Perceptions of individuals in Umlazi on the quality of care provided by community health workers

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Declaration on Plagiarism

I, Ziphezinhle Londeka Precious Mpanza declare that:

1. This dissertation is my original research except where otherwise indicated.
2. This dissertation has not been submitted for any degree or examination at any other university.
3. This dissertation does not contain other people's data, unless specifically acknowledged as been sourced.
4. This dissertation does not have other people's writing, unless specifically acknowledged and all the quoted sources have been referenced.
5. Where the exact words of participants have been used, their words have been placed in italics and inside quotation marks and referenced.

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Abstract

CHW programs should be developed in such that they are suitable for the local community. It is necessary to understand the perceptions about CHWs in the local context. The main objective of the qualitative research was to examine the community perceptions of the quality of care provided by CHWs based on a qualitative case study in the community of UMlazi BB Township. The study was conducted among 12 participants who are permanent residents of UMlazi BB Township and who had previous interactions with CHWs. The participants were selected through randomly visiting households and presenting the research requirements to the participants. In depth interview guide was used as a research instrument and the voice recorder was used to capture the verbal responses of the participants. The researcher collected data at the household of each participant and transcribed the voice recordings into textual data. The textual data was analyzed to find relevant themes that established the community perceptions of CHWs, the quality of care by CHWs and recommendations from the community.

The research found that the long-term perceptions of CHWs was that they demonstrated empathy by being patient and caring for the health and wellbeing of the community members. CHWs were found to be reliable as community members perceived them as being trustworthy, dedicated and persistent. The quality of care was mainly affected by tangible aspects such as resources and it was found that CHWs did not have enough of these resources. Overall, the research found that it is important for CHWs to engage with communities to strengthen their trust and reliability, to develop strategies of optimal use of limited resources, and to continually improve their knowledge and social skills.

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Dedication

This dissertation is dedicated to my late father who never got to see the success of his children. Mr Reginald Musawenkosi Mpanza, I hope I have made you proud!

In memory of Hlengiwe Dubazane, Sithembile Mpanza, Ndabezinhle Gumbi and Bonga Mbatha… your presence was felt, Rest in Peace!

Abbreviations

AIDS: Acquired Immune Deficiency Syndrome

ANM: Auxiliary Nurse Midwives

CCG: Community Care Givers

CHW: Community Health Worker

HIV: Human Immune-deficiency Virus

LMIC: Low Middle Income Countries

NDoH: National Department of Health

PHC: Primary Health Care

Stats SA: Statistics South Africa

USA: United States of America

VHW: Village Health Workers

WHO: World Health Organization

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Chapter One: Introduction

Health care systems have uncovered the need for an additional health-care force that will provide basic services using knowledge and skills to fully implement change. (Leslie & O'Neil, 1993)

1.1. Introduction of Chapter

This chapter will focus on the background of CHWs. By doing so, the chapter shall look at the dilemma of the shortage of health skilled workers to narrate the need for CHWs services. Moreover, a brief history of CHWs and the PHC will be presented. The chapter will also feature the following themes; significance of the study, problem statement, research objectives, the overview of this dissertation and chapter conclusions.

1.2. Background of the study

Several countries are striving to achieve health for all. The concept of universal health coverage which promotes everyone's access to good quality health services without undue financial hardship has been growing across the globe (WHO, 2010). However, in many parts of the world, equitable access to health care services is still not achieved (Barros et al., 2012; Neal et al., 2015). Health systems, in particular those in low and middle-income countries (LMICs), are struggling to serve poor and vulnerable communities that bear the brunt of the burden of disease (Perry et al., 2014).

Improving equitable access to quality health care services needs global and national investments in close- to client primary health care (Rao and Pilot, 2014; WHO, 2008). Basic but essential health care services need to be available in close physical proximity to individuals, families and communities. Equally, health care services should be close to where people live and work, and constitute the first element of a continuous health care process (Rao & Pilot, 2014).

Community health workers (CHWs) are an instrumental group of health workers who provide these health care services at the community level (Bhutta et al., 2010). Evidence shows that CHWs can be effective in improving population health in LMICs (Gilmore & McAuliffe 2013; Perry et al.,, 2014). CHWs are extensively involved in the provision of promotive, preventive and some basic curative health care services. They often substitute professional health workers

as a result of task shifting in a context of constrained human resources for health (Chopra et al., 2008). Therefore, CHWs extend services to hard-to-reach groups and areas, delivering health interventions right in their communities, which tends to be more equitable than services delivered at health facilities (Barros et al., 2012).

