Kawasaki et al. (2015:19) indicate that CHWs walk long distances to cover their catchment areas. The Tool Kit document for PHC re-engineering indicates that each CHW is allocated an average of 270 households depending on density and geography as well as the burden of disease. The allocation is done without offering any transportation to households to render the PHC outreach service (Department of Health 2011:2). Community health care workers are thus forced to walk long distances (Nxumalo et al, 2016: 68) in order to reach their clients. Community health care workers emphasised the lack of resources, stating that in some instances they did not have anything to offer to patients apart from psychological support (Nxumalo et al, 2016: 68). According to the findings, monitoring vital signs is one of the key screening activities that will determine the progress of the client. These vital signs will guide and assist the CHWs as to which intervention to recommend. Lack of resources such as baumanometer machines, glucometers and gloves that are not in good working order result into undesirable working conditions for CHWs and may lead to poor outcomes. In some cases, CHWs would improvise by using plastic bags to cover their hands when gloves are not available in stock (Mlotshwa, Harris, Schneder & Moshabela 2015:6).

Recommendations which come from several studies indicate that the working conditions of CHWs need to be improved (Pillay & Barron 2011:3; Perry, Zullinger & Rogers 2014:4). Another study by Mampe, Schneider and Reagon (2016:40) alluded to the improvement of the working conditions of CHWs in African and Asian countries, including India. The same study revealed that CHWs' conditions of employment have been overlooked ever since the inception of the concept in South Africa. There is a misconception that CHWs are volunteers, despite being part of the implementation of the PHC outreach programme (Turinawe et al. 2016:96; Tsolekile et al. 2014:2).

4.2.3 Benefits to the community

Benefits of CHWs to the community emerged as the third theme. The following sub-themes emerged under the theme: appreciation of the PHC outreach services, and reduction of waiting periods at the clinic.

The PHC outreach service benefits the community members, as CHWs can reach the community in their households and the community do not always have to visit the clinics. According to the findings, most community members and CHWs appreciate the PHC outreach service. In this study, positive comments and the execution of the health promotion information and strategies by CHWs were signs of such appreciation.

The findings indicated that community members visit clinics only when it is necessary, unlike before implementation of the PHC outreach programme when chronic patients would have to visit the clinic to collect medication or for measurement of blood pressure. In sub-Saharan Africa, the PHC outreach service is regarded as being beneficial and integral to the communities. Scientific evidence outlined the benefits as: reduced waiting times in the local health facilities, preventive and promotive services given at the household, and diminishing the workload in the local health care facilities (Mampe, Schneider & Reagon 2016:45; Mlotshwa et al. 2015:1). According to Nxumalo et al. (2016:67), the workload in local health care facilities has improved due to the interventions of CHWs (Mampe et al. 2016:15). In addition to these findings, the implementation of PHC is also evident in the reduction of mortality and morbidity rates in countries where this programme is implemented such as South Africa.

In South Africa, the North-West Province (NWP) was amongst the first provinces to implement the PHC outreach programme in 2011. An evaluation assessing the effectiveness of the programme was conducted in 2015 (Mampe et al 2016:1). This study revealed that there was an improvement in the following service areas: vaccination rate of children under five, coverage of vaccination against measles for children under one, Vitamin A coverage, the treatment of children under five with diarrhoea or dehydration, and the first visits to antenatal care (Mampe et al. 2016:15). Several studies also confirm the benefits of the PHC outreach through CHWs since its inception (Zulliger, Moshabela & Schneider 2014:630; Kawasaki et al. 2015:18; Perry, Zullinger & Rogers 2014:413). In addition to these findings, it was found that queues in local health care facilities are shorter and most chronic patients are visited in their households through the introduction of PHC outreach services. The community members appreciate the reduction of the waiting period at the local clinics. The PHC outreach service has transformed preventative and promotive health care services (Moosa, Derese & Peersman 2017:5). Health district managers confirmed that the service has reduced the burden on the facilities (Nxumalo et al, 2016:67).

4.2.4 Recognition by the Department of Health

Acknowledgement of by the DOH emerged as the fourth theme. The following sub-themes emerged from recognition by the Department of Health: remuneration, permanent employment, and career development.

The findings revealed the raw emotions of the CHWs when relating their perceptions regarding not being recognised by the same DoH that indicates that CHWs are recognised and key players in the PHC outreach programme. Meanwhile, they are volunteers, earning stipends which are not regular .Community health care workers in South Africa are at the front lines in implementing the re-engineering of PHC even though they are not permanently employed. The impact of the service the CHWs provide is acknowledged by the DoH (Nxumalo et al, 2016: 68).

Studies in sub-Saharan Africa, Asia and India confirm that CHWs are not recognised as permanent health care workers (Turinawe et al, 2016:86). Tsolekile et al. (2014:2) further confirm that CHWs are regarded as volunteers, hence they are paid a stipend and not a salary in South Africa. The same study indicated a lack of recognition and permanent status hinders the career development of CHWs (Turinawe et al, 2016:96; Tsolekile et al, 2014:2). The DOH has implemented the PHC outreach service in which CHWs are regarded as an important vehicle for the service (Department of Health, 2011:2).

According to the findings, lack of recognition is noted through remuneration, as the CHWs earn only a stipend that is not always regular. In addition, CHWs described recognition as acknowledgement of the work done by being paid a salary, which is not happening according to the findings. Remuneration of CHWs is a challenge in most sub-Saharan African countries (Turinawe et al. 2016:86; Nxumalo et al, 2016:9). For example, in Tanzania, the CHWs relied on their families and community for support, despite the type of service they provide for their communities (Greenspan, McMahon, Chebet, Mpunga, Urassa & Winch 2013:10). In Ethiopia and Mozambique, the plight of CHWs was compared to the colonial past of exploitation due to their low remuneration or not being paid regularly (Maes & Kalanfos 2014:12). Meanwhile in South Africa, CHWs are paid a stipend which is not sufficient and irregular (Mampe et al. 2016:29). In addition, throughout the African continent the CHWs aspire to earn a good income that will enable them to move beyond poverty.