Over the past years, many LMICs have made efforts to strengthen their CHW programmes as one of the elements contributing to achieving universal health coverage (Tulenko et al., 2013). CHWs work at the complex interface of communities and the health sector where over time there has been a marked increase in the tasks and responsibilities assigned to this cadre of health workers but with limited training and in the context of numerous resource constraints. Policy makers and programme managers who aim to optimize and scale up CHW programmes are in search for strategies that could support the performance of CHWs (Glenton et al., 2013). Globally, the health sector remains challenged in resource poor settings by the shortage of medical staff to respond to the ill health problems of the growing population (Mlotshwa et al., 2013 & Haines et al., 2007). The pronounced 'care drain' affecting many countries in which most of its population relatively rely on provisioned health care service, has brought about many challenges upon governments in developing countries and this has resulted in developing states to be declared burdened (Chopra et al., 2008).

In other countries, CHWs have been involved in providing basic healthcare delivery that extends delivery from facilities to communities and thus proclaimed as local solution to a global problem (Singh & Chokshi, 2013). For example, in India, 600,000 CHWs have been employed and are paid for their basic service system which require them to provide primary care functions that include immunization and nutrition preparation and planning (Singh & Chokshi, 2013). In Brazil, CHWs are community agents that have been part of family health teams for many years and in dated research, they are in care of 110 million patients whose health care provision consists of maternal and child health and chronic disease management (Singh & Chokshi, 2013). Furthermore, the United States reports the presence of these health advocates in California and other border states promoting and addressing reproductive health issues, diabetes and cardiovascular health. It has been evidenced that CHWs have been health merges with accreditation as lay workers within the Department of Health (Singh & Chokshi, 2013).

The utilisation of CHWs has been widely recognised in the Sub-Saharan Africa. The CHWs workforce within these countries has been seen as a local solution that aims to scale up health

care provision, improve health outcomes, reduce health care costs and most importantly create employment (Singh & Chokshi, 2013). According to Nxumalo et al., (2016) in South Africa, CHWs have engaged in the process of comprehensive, high quality of care for its population by considering CHW programs to enhance the service delivery of CHWs in the community levels. The early establishments of these services to care in South Africa were mapped in Gauteng and the Eastern Cape provinces after witnessing the complex issues and poor maintenance and primary care outreach in the communities within these provinces. The limited resources and health force is a complicated situation that placed pressure on the department of health to revitalize its system and provide support services that will cater for the impoverished circumstances in poor households (Nxumalo et al., 2016).

As mentioned above, CHWs were one of the proposed priorities that were relied upon to bridge the gap in the shortage of health care professionals in the lower-middle income countries. They provide health care services in the underserved parts of developing countries and eliminate the supposed inequality in health provision in the remote areas (Swider, 2002).

1.3. What is a CHW?

Over the past decades, the PHC system has had a major influence on skilled health workers in numerous developing countries yet its origins surrounding the term PHC, roles as well as its operation in developing countries has been unclear (Cueto, 2004). In consequence, what is known about PHC is mostly on its grass root level as the responsive structure that responded to the world hegemony and the world's political context of that time.

CHWs have been the cutting edge of the public health for over a number of years. There are a number of ways in which CHWs are described and defining who would be considered a CHW varies across settings. In many occurrences, CHWs have been described according to the roles and the services they provide and in other contexts. CHWs are defined by members of the community according to their perception, knowledge and through their delivered care to their patients.

Similarly, Love et al., (1997) proclaim that CHWs are indigenous health care workers who generally work with the underserved communities in which they reside in. They are often selected by members of the community in trust that the selected CHWs will become responsible for the communities health needs. Within these communities, CHWs have become the insiders

of communities. However, in perception, CHWs are treated as outsiders with a close eye and a gut of suspicion (Nxumalo et al., 2016). In contrast to the above illustration, this umbrella term defines the variety of basic services that these semi-skilled professionals render to their ill patients in terms of volunteering.

1.4. The history of CHW and how they spread

The emergence of CHWs was to respond to the need to render basic health care service to economically vulnerable communities. CHWs were marked as agents of basic health care deliverance at the community level in the mid 1950's and 1960's (Lehmann & Sanders, 2007).

The early origins of CHWs are traced back in the early 1930's when health care services where introduced to the middle level countries. According Lehmann & Sanders (2007) and Matwa (2008), the barefoot doctors were the earliest auxiliaries and CHWs of the health service in the past decade and their responsibilities entailed visits to the homes of those members of the community with ill health and providing them with basic medical assistance (Lehmann & Sanders, 2007; Lehmann & Matwa, 2008). China, Indonesia and Tanzania were countries amongst many others that were popularly known for the introduction of this middle health services and the functions of these services in communities. In these countries, CHWs were the mouthpieces of the communities in which they served and fought for the decentralization of health care service for remote areas and the intervention of these semi-skilled workers raised awareness and greater effectiveness for the dependent population until the late 1970's (Christopher et al., 2011; Lehmann & Sanders, 2007).

On record, village health workers (VHW) were also emphasized as care-giving providers that existed alongside barefoot doctors in the early 1930's until the late 1960's. These health agents functioned as advocates that promoted social change, fought against health inequalities and as agents that reflected the revitalized roles and functions of the comprehensive primary care system (Lehmann & Sanders, 2007). In literature, barefoot doctors and VHW were the programmes and initiatives in Africa that were used as solutions to the oppressive political context that denied equal access to health care services which in turn suppressed the right to access and attain better quality of care (Lehmann & Sanders, 2007; Haines et al., 2007).

In the 1980's there was a recession, where the economies of developing countries brought forward shifts in the health policy that initiated policy reform that focused on "liberation,

decolonization, democratization, self-reliance and the basic needs approach to development" which the World Bank derived (Lehmann & Sanders, 2007:5). As mentioned above, CHWs programmes emerged in various countries and in the first decade of implementation these programmes responded on a top-down approach with the urge of decentralizing healthcare to remote areas.

CHWs have become prominent in national states as national programs for CHWs have been and still are in use till this date. The arguments and debates around CHWs in the 1980's and 1990's came to similar conclusions resulting the poor use of their application, the scale of poor delivery of healthcare service, poor training, lack in supervision and the lack of financial and logistical support of CHW programme. Amongst the challenges to this model, the practice of CHW programs reported to have failed to address the health disparities at that time and therefore the model and practice of CHWs was viewed as inadequate (Lehmann & Sanders, 2007).

While the major role of CHW is to provide preventive healthcare measures, their attempts to adhere to these pillars are challenged by poor motivation and minimal health training (Haines et al., 2007). In South Africa, the significance of CHW has been highly recognized and relied upon in reducing many health risks and health threats that have led to mortality (Lehmann & Sanders, 2007). The ongoing literature pertaining CHWs and their spread in South Africa has mapped this cadre of health care highly. This includes, performing in poor remote countries, responding to the HIV/AIDS pandemic that has burned many states across Sub-Saharan Africa (Lehmann & Sanders, 2007).

1.5. The history of Primary Health Care

The landmark conference for PHC was launched in September 1978 and its significance was to provide a platform for the ideas and changes that were going to be adopted by the PHC parameters for the change in the PHC system. In that conference, universal access to health care for all was emphasised as a major component to human existence in developing and less developed countries (Christopher et al., 2011). Due to the inequalities between health provision in developed and developing countries, the Alma Alta declaration presented on the guidelines that were going to address the basic health needs of both core and periphery countries. The PHC in collaboration with the Alma Alta declaration included programmes that focused more

on disease prevention and health promotion and further emphasised the need for community participation (Schaay & Sanders, 2008; Walley, 2008).

In the last 30 years since the passing of the Alma Alta declaration, the efforts to implement the core values of the declaration have been challenged due to the on-growing health disparities in developing countries. The core attributes to the PHC have been limited and their practices to reshape the PHC system have been compromised (Lawn, 2008; Rasanathan, 2011). Even though it is approved, the on-going global crisis of the inequalities that exist when seeking healthcare provision are still prevalent, the remaining principles of the declaration resonate the reflection of the promised action plan that will be adopted, used and integrated in the health systems in order to strengthen human resource, programmes and the services provided. Noticeably, for numerous years, countries have tried to improve their healthcare systems by developing mechanisms that will increase and strengthen its human resource. They tried this by implementing provisions of health services that will shift from an "individualized, passive, curative and a vertical system to a population based, integrated and proactive model" approach in the PHC sphere (Nxumalo et al., 2016:62). In response to that, South Africa's efforts have been made in reshaping its PHC system through the concession that PHC is one of the most important core and central components of any country's health care system.

Having said that, PHC provision has managed to establish direct links between the health care and the members of the community. With the need to implement these concerns towards the improvement of the quality of care to be provided to the ill health, CHWs were part of the solutions that geared the improvements of PHC in South Africa (Nxumalo et al., 2016).