The findings revealed that CHWs see themselves as doing a good job, with an impact that is evident in communities and local health care facilities. Despite this, they are not permanent staff of the DoH (Turinawe et al. 2016: 94). In rural areas, the impact of CHWs is very high. Mlotshwa et al. (2015:8) attest to the idea of legitimising the CHWs' work. Mampe et al. evaluated the PHC outreach service, and their findings revealed the effectiveness of the service and the need to formalise the training of CHWs (Mampe et al. 2016). The formalisation of the training of CHWs will lead to permanent employment (Kok & Muula 2013:10). According to the findings, some of the CHWs have been working for more than five years and they do not have a career to follow. Some of the CHWs have Grade 12 certificates and have been working in this field for many years. They have also indicated the aspiration to further their careers to be nurses. Lack of development predisposes CHWs to remain at one rank, which disadvantages them and denies them the opportunity of rank promotion or development (Zhang, Wang, Yan & Li 2016:18; Moosa et al. 2017:20).

In Asia and most African countries, the development of CHWs is not addressed adequately and is regarded as unfair (Turinawe et al. 2016:96; Tsolekile et al. 2014:2). In South Africa, there is no career development at all. Thus, while CHWs are currently providing the PHC outreach service, which is a mandate from the DoH (Department of Health 2011:2), their career development remains stagnant. The career development of CHWs is essential, given the responsibilities and services they provide in South Africa (Moosa et al. 2017:20). The service that CHWs provide to communities deserves to be acknowledged in the form of a living wage, career development and permanent employment. Community health care workers need to be given priority to train as nurses as they are already recognised as members of the health care team. Several studies attest that training CHWs as professionals will entitle them to permanent employment and career progression (Turinawe et al. 2016:96; Moosa et al. 2017:20; Zhang, Wang, Yan & Li 2016:20).

4.3 SUMMARY

Chapter 4 discussed the themes and sub-themes that emerged from the findings in relation to the literature. The discussion focused on the different household activities that are performed by CHWs as part of PHC re-engineering outreach teams. In addition, attention was paid to the working conditions, acknowledgement by the DOH and the benefits of the outreach PHC to the different communities, especially in rural areas where access to health care is still a challenge. These factors were discussed and supported with the literature. Most importantly, the chapter

discussed the need to acknowledge the CHWs by the DoH, which will ultimately lead to their career development in the health care sector. The next chapter will discuss the implications, recommendations and limitations of the study.

CHAPTER 5

SUMMARY OF THE STUDY

5.1 INTRODUCTION

The previous chapter discussed the themes and sub-themes that emerged from the findings in relation to the literature. This chapter will discuss the summary of the findings of the study, as well as the implications and recommendations thereof.

5.2 RESEARCH OBJECTIVES

The current study was intended to explore and describe the perceptions of CHWs regarding the PHC outreach service in Tshwane sub-district.

5.3 RESEARCH QUESTION

The research question that was posed by the study was: What are the perceptions of CHWs regarding the PHC outreach service in Tshwane sub-district?

5.4 RESEARCH METHODOLOGY

A qualitative research approach was used to meet the aim and objectives of the study. A focused ethnographic design was conducted with CHWs within the health care system in order to explore their perceptions regarding the PHC outreach service within a short period of time. The researcher used ethnographic interviews and a review of relevant site documents to obtain specific rich information on the phenomenon of interest. All the interviews were recorded to support the process of data collection. Braun and Clark's (2006) six phases of thematic analysis were used to analyse the data. The researcher adhered to the steps by: listening to the audio tapes and reading the

transcribed data; coding the data to establish patterns by using different colours; identifying themes by grouping data from the codes. Finally, the themes were reviewed and named, and a comprehensive narrative was written about the perceptions of CHWs regarding the PHC outreach service from the information gathered.

5.5 SUMMARY OF RESEARCH FINDINGS

From the analysis of the data and interpretation, the findings of the study were divided into a few themes: the household activities performed by community health care workers, working conditions of CHWs, benefits of PHC to the community and acknowledgement by the DOH

5.5.1 The household activities performed by community health care workers

The community health care workers in the study expounded on the household activities that they were performing as part of their daily activities. These activities are geared for preventative and promotive health care services. They were targeted at both children and adults.

In children, such household activities included the following: checking the child health cards of all children under five years of age in order to determine their status of immunisation as well as vitamin A and deworming. In case there was defaulting on immunisation, vitamin A or deworming, the CHWs provided on the spot service, or referred the child to the clinic for immunisation (Nsibande et al. 2013: 47; Ingram et al. 2012:259; Callaghan-Koru et al. 2012: 7). Additionally, among the activities, the CHW determine the HIV status of the children, and provide health education to family members on topics such as: prevention and treatment of diarrhoea, good nutrition, exclusive breastfeeding, prevention of mother to child HIV transmission, and post-natal care of the infant including cord care (Nsibande et al. 2013:47).

In the case of household activities for adults, the CHWs perform the following: assessment and screening of all adults in the household. The assessment and screening are done for the following: communicable diseases such as HIV/AIDS and tuberculosis, non-communicable diseases such as hypertension and diabetes, and diseases of the cardiovascular system. Special attention is also provided to bedridden patients, who are provided with holistic basic care (including bathing,

feeding and position changing). The community health care workers indicated that they also administer chronic medication to elderly members of the family and monitor compliance with such. Most importantly, the CHWs provide health promotion, conduct screening for pregnancy and provide antenatal care. Pregnant women are referred to the ante-natal clinic. After delivery, mothers are also referred to postnatal clinics and their attendance is monitored (Nxumalo, Gaudge & Manderson 2016: 68; Perry, Zullinger & Rogers 2014:413).