1.6. Where CHW fit in?

The core values of the Alma-Alta have been relevant in today's PHC environment clearly in the deployment of CHWs to decentralize access to health care in remote areas. With many difficulties encountered by developing countries, CHWs are a key human resource in providing universal coverage in remote settings.

Apart from their undermined role in the health system, CHWs provide tasks that include; "home visits, environmental sanitation, provision of water supply, first aid and treatment of simple and common ailments, health education, nutrition and surveillance, maternal and child health and family planning activities, communicable disease control, community development

activities, referrals, record-keeping, and collection of data on vital events" (OfosuAmaah, 1983 cited in Lehmann & Sanders, 2007: 8).

Therefore, the CHWs fit in and strengthen the PHC system by delivering low cost primary services to the communities in which they serve (Rachils et al., 2016). With their combined service functions, CHWs have expanded the global workforce by training and retaining CHWs to render developmental and promotional health services in remote settings (Lehmann & Sanders, 2007). Furthermore, CHWs have become feasible links between the community and the health sector and more importantly, CHWs have expanded the goal of improved health in communities. Overall, the advanced interim of providing basic medical assistance to remote communities being achieved, CHWs have rescued the inequalities faced by remote members of communities by bridging the communities and formal health services to meet access to health care. Lastly, the ultimate goal of decentralizing health care services to vulnerable communities is achieved by CHW program; thus, the proposed plans of a revitalized health system have been obtained (Nxumalo et al., 2016).

1.7. Conceptual framework and operationalisation of concepts

Conceptual frameworks are descriptive tools used to map and define relations between a problem and the elements contributing to it. The conceptual framework guiding this study is based on the quality of care framework.

Quality of care is a terminology that is widely used in healthcare settings to determine the dimensions of "perceived service quality" served by hospitals, clinics and care givers (Padma, Rajendran & Sai, 2009:159). Noticeably, 'quality' is an indicator that is highly emphasised as an element that is measured by an outcome of results and satisfaction after rendered services (Mosadeghrad, 2012).

Furthermore, the quality of care framework is proposed that service users evaluate quality of care they receive using five dimensions or criteria. Parasuraman et al (1985) asserts that service quality is a dimension of the differences of groups between customer expectation, performance and quality dimensions and that these attributes of quality care are depicted in five categories namely: "reliability, responsiveness, assurance, empathy and tangibles" (Parasuraman et al., 1988).

In accordance to Parasuraman et al (1988) *reliability* refers to the ability to provide services accurately and dependently and CHWs provide this by rendering basic services to community members through their understanding of delivering basic healthcare services and also from the enriched knowledge attained from the short courses provided to CHWs.

Responsiveness refers to readiness or quickness in responding to patient's needs (Parasuraman et al.,1988). This signals that CHWs are the first aiders of the community in providing efficient, basic and responsive services to the vulnerable communities. Ideally, fetching pills for the ill-health from clinics, providing HIV/AIDS counselling and testing in their homes and also providing health promotion services are most common roles CHWs play.

Assurance refers to courtesy and the ability to convey trust and confidence by keeping to privacy and confidentiality of their patients matters (Parasuraman et al.,1988). This is an important attribute that CHWs must present when working with members of their communities as revealing matters of the patients that they assist in their homes is unwanted.

Empathy refers to caring and giving individualized attention to their patients (Parasuraman et al.,1988). The significance of CHWs assistance is to give ultimate attention and quality care to patients in need by providing and basic health care.

Tangibles refers to the physical items such as medication and equipment to provide quality care to the community members in need of CHWs service (Parasuraman et al.,1988). Prior to receiving CHWs assistance, attitude or overall demeanor is very important and presenting yourself knowledgeable and uniformed asserts trust for community members.

In light of this research, this framework describes how CHWs have enhanced the provision of quality health services to improve the community members' health expectations by providing basic complementary services to support the community.

1.8 Significance of the study

Successful programmes related to CHWs have been initiated in many remote areas and underserved communities (Swider, 2002). However, previous studies conducted in other

contexts have identified weaknesses in the CHW programme in responding to localism, community perceptions, and the quality of care that patients receive from CHWs (Rachils et al., 2016).

In particular there is little research on how community members feel about CHW, the perceptions that community members have concerning CHWs as well as the quality of care that CHWs provide to community members during CHWs visits to their patients' households. Having said that, this study will address the local content on community members' experience and attitudes surrounding the quality of care and the services rendered by CHWs.