The study findings also indicated that the CHWs are a link between the community and other stakeholders. In cases where the CHWs detect social problems or any other problem during the screening process in the households, they are obliged to refer these for further management (Tsolekile, Puoane, Schneider, Levitt & Steyn 2014:7). The most common problems that the CHWs refer were related to mental, social and economic reasons. The social problems that the CHWs are encountering on a daily basis amongst others are: unemployment, lack of food and proper housing, and household members not being able to access government grants due to the absence of relevant documentation like identification documents (Mlotshwa, Harris, Schneder & Moshabela 2015:2). The findings indicated that there is a need to attend to such social problems, as non-attendance may predispose the household members to poor social and ill-health outcomes. Not only do the CHWs have to identify the problems, they also intervene and refer these to relevant stakeholders such as Home Affairs and social service departments, as part of their work activities.

5.5.2. Working conditions of CHWs

Regardless of CHWs being key players in the implementation of the PHC outreach programme their working conditions are poor (Nxumalo, Goudge & Manderson 2016:68). From the study findings, the poor working conditions were evidenced by a lack of resources such as infrastructure, transportation and equipment.

According to the endorsed legislation on PHC outreach, the local clinic that the CHWs are working under is supposed to provide most of the relevant equipment starting with working space. However, in this study the findings revealed that this was not the case. Community health care workers as part of the PHC outreach team are neglected. The findings reveal that there is a lack of and insufficient resources, which poses a challenge in the provision of services. The community health care workers have to report at the local clinic before their visits to different households and

in most cases these households are far from the clinic. The community health care workers have to walk to those households. The same walking distance is also covered in the afternoon, as the CHWs are also expected to come back from the households to the clinic to knock off. Hence, the findings indicated dissatisfaction regarding these long distances, with the CHWs sometimes even walking in extreme weather (Kawasaki et al. 2015:19). Amongst the suggestions, the CHWs are believe that an offer for transportation to households will be a better solution.

From the study, it was found that the basic equipment such as baumanometers is not always in good working order, which poses a problem for monitoring the vital signs of the patients at household levels. Other equipment such as glucometers are not always sufficient for the CHWs to have their own (Mlotshwa, Harris, Schneder & Moshabela 2015:6).

The study findings also highlighted the poor relationships between CHWs and some of the health care team members (Puett, Alderman, Sadler & Coates 2015:101; Mampe, Schneider & Reagon 2016:33). According to the findings some members of the health care team in the clinic are reluctant to assist on issues like medication dispatch. This usually occurs when the CHWs' operational team leader is not available to provide or execute such tasks.

From the findings, despite the discrimination which the CHWs face they still consider themselves to be integral members of the health care system according to PHC engineering (Turinawe et al. 2016:85).

5.5.3 Benefits to the community

The participants in this study indicated that the PHC outreach service is of great benefit to the communities. From the findings, the benefits are noticeable from the household visits that are provided by CHWs. Therefore, the health and social needs of the community members are met at household level most of the time. This reduces the waiting times at the local clinic and the long distances the community have to travel in order to access health services. Additionally, there is also a reduced workload in local health care facilities. According to the findings, the PHC outreach program is a good strategy to reduce mortality and morbidity rates (Mampe, Schneider & Reagon 2016:15) through the work of CHWs.

5.5.4 Acknowledgement by the Department of Health

The findings of this study revealed that the CHWs were not being acknowledged by the Department of Health when it comes to remuneration, permanent employment and career development. This is regardless of them being key members of the PHC outreach service. In most cases, the CHWs are regarded as volunteers, and not as professional members (Nxumalo, Goudge & Manderson 2016:650). This is problematic as CHWs cannot develop further in a health-related career path.

Community health care workers also experience the challenges of unfair labour practices, such as insufficient and irregular payments of their stipend (Mampe, Schneider & Reagon 2016:40). The study pointed out that CHWs were not even being paid their stipend regularly. For example, at the time of the study the CHWs had not been paid for three months. In Gauteng province, currently the payment of CHWs is handled by an outsourced service provider, Smart Purse. This poses a challenge as CHWs are not given certainty as to whether their salaries are going to be back-paid and updated. From the findings, there was already dissatisfaction with the outsourcing of the service provider.

The findings indicate that the recognition that the Department of Health is proclaiming regarding CHWs is not a true reflection as they are not considered to be permanent staff members (Mlotshwa, Harris, Schneder & Moshabela 2015:8). Instead, the CHWs expressed dissatisfaction that they are being strategically used by the national Department of Health. From the findings, the CHWs work on a daily basis but are not afforded the status of permanent staff members and are not being awarded the same rights as permanent employees.

Apart from permanent employment, the findings showed that CHWs need to be developed in their career paths (Turinawe et al. 2016:96; Moosa et al. 2017:20; Zhang, Wang, Yan & Li 2016:20). From the study, it was found that some CHWs have been working for more than five years as PHC outreach CHWs. Without any career progression, the CHWs are uncertain about their future. Most of the CHWs have Grade 12 certificates and aspire to be trained further in health-related fields like nursing (Kok & Muula 2013:10). The wish for career progression among CHWs was a priority as they are already members of the health team.

5.6 IMPLICATIONS OF THE STUDY FINDINGS

The findings of this study might have implications for primary health care practice as well as policy implications.

5.6.1 Primary health care practice

The research has highlighted the daily activities that CHWs provide to the communities. The household activities that are provided by CHWs as indicated are in line with the duties of nurses. The duties include amongst others include health promotion, screening for diseases and social problems, basic nursing care, follow-up care and referrals. There is a thin line between CHWs' duties and the nurses' duties. Hence, the findings indicated that ever since the implementation of PHC outreach teams in this sub-district the nurses' workload has been reduced. It is important to know that the opportunities exist to enhance the working conditions of CHWs in the local clinic to optimise the primary health care services.

Additionally, from the findings it was noted that the communities are benefiting from the service provided by the PHC outreach team. From the study, all that is needed from the staff in the local clinic is to co-operate with the CHWs and appreciate the work that they are offering in this sub-district on a daily basis. This will encourage the CHWs to provide quality primary health care services.

5.6.2 Policy implications

The study indicated an urgent need for the national Department of Health to revisit the legislation on CHWs within the primary health care outreach team. The Department of Health needs to recognise the CHWs as permanent members of the primary health care team as they are on the front-lines of care at the household level. Through this recognition, the CHWs will be able to become full -time workers and earn a salary not a stipend, and also be regarded as professionals so that their career can be developed and they can be registered with a statutory body.

Health care staff members will more readily accept CHWs as their service is already noticeable in the improvement of the quality of care in the communities and local clinics (Nxumalo, Goudge & Manderson 2016:650).

Based on the findings and implications stated, the researcher proposes the following recommendations for the Department of Health, health care personnel, stakeholders and non-government organisations in their pursuit to address the plight of the CHWs.

5.7 RECOMMENDATIONS OF THE STUDY

5.7.1. Department of Health

- The Department of Health should provide resources including infrastructure and equipment for the PHC outreach teams to address the service provision of household health care.
- The DOH should design one policy that will be used in all provinces in South Africa for CHWs, which will assist in guidelines for planning a training programme in such a way that it will meet the criteria of tertiary education whereby development in a career is possible. The qualification obtained after training of CHWs should be recognised as prior learning to nursing auxiliary certificate training. That will contribute in formalising the CHWs' qualifications.
- The current CHWs who are providing PHC outreach services should be employed as full-time members like other members of the health care team.
- The CHWs should be paid directly under the Persal system with all benefits that all government employees are entitled to.
- The conditions of employment of the CHWs should be clearly stipulated regarding hours to be worked in a week, rights, sick leave, annual leave, etc.
- Poor organisational support including poor supervision of CHWs by clinic staff members hinders the effectiveness of the service. Health care personnel including administrative staff, pharmacists and all categories of nursing personnel need to recognise CHWs as members of the health care team and that will enhance the effectiveness in the reengineering process of the PHC.

5.7.2 Health care personnel

- The poor relationship of health care staff members towards CHWs should be addressed. The outreach team leader and facility operational managers should facilitate a programme of improving relationships between health care staff members and CHWs. Recognition and support of CHWs by health facilities' operational managers should endorse the PHC outreach team to all staff members by creating awareness of the impact of the service on the everyday functioning of PHC in the facilities. Furthermore, such awareness of staff members might create greater acceptance of CHWs by clinic staff members. Coordination of services in the clinic and households may contribute to a further reduction in workload, and improvements in the statistics in services such as immunisation coverage, childhood diseases, communicable and non-communicable diseases
- In addition, facility managers should put remedial measures in place to improve relationships. Measures put in place should be evaluated often to see if they are functional or need to be reviewed in order to meet the desired objectives of maintaining good relationships. Feedback of the programme should be given to all staff members and higher authority. Good relationships might improve communication, support, effectiveness of the PHC outreach service and attitudes towards the CHWs.

5.7.3 Other stakeholders

- Other stakeholders such as Social Services, Home Affairs, and Correctional Services should recognise and accept the CHWs by making personnel aware of the PHC outreach service. This awareness will improve communication and feedback with all stakeholders.

- Charity organisations within communities should get access to PHC outreach team leaders to indicate the households that are in need.

5.7.4 Non-government organisations

- Non-government organisations who are directly funding the service by means of donations or are involved with the existence of the PHC outreach service should rally to convince the DoH to formalise the service. Formalising of the service would involve recognising the qualification of CHWs and allowing them to be absorbed in the health care system as CHWs.

5.8 LIMITATIONS OF THE STUDY

- The study was conducted in Region C in one Tshwane sub-district. Other sub-districts in Tshwane were not included, therefore the findings could not be generalised to all sub-districts in Tshwane.

- CHWs providing the PHC outreach service in Region C Tshwane sub-district were included in the study, while other CHWs providing different programmes were not included in the study, therefore the findings could not be generalised to all CHWs in Tshwane sub-district.

5.9 CONCLUSION

The objective of the study was to explore the perceptions of CHWs regarding the PHC outreach service in Tshwane sub-district. A qualitative approach was followed using focused ethnography as the research design to reach the aim and objective of the study which was: To explore and describe the perceptions of CHWs regarding the PHC outreach service in Tshwane sub-district. Data was collected using ethnographic unstructured interviews and review of the relevant site documents. Multiple responses from CHWs were captured that indicated their perceptions of the PHC service. Thematic data analysis was used to analyse the collected data. The following themes were identified: household activities performed by community health care workers, working conditions, benefits to the community, and acknowledgement by the Department of Health. The themes and sub-themes were controlled with literature. CHWs raised dissatisfaction regarding the hard work they are providing to the communities without being acknowledged by the national Department of Health as permanent workers.

Currently CHWs are regarded as volunteers despite the fact that they provide full-time service to the community. Amongst other challenges are: a lack of acceptance and support from other staff members, irregular payments of salary, not being offered full-time employment, lack of career development, and poor working conditions such as walking long distances to households. Despite the poor working conditions and dissatisfaction, the communities and health care facilities are benefiting from the service, as proven by improvements in other services at the facilities and in the community.

The findings and recommendations stipulated will be forwarded to relevant authorities that may assist in the improvement of working conditions and improvement of the PHC outreach service. Based on the study findings conclusions could be reached showing that the aim of the study, to explore perceptions of CHWs regarding the PHC outreach service, has been achieved.