1.8.1. Motivation of the study

The motivation for this study was to navigate on the perceptions and experiences of individuals in Umlazi on the quality of care provided by CHWs. The rationale behind this study was to adopt the individual experiences when assisted by CHW and examine how their experiences with CHWs may be used to improve the quality of care they receive from CHWs in the future.

1.9. Aims and objectives of the study

1.9.1. Overall aim

The aim of this study is to examine the community perceptions of the quality of care provided by CHWs and by providing these findings, the community of UMlazi BB Township would be used as a case study. For further analysis, the community members of the designated area will be asked to comment on their experiences with CHWs and whether the services that CHWs provide have been beneficial to them or not.

1.9.2. Objectives

The objectives of this study are:

1. To explore the experiences of community members when visited by the CHW.
2. To explore how community members perceived CHW.

3. To explore the perceived quality of care provided by CHW.
4. To explore recommendations made by community members about CHW.

This study used a qualitative method from in-depth interviews with the community members of UMlazi BB Township in Durban. The sample population consisted of 12 community members who live in this respective township and have experienced the basic services rendered by the CHWs of this area. The findings from these one-on-one interviews enabled greater insight on the perceptions of community members regarding the quality of care offered by these para-professionals.

1.10. Structure of the dissertation

This dissertation comprises of five chapters covering the introduction, literature review, methodology, research findings and conclusions and recommendations.

Chapter two presents a literature review which discusses CHWs and CHWs roles. Further to this the selection, training, monitoring, sustainability and motivations for CHWs is reviewed. This chapter continues to present the Global and African perceptions of CHWs and outline the lack in literature that postulates on community perceptions of CHWs.

Chapter three gives the description of the research methodology and the research method used for this study. The research method chosen will be inclusive of the population sample and the rationale behind the choice of this research method. The experiences, challenges and limitations of data collection upon this proposed study will also be discussed.

Chapter four presents and discuss the research findings on the community perceptions on the quality of care provided by CHWs.

Chapter 5 summarizes the main themes that were answerable to this research. This section examines closely at whether the objectives, rationale and the research questions pertaining to this research have been achieved. Furthermore, this chapter present recommendations and consider how these recommendations may be conceptualised in order to improve CHW.

Chapter two: Literature Review

The best way to find yourself is to lose yourself in the service of others. (Mahatma Gandhi)

2.1. Introduction of the chapter

This literature review begins by providing a background, definition of CHWs and gives a description of the role of CHWs. In addition, the chapter provides an overview of the selection

of CHWs, the design and implementation of training programs for CHWs as well as the role of community participation in these processes. Furthermore, the factors that influence CHWs including motivation and incentives were explored in the chapter. In addition to the general overview, the research presented the global and South African contexts of CHWs. Finally, the community perceptions and quality of care of CHWs is explored.

2.2. Background

2.2.1. Alma Ata Declaration

Subsequent to the 1978 Declaration of Alma-Ata, there has been a positive adoption of community engagement within the health sector and as a result, it has become fundamental to good public health practice (Haines et al., 2007). Community engagement has been considered to be an important additional contribution to facility-based care. In addition, it is a positive component on socio-economic and environmental factors that influence health development (Haines et al., 2007). As a result of the knowledge on the importance of community engagement, community health workers (CHWs) are vital in increasing the reach of health systems through a broad social involvement in delivery of health services and fulfilling the demand for these services at a lower cost (Witmer, et al., 1995). There has been compelling evidence and a substantial growth in theory related to the success and cost efficiency of CHWs. However, there is still a need to fully increase the reach and effectiveness of CHW programs (Haines et al., 2007).

2.2.2. Definition of Community Health Workers

In accordance to the HRSA Community Health Workers National Workforce Study (2007), CHWs are individuals belonging to communities without expert knowledge of health care. These individuals work for a wage, or for free, in coalition with the local health care system in both urban and rural environments. The common characteristics of CHWs are that they belong to the communities which they provide services for, they are accountable to these communities, receive support from the health network and undergo less training than health professionals (Lehmann & Sanders, 2007). In addition to being resident in the community where they work, the WHO (1990) highlighted that individuals should be selected by the community members, and also have the ability to work closely with health systems (WHO, 1990). Furthermore, Witmer et al (1995) adds that CHWs are a valuable link between consumers and health care

providers as they have an ability to persuade those that have not formerly used health services before to start using them.