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ANNEXURE A 1

Permission letter to conduct the study

Permission to access information from Community health care workers at Tshwane sub-district 2

TO: **The ward based co-ordinator/manager**
Tshwane sub-district 2
Information Officer

FROM: Ms S Mpshane
SG Lourens Nursing College
Investigator

Re: Permission to conduct research at Tshwane sub-district 2

TITLE OF STUDY: The perceptions of community health care workers regarding PHC outreach services in Tshwane sub-district.

This request is lodged with you in terms of the requirements of the Promotion of Access to Information Act. No. 2 of 2000.

I am a researcher / student at the Department of ***Nursing at the University of Pretoria /***

I am working with ***Dr S R Mogale***

I herewith request permission on behalf of all of us to conduct a study on the above topic . This study involves obtaining information from community health workers.

We intend to publish the findings of the study in a professional journal and/ or to present them at professional meetings like symposia, congresses, or other meetings of such a nature.

We intend to protect the personal identity of community health care workers by assigning each individual a random code number.

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.

Yours sincerely

Signature of the Principal Investigator

Permission to do the research study at this hospital / clinic and to access the information as requested, is hereby approved.

Title and name of Chief Executive Officer: S. R. Lerumo

Name of hospital / clinic: Tshwane Sub district 2

Signature:

Date: 26/04/2016

GAUTENG PROVINCE
DISTRICT HEALTH SERVICES

Official Stamp

PRETORIA REGION
P.O. BOX 9514, PRETORIA 0001

ANNEXURE B 1

Ethics Clearance Certificate

The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.
- FNA 00002567, Approved dd 22 May 2002 and Expires 20 Oct 2016.
- IRB 0000 2235 IORG0001762 Approved dd 22/04/2014 and Expires 22/04/2017.

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences Research Ethics Committee

26/05/2016

Approval Certificate
New Application

Ethics Reference No.: 174/2016

Title: THE PERCEPTIONS OF COMMUNITY HEALTH CARE WORKERS REGARDING PHC OUTREACH SERVICES IN THE TSHWANE SUB-DISTRICT

Dear Sarah Mpshane

The New Application as supported by documents specified in your cover letter dated 17/05/2016 for your research received on the 17/05/2016, was approved by the Faculty of Health Sciences Research Ethics Committee on its quorate meeting of 25/05/2016.

Please note the following about your ethics approval:

Ethics Approval is valid for 1 year

- Please remember to use your protocol number (174/2016) 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, or monitor the conduct of your research.

Ethics approval is subject to the following:

- The ethics approval is conditional on the receipt of 6 monthly written Progress Reports and
- 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); MFmd Med.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 2004 (Department of Health).

Tel 012 356 3085 | fhsethics@up.ac.za | http://www.up.ac.za/healthethics
Private Bag X323, Arcadia, 0007 - Tswelopele Building | Level 4-59, Gezina, Pretoria

ANNEXURE B 2

Tshwane Research Committee

Clearance Certificate

Kuyasheshwa! Gauteng Working Better
GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

427 Hilda Street, 4th floor, The Fields Building, Hatfield Pretoria 0001 South Africa. Tel: +27 12 451 9036
Enquiries: Dr. Molapane Chueu-Shabangu
e-mail: Molapane.Shabangu@gauteng.gov.za

TSHWANE RESEARCH COMMITTEE

CLEARANCE CERTIFICATE

Meeting: N/A

PROJECT NUMBER: 21/2016

Title: The Perceptions of Community Health Care Workers Regarding PHC Outreach Services in the Tshwane Sub-District

Researcher: Sarah Mpshane

Supervisor: Dr. RS Mogale

Co-Supervisor: Dr SS Moloko-Phiri

Department: Nursing Science, University of Pretoria

DECISION OF THE COMMITTEE

Approved

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

Date: 29/06/2016

.....
Dr. Molapane Chueu-Shabangu
Chairperson Tshwane Research Committee
Tshwane Health District

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

NOTE: Resubmission of the protocol by researcher(s) is required if there is departure from the protocol procedures as approved by the committee.

ANNEXURE C

Information leaflet and Informed consent for Educational, Health Systems or Non-Clinical Operational Research

TITLE OF THE STUDY: Perceptions of Community Health Workers regarding Primary Health Care Outreach Services in Tshwane sub-district, Gauteng Province

AIM: To explore and describe the perceptions of community health workers (CHWs) regarding primary health care outreach services in Tshwane sub-district, Gauteng Province

1. INTRODUCTION

Ms S. Mpshane will conduct the study as part of her master's degree in the Department of Nursing Science, University of Pretoria.

You are invited to take part in this research study. This information leaflet is to help you to decide if you would like to participate. If you have any questions regarding this study please do not hesitate to ask the researcher. Your participation is appreciated and important for the professional development in the health care field

2. WHAT IS THE PURPOSE OF THE STUDY?

The purpose of the study is to explore and describe the perceptions of community health workers (CHWs) regarding primary health care outreach services in Tshwane sub-district.

3. WHAT IS EXPECTED OF YOU DURING THIS STUDY?

You will be requested to participate in an unstructured interview that will be conducted by the researcher. You will meet the researcher at the designated clinic in Tshwane sub-district The researcher will ensure that the chosen place is comfortable and private. All participants will be individually interviewed by the researcher.

Different communication skills will be used in order to gather more information regarding your perceptions. Communication skills such as probing, reflection, paraphrasing and others will be used. The researcher will use a tape recorder to record the interview. You will be expected to talk while the tape recorder is recording the conversation between you and the researcher. The researcher will also take notes. These will be used as reference during data analysis. All the information that will be recorded will be used only for the purpose of the study. As soon as the data is analysed the recorded information will be deleted or destroyed.