To summarize, CHWs are members belonging to a community who receive less training than professional workers (Lehmann & Sanders, 2007; HRSRA, 2017) enabling them to provide solutions to the health needs of those in the community (WHO, 1990). They also work closely with health care systems so as to provide a link between consumers deprived of health care and providers of health care (Witmer, et al., 1995).

2.3. Overview

2.3.1. The roles of CHWs

The roles of CHWs varies and are dependent on factors such as the sector in which they function which can be social services or health care services. It has been recognised that the roles of CHWs are influenced by the services that they render include encouraging health practices, increasing the reach of health services within the community, educating the community and providing clinical services (Gelson et al., 2005). The roles that CHWs will take on are highly dependent on the community in which they provide services and as a result of conforming to this, CHWs become acceptable and are considered credible. In addition to the provision of health-related advice and services, CHWs should actively engage with their community's social development requirements (Dick et al., 2007). The level of reliability is highly dependent on how society views their experiences based on how CHWs render services for them and CHWs are valued when they are attentive and caring to the public needs.

Correspondingly, Altobelli et al (2009) found that it is necessary for CHWs to demonstrate that they personally implement the health advice that they give, be persistent, and demonstrate a high level of care when advocating for preventive practices. The trust between CHWs and the community is influenced by a well-balanced combination of factors which include reliability, achieving expected results, credibility and continual reinforcement of all these factors in the future.

CHWs also complement the provision of health services by translating and interpreting these services, delivering health care knowledge and information so that it is appropriate for the culture of the community. In addition, they also provide friendly and easy-going professional help and advice on health behaviors, being proponents of community health requirements, and

through providing additional services such as first aid and blood pressure testing (HRSRA, 2017). The clear identification of a problem being faced by the community by a CHW enables creative solutions to be created and allows an effective and efficient implementation of the solution in the community.

Furthermore, Andrews, et al., (2004) investigated the roles of CHWs in research on ethnic minority women in the USA. Medline database covering the period from 1966 to 2002 and CINAHL database covering the period from 1982 to 2002 was used to obtain studies. Twenty-four (24) research studies were used for the final results of the study. The most common role that was found from the study was that CHWs provided education to the community they served. This was followed by the role of the CHW reaching out to the community and marketing programs in the community. On the other hand, Mwai, et al., (2013) investigated the role of CHWs in HIV care. The databases used included JSTOR, PsychInfo, WHOLIS, Web of Service, SAGE Journals and Embase. Twenty-three research papers were used for the final results of the study. It was found that CHWs provided education on HIV and health services to the community. In addition, the CHWs also provided training in antiretroviral treatment and they provided counselling to encourage safe behavior that helps prevent HIV infection. The CHWs also improved the filing of medical records and did this with a very low error rate which was about one third of trained medical workers. Additionally, Willmott & Olphen, (2005) argues that CHWs can also assist in the reintegration of former prisoners into the society and they can also assist in reducing the negative health effects on incarceration. The CHWs ability to advocate within the community is helpful in getting society to generally accept former prisoners into the society. CHWs also help in reducing health inequalities by using their deep knowledge of the community that enables them to link most of the community to health services.

2.3.2. Community Participation: CHW Program Design, CHW Selection, and Implementation

The literature further demonstrates the importance of CHW programs as also emphasized by Rosato et al (2008) that the importance of starting any CHW program with a community meeting advocating participation in education of health issues is crucial to the community. It is suggested that literature has acknowledged the purpose of basic characteristics of methods of choosing CHWs in enabling the CHWs actions within society. For example, the first serious prerequisite in the choice for a CHW is that the individual belongs to the community that they

will serve (Bender & Pitkin, 1987; Lehmann & Sanders, 2007; Werner, 1977). This is particularly important as it is the responsibility of the CHWs to ensure that their activities are relevant to the community they serve (Sanders, 1990). In contrast to this, Bender & Pitkin (1987) argues that the responsibilities of the CHW is dependent on who pays the wages to the CHW.

According to Schneider et al (2008), a measure of CHW success, which represents a large correlation between CHW and the public is known by the term "community embeddedness". CHWs are an excellent agent for uniting existing technical proof, best practices and information on the needs of the community (Schneider et al., 2008). There is a strong realization by reviews and articles that public embeddedness can be developed by including people belonging in the community in CHW selection, setting targets for the program, and control of the program (Bhattacharyya et al.,, 2001; Gilroy & Winch, 2006; Haines et al., 2007).