4. HAS THE STUDY RECEIVED ETHICAL APPROVAL?

The study has been approved by the research ethics committee of the University of Pretoria, faculty of Health Science.

5. WHAT ARE MY RIGHTS AS PARTICIPANTS IN THIS STUDY?

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

6. MAY ANY OF THESE STUDY PROCEDURES RESULT IN DISCOMFORT AND RISKS?

Since the study is related to your perceptions, you might experience mild discomfort. Therefore, you are requested to report any uneasy feelings so that they can be handled as soon as possible. The study will not include any experiments.

7. WHAT ARE THE POSSIBLE BENEFITS OF THE STUDY?

The study will benefit you as a community health worker as it provides us with the information about your perceptions with regard working conditions in primary health care outreach services in Tshwane, sub-district. The research could lead to improvements in policy development and improvements in the provision of primary health care outreach services, which will contribute to the promotion of the general health status of the community and better working conditions for CHWs.

8. CONFIDENTIALITY

All information obtained during the course of this study is strictly confidential. The information obtained during the interview will be kept safe and will not be used for any other purpose except for the research project. There will be no names attached to the research report.

9. SOURCES OF ADDITIONAL INFORMATION

Should you have any questions during the study, please do not hesitate to contact the researcher:

Researcher: S. Mpshane (0723499673)

Supervisor: Dr RS Mogale (0715591327)

Co-Supervisor: Dr SS Moloko-Phiri

Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee: Dr R Sommers (012 354 1677)

CONSENT TO PARTICIPATE IN THIS STUDY

I hereby confirm that I have been informed by the researcher, Mrs S. Mpshane, about the nature, conduct, benefit and risks of the study. I have also received, read and understood the participant information leaflet regarding the study. I am aware that the results of the study including personal details will be anonymously processed into the report.

I may, at any stage without prejudice, withdraw my consent and participation in this study. I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in this study

Participant's name: ---------- (please print)

Participant's signature----------Date ----------

Researcher's name: ---------- (please print)

Researcher's signature: ----------Date ----------

Witness name: ----------(please print)

Witness signature: ----------Date ----------

VERBAL INFORMED CONSENT

I, the undersigned, have read and have fully explained the participants' information leaflet, which explains the nature, process, risks, discomforts and benefits of the study to the participants whom I have asked to participate in the study.

The participant indicates that s/he understands that the results of the study, including personal details regarding the interview will be anonymously processed into a research report. The participant indicates that s/he has had time to ask questions and has no objection to participate in the interview. S/he understands that there is no penalty should s/he wish to discontinue with the study and his/her withdrawal will not affect the study in any way. I hereby certify that the client has agreed to participate in this study.

Participant's Name .....…….. (Please print)

Person seeking consent .....…..... (Please print)

Signature .....…….....Date.....

Witness's name .....…….…..... (Please print)

Signature .....……Date.….....

ANNEXURE D

Topic Guide

TITLE: Perceptions of Community Health Workers regarding Primary Healthcare Outreach Services in Tshwane sub-district, Gauteng Province

AIM: To explore and describe the perceptions of community health workers (CHWs) regarding Primary Health Care Outreach Services in Tshwane sub-district.

The main question that the researcher will ask each participant at the beginning of an interview will be:

What are your perceptions regarding PHC outreach service?

The following communication skills will be used during interviews:

1. Probing, e.g. can you tell me more about that?
2. Paraphrasing, e.g. what do you mean by saying you lack support?
3. Reflection, e.g. I can see that you are worried about transport to your workplace.
4. To participants who are reluctant to divulge information, supportive remarks will be provided such as I'm listening, go on, exclamations, or nodding the head to encourage participants to talk.

ANNEXURE E

Interview Transcript Exampler

I: Interviewer

P: Participant

I: Good morning again Sir

P: I'm ok

I: Good day and how are you

P: I'm alright

I: As we have already discussed the information leaflet that was describing the nature, the conduct, benefits, risks of the study, the results of the study personal details that will be anonymously processed into the report, and that you may withdraw your consent and at any time. We have also explained that you may withdraw you have been given enough time to ask questions, and do you still agree to continue with the interview?

P: Yes, I agree

I: I am going to ask you the question that says: What are your perceptions regarding the PHC outreach service that you render here in your sub district?

P: Mhh the PHC services that I'm rendering is very good because some of the community they like it because we distribute treatment for elderly people ok those who can't come to the clinic also, we do health education at the houses we distribute condoms.

P: We do health education. There are some people who are sick but they don't want to come out while we are busy doing the ehh registration we can find those people and we help them

I: Ok you say the community likes it?

P: Yes the community likes it. So far, the community likes it we have not heard any negative thing that is not good.

I: What are the community saying regarding this service?

P: They like it especially for the treatment because some elderly people come to clinic and wait for long time to get only treatment, but If we have BP machine blood sugar machine to check we give them treatment. Even at the crèches we go and do immunisations.

I: You also visit the crèches?

P: Yes, we also visit the creches

I: When you are at the crèches what are you doing?

P: We do immunisation we give vitamin A and deworming, also we educate the teachers at the crèches that they must always check the card sometimes the mother may bring the child to crèche but they don't know how the card works that they must always bring the card for the teacher to check it for them. We do everything but the DOH does not want to employ us as CHWs or at least train us.

I: Have you been train for being a community health worker?

P: The Department of Health train you every year. Each and every year we do one thing, they must at least try to change the format those short courses that we are doing they must register attendance. The certificates are not registered, they must improve us.

I: You think the DoH must train you further, may you just explain that again?

P: If they train us the certificates should be registered, all certificate we've got are not registered. The short courses that we are doing should be combined to make one certificate. Even if you apply somewhere you are told the certificate is not registered

I: You are not recognised. Are you not registered with any authoritative body as health care workers?

P: No, we are not registered, we are told we are volunteers we have been volunteers for many years.