CHW programs are successful when communities and CHWs work together as committed partners, but struggle when they are exclusively responsible for motivating and organizing communities alone (Bhutta et al.,, 2010). The continual deployment of CHWs over a long period of time into the community has been difficult to sustain especially for those helpless groups at the community level. Early literature studied programs that were initiated and maintained by public sector departments as these were the most common but lately CHW programs have become more common in the initiation of NGO community-grounded plans, social advertising agendas, and social franchising (Bhutta et al., 2010).

CHWs for a community-based program should meet predefined requirements before they are considered eligible and these requirements may be related to the demographic profile, the education level, the capability to finish training on standard proficiency in health approach within the community, and the capability to execute tasks based on their roles (Lehmann & Sanders, 2007). According to Rockville & Maryland (1998), language skills is another important selection criterion for CHWs. A CHW who resides in the community he/she serves will have a high chance of speaking the popular languages within that community making it easier for the CHW to communicate with the local people (Rockville & Maryland, 1998).

CHWs may be selected on the basis of culture, gender and social norms which can also be used as indicators for CHW effectiveness. Krishnamurthy & Zaidi (2005) found that all levels of literacy could be incorporated into CHW programs and these programs would still be successful. Other factors to be considered were: the passion for community work, the level of

family duties, and the time available to conduct community work. Schultz et al (2002) found that characteristics such as the reputation of the CHW in the community were important as such would ensure that CHWs have the trust and respect of the community.

In countries such as Pakistan, India and Ethiopia, the community health approach prioritizes family planning, maternal and child health services and there is a requirement that CHWs actually immerse themselves in the community such as visiting each person at their place of residence (Department of Education, 2001). Difficulties were experienced when the CHW was male as they would not be allowed to enter the residence by a female resident and this meant that if there were only male CHWs, the effectiveness of the CHW would be lower (Department of Education, 2001).

Additionally, the level of tuition and the ability to complete training related to the skills required to successfully fulfill the roles and responsibilities expected within the specific community-based health strategy are other selection criteria. More than the level of education, it is important that the person selected is passionate about his or her work, responsive, accountable, respected, and trusted by the community. As stated by Lehmann & Sanders (2007), communities regularly associate these features with those individuals of an older age and to those that have children in their care. If you are a CHW, you do not need high qualifications, but CHWs must be open to learning (Lehmann & Sanders, 2007).

As identified by Department of Education (2001), "when a more advanced level of preventive and curative care is required, the selection criteria may include higher-level qualifications or a stricter age range" (Department of Education, 2001). In India, for example, Auxiliary Nurse midwives (ANMs) should complete 12 years of education and should be aged within seventeen and thirty-five years' age range so as to be admitted in the one and half year ANM training programs in nursing schools (Department of Education, 2001).

There are also some instances where society and government departments create the standard of CHWs. For example, in Mozambique, CHWs have been nationally documented as a health worker cadre, for which training, qualifications, and selection criteria has been the same nationally (GHI, 2011). Moreover, it is suggested that any change morals regarding CHW abilities should be the same if there is a common preparation (George et al., 2011).

2.3.3. Training of CHWs

Rifkin (2009) found that training, management and support to CHWs influenced the standard of health services they provided. The type of training, revision of training material and more frequent supervision had a large effect on CHW achievement and conduct. The prior and continual education that CHWs acquire affects the quality of their skills (Bhutta et al., 2011). "Training does not only provide preventive, curative, or other relevant services to the community, it also provides teaching and communicating with community residents" (Bhattacharya et al, 2001:22).

The CHWs grow and keep up to date with required skills by revision of prior training and continual training. CHWs' experience develops through a process of repeated trial learning and teaching comprising of natural knowledge and technical exercise (Pinto et al.,, 2012). Altobelli (2012) stated that, teaching measures for adults, for example education characterized by participation, experimentation and recommendations are important in the role of influencing the ability of CHWs to learn and perform satisfactorily.

According to WHO (2007), training has to assess the competency and be based on practice by the CHW. There is a need for the training material and the tasks that are tailor made for the CHWs. It is also essential that the training is in close proximity to the community which the CHW is expected to serve. Furthermore, it is essential that there is continual revising and updating of skills and knowledge (WHO, 2007).