I: How long have you been working

P: Ten years I started in 2006 doing WABOT

I: Doing WABOT?

P: No WABOT started in 2013 they took us form the NGO we were at NGO was transferred to the clinic.

I: Ok I get it. Your problem is you want to be registered

P: Yes, to be registered at least to be recognised, even the stipend should be every month, because we are getting it this month, tomorrow we don't get it is stressing us (sadness in the voice and frustration).

I: How is the system now of paying you?

P: We don't know the system now we have only signed the contract last week we don't know how the system works. This system the people who call themselves Smart Purse they give us it's like SASA card

I: So, they gave you a card?

P: Yes

I: How is it operating do you take it somewhere to get paid?

P: I'm going to withdraw money with that card. The problem we don't know if it's accurate it does not have account number. If the card is if I find myself at the ATM it doesn't want to get out they said no you must come back to us don't get into the bank. The previous method of paying us we were paid from our accounts. That one we must get the card get money from the ATM machine.

I: Are you all CHWs paid by Smart Purse?

P: Some qualify some did not qualify

I: Ohh!! not everyone signed the contract?

P: Not everyone signed the contract, they don't have qualifications. The criteria you must have qualifications. That is why I'm saying that the courses they are giving us should be recognised

I:For you to qualify what is the criteria?

P: They wanted grade 9,10, 11 12 If you don't have them you don't qualify also they wanted the DOH certificate

I: The DOH certificate?

P: Let's say for example they needed 50 people they take10 at Temba clinic and ten at other clinics and ten somewhere else some don't have that training it's difficult for them to get the certificates

I: So, but a at the end of the day you are all going to get paid irrespective of you signed the contractor or what?

P: No we are not going to get paid

I: Those who signed the Smart Purse contract are going to be paid by Smart Purse but now ,we are still waiting for the money outstanding for 3 months

When we ask Smart Purse is it going to give us that money and DOH says we must ask Smart Purse, DoH says its smart Purse, so we are confused

I: So, well i just want to ask you more regarding this training so you said you wanted to be trained to be recognised

P: Yes

I: As what?

P: As we are CHWs they must show us we are CHWs, some nurses they just say ahhh! they don't know the work they use us to do their work but we don't get anything for the work that we do. Even the work that we are doing the stats goes to the clinic. Even the reward goes to the clinic but the work load is from us at least if they say we are CHWs we must be registered, the workload is from us even if we are CHWs we should be recognised, but at least we must be registered (frustration on the face and voice).

I: Registered with authoritative body like SANC?

P: (Interjected) the DOH they should take us permanent.

I: Where do you see yourself in 5 years

P: Having my own house, car, working in a company for government institution that will benefit me because right now I'm clueless. But if i can see myself in a registered company to know that you are permanent

I: Do you like nursing?

P: Yes, I do like nursing but the way they are treating us you can say Aaihh! Let me forget it.

I: This treatment you are talking about is it from the higher authority or clinic staff?

P: I think is from both from higher to the clinic staff. We formed a group called task team (union)so that we can fight our own battles.

I: Where do you fight your own battles?

P: At the he DoH

I: Something like a union?

P: Now we have a union we don't know if it is legit or not. Not all CHWs joined the union

I: You don't know whether its recognised?

P: But there is NUPSO that one is recognised

I: What does it stand for NUPSO?

P: That one is busy helping us to fight this Smart purse we did not want to sign their contract but because we were hungry we had to sign Smart Purse. They told that if you sign well pay you your money. The only challenge is the salary

I: So I'm interested with this union which problems do you give to your task team to solve?

P: Such as the first one is the stipend I tell somebody from the task team to help me I will manage to get paid ever since task team was formed there is a huge difference. Because before task team was formed I was getting paid but my colleague did not get paid, when you are in a union you get paid. I was getting paid but my colleagues will not get paid. They will keep on skipping him sometimes they skip me but many CHWs are not getting paid monthly, even at the clinics when we have problem we give it to them they will not come and solve

I: And then you said the staff also at the clinics are giving you problems. What are the problems?

P: Because we deliver medication for the elderly at home maybe for example today is the date for the delivery I will go to the filling room issue them the number patient the file number, because sisters are not the same they differ in their ranks I have to find the professional nurse who can prescribe medication for the patient. If I go to that nurse will say I'm not your OTL (operational team leader). The patient will default because our team leader is not there I can't prescribe even staff nurse don't do that they want to help but because of their rank they can't. Some they call us nurse makaka(faeces)

I: What! wow! thats, what they do?(amazed)

P: yes

I: Have you ever reported to higher authority?

P: Yes, we reported to our team leader almost in all the clinic we have the similar problem

Almost we have similar problems. But I think if they train nurse to tell them about us that we have CHWs that will be working outside

I: You think that might be due that the clinic staff not being informed about you?

P: Yes they said they did not know what we are doing, we are so many

I: ok

P: They thought we are 2 or 3 even now we don't have space at the clinic to put our things you see they ended up giving us space in Hosperse.

I: Ok that is that but generally what are the services that you render?

P: Ok the services that I'm rendering I rehabilitate I prevent, I promote, I educate even issue treatment.

I: By rehabilitating, can you just expanciate on that one?

P: By rehabilitation such as palliative care, adherence to treatment make sure patient take treatment correctly They do not default

I: And promotion?

P: promotion like if the patient is on treatment they do not default to take treatment, to eat balanced diet not to eat fatty food

I: Education?

P: Education it is still the same sometime we do condom distribution at there at the tarvens and at malls

I: I learned You are also doing campaigns

P: Yes but It differs

I: May you explain this campaigns?

P: Sometimes it comes from the clinics we assist them, DoH invite all the WABOT clinics but even there are Some health promoters will treat us badly

I: How?

P: Someone who did the campaign maybe he applied for funds they are given food and water if we ask for that water they don't want to give us

I: I learned they don't give you food even if food is available?

P: Yes, they don't

I: Oh! Ok but have you ever complaint?

P: Yes, we complain a lot

I: Hmm

P: Even at higher authority they know especially issue of lack of space, We tell task team that we don't have space, Sometimes you need to write standing when you are given lectures it's difficult to write. At least here we are better but when we were at the clinic we were standing in the tiny space

That side at the clinic we stand in a smallspace when it is raining it rains on us

I: How do you get back at the household?

P: According to the way I know it When it is raining we don't do household we only do households when it is not raining. Some of us we clock here we must go back we don't have transport we end up going there not coming back. We don't have anything we end up going there but we don't come back

But the contract of Smart Purse wants us to come back and it's very difficult. But the nurses our OTL understand our situation in the morning we give report.

I: Have you ever raised this complain that is too much for you to go and come back?

P: They know it even the sector manager we even negotiate the Smart purse the CHWs must not come back and clock they are busy negotiating that.

I: Ok then, at the house hold ehh what do you do when you get there?

P: If it a new household I enter I introduce myself if they allow me to do the thing I want to do I explain myself why I'm there. Household register form will guide me because it's got questions

I: Ok

P: If there is somebody who is sick I will know because I will be busy asking the question. If they are interested for us to help them we help.

I: Which services do you render in the household?

P: If I find out there is someone who is bed ridden I bath them, make food for her if staying alone if living with the family I will educate them how to take care of the patients, If staying alone give care if staying with family I will educate the family

P: What else?

P: I give medication sometimes we find social problems maybe they are orphans they don't know how to register for foster grant, I will tell someone older to go and register to the social services or whoever

I: And they do get help?

P: Some they do get help. We have problem with the back referral if it does not come back. If I refer person to home affairs they don't want to fill the form they don't know what it is (hitting the table showing with hands). Home affairs they say they don't know what that form is. If this WABOT and CHWs was introduced properly to them it was going to be better. Some social workers came to say there are those people who come with this letter we don't know what it is (hitting the table) that CHWs who referred. The sister went to introduce WABOT to the home affairs

I: But do they fill them now?

P: It's only at the police station and home affairs

I: Who created these forms?

P: Was created by the DoH

I: Ok

P: All the forms have logos of DoH

I: Services of under-five at home?

P: I check the card if the child misses immunisation and that immunisation if I'm allowed to give I give if I don't have it I will come back tomorrow I give vitamins and I also fill the chart, I refer, the mother to clinic or I come tomorrow or my OTL will make sure she come back to the house

I: You also mentioned that with deworming and vitamins that you give its for nurses not your own statistics

P: No if it's a campaign we give that deworming is for the clinic. But if I go individual on my own to household that stats is for WABOT, I will give it to my OTL. At the crèche I have to be with a professional they think we are taking chances its not easy to believe someone who is not registered

I: There's no way you can introduce yourself

P: We are given the confirmation letter.

I: That's how you care for the under 5?

P: Yes the under 5 there is nothing we can do only nurses are allowed to give immunisation

I: The screening that you do in the household?

P: If I see that the household is not good I'm not going to tell that person do this I will advise

P: I will advise that I'm going to advice what to do it differs with the screening if there is somebody who is sick with TB I, will advise them to open windows so that ventilation might occur

I: Do you also do TB screening?

P: Yes we do TB screening

I: The HIV screening?

P: Yes we do

I: What other screening do you do?

P: HCT there are those who are trained, me I don't do HCT someone who is trained will do it, me I don't have the certificate but if there is somebody who wants to test I will arrange somebody to do it

I will arrange with somebody who is trained to do it. When we come we will ask for a room for privacy

I: STIs screening? Regarding this care and the pregnant women how do you cater for PNC?

I: If someone is pregnant we are going to make sure that she does not skip the clinic there is 1stvist 2nd visit

We write ehhhh the other form which is called tick sheet for appointment for that person and maternal after you came we record all visits 1st 2ndafter giving birth we check if the mother and the child are going to the clinic also the umbilical cord is taken care

I: I learned that sometimes due to their traditional beliefs they don't allow you to where the baby is?

P: Yes we ask, if they don't allow us we ask them how the umbilical cord is, we advise them to use to clean the cord with surgical spirit not ordinary spirit we show them how to wash the umbilical cord it if not off must come back to the clinic

I: For the post-natal women how do you care for them?

P: That is why I say we go and check for child and the mother We visit them 4 visit for baby and the PNC only.

I: Generally, what can you say about your general perceptions regarding this care that you render?

P: The care that I'm rendering is good it improves the lifestyle of the community some lack information we educate them about many things and some like it because of it's not easy to come and test for HIV. but when we did some campaigns its easy because all people are coming especially during campaigns. The clinic have its own method they know that this side is for the HIV that side is for TB. During campaigns It is very good

I: To the community how good is it ?

P: It is very good even the community we have created exercises groups like every Friday elderly people coming to exercise, we started with few granny and grand pas but now the number is increasing

They like what we are doing. there is this campaign called the 90/90/ we can arrange to go anywhere when we arrive there we take their BP everything even to the firms the industries s it's not easy for a man to go to clinic they like it clinic came to them the community like it even some they still doubt it

I: Is it WABOT campaign?

P: When it was lounged we did not know it, there are people at top who decides when the facility manger came asked 4 CHWs we did not know it is for clinic it's for WABOT, after we learned the 90/90/it's not for the clinic is for WABOT but after we learned it's for WABOT we decided to go with them They don't want us to give us their statistics but we created our own by going to churches, after church service we can do the screening schools and crèches.

Sometimes school nurses don't go to schools every month or every day we ask the principal can you give us chance to do this and that if the principal agrees then we come

I: Is there anything you want to add

P: No, I think I'm covered

I: Thank you for the information