2.3.4. Motivation/Incentives

Amare (2009) argues that the willingness of a CHW to participate in working for the community voluntarily or for ordinary wages, encouraging health practices and ensuring their health is very important. Volunteering is still present and identifiable in different communities, however, there are several instances in which CHWs receive wages for their services and income resulting from the sale of medical goods (Wagner, 2012). Based on CHWs within the Bangladesh Rural Advancement Committee program, it was discovered that even though social motivations are important for maintenance, financial motivations are the utmost frequently discussed issues. Financial motivation was considered important in ensuring the continuity and survival of CHW programs in Tanzania. Furthermore, based on a study in South Africa, non-

monetary motivations served as "enablers" while monetary motivations were the "real motivations" (Kironde & Klaasen, 2002).

Greenspan et al., (2013) conducted a study to investigate sources of CHW motivation in the Morogoro region in Tanzania. The CHWs in Tanzania are not employed by the state and they volunteer their services to the community. In this study, it was found that CHWs had a passion to serve and educate the community and a strong feeling of wanting to gain health education. The families of CHWs also provided motivation by giving positive encouragement, financial assistance, providing resources and assistance for work related tasks to the CHW. In addition, the community also positively motivated the CHWs by recognizing and encouraging CHWs, providing financial assistance, resources and assistance for work related tasks. Furthermore, the organizations provided assistance and motivation such as providing resources for the CHWs to conduct their work, providing training and positive assistance from facility-based health workers. (Greenspan et al., 2013).

2.3.5 Factors that affect the effectiveness of CHW programmes

Factors such as geographical context, values, socioeconomic status, and health organization features affect admission, mandate, support, and belief in CHWs (Bhattacharyya et al., 2001; Stone, 1992). The factors mentioned affect views that the public has on CHWs and hence, the ability to effectively work in the society. The preferred CHWs in rural Peru were female because women were generally believed to be reliable in dealing with pregnant women and family planning (Altobelli et al., 2009). In other circumstances, men might be interested in being a CHW if they believe that it will give them a chance to earn a reasonable income (Walt et al., 1989).

Numerous investigations in the role of the community in creating the need and reach of CHWs has been conducted in rural area settings, therefore the research findings are limited to the rural setting (Bhutta et al., 2011). This means that there is a limit in using these findings for future programs since the majority of the people in Sub-Saharan Africa and South Asia will be residents of urban areas and many of the most vulnerable people will be living in informal settlements and shanty towns. Therefore, it is also necessary to expand research on the effect of community engagement on CHW programs to the urban areas to better inform future CHW programs (Bhutta et al., 2011).

In rural areas, there is a low availability of medical services, and customary notions of disease and cultural methods occur more frequently. Therefore, the required competency of the CHW differs in comparison to the urban areas where the community is likely more educated (Kroeger et al., 1996). For example, in Africa, where cultural health notions of disease and associated local language prevail, CHWs are required to have distinct health education expertise. This access to higher expertise and knowledge is crucial in retaining CHWs in the rural setting, however it did not have any effect in retaining CHWs in the urban areas in Bangladesh (Alam et al., 2011). In urban communities, there is less reluctance in accepting that CHWs have a purpose compared to rural communities where more CHWs have been disapproved by some people in the community. The cultural setting has an important role in determining the association between CHWs and the community. In Nepal, CHW programs are affected by a tradition of volunteerism, resistance to unethical behavior from paid government employees and the program's "community embeddedness" (Glenton et al., 2010).

According to Kalyango et al (2012), the factors that increased the performance of CHWs were the continual review and development of knowledge using monthly meetings, accessibility of medicine, the use of safe medication and having their cost of transport to get medicines sufficiently refunded. In addition, the factors that reduced their performance included not having enough resources to conduct their work at night and when it is raining, failure to get transport and to travel long distances to check up on the children that had received treatment.

2.4. Bangladesh Case Study

According to Wyon et al (2002), the Bangladesh government has delivered basic services and strengthened NGOs to work with societies through the use of many strategies to deliver health services. There is no single solution for public health problems but rather a large number of strategies by non-governmental systems, most with a solid base in the public sector (Wyon et al., 2002). The CHW program in Bangladesh started off at small level and was eventually a success and increased in size (Hossain, 1999).

2.4.1. Selection of (CHWs)

As identified by Khan et al (1998) and Hossain (1999), in Bangladesh, the choice of CHWs was based on the criteria that candidates were married women who were accepted in the

community aged in the range from twenty-five to thirty-five years who had children older than 5years, were keen to actively work in the community, were preferably educated and their residential locations were far away from the local medical facility. Khan et al (1998) & Hossain (1999) points out that although CHWs do not receive wages, there is an awareness of a small income from the sale of medicines required to treat communicable diseases (Khan et al, 1998 & Hossain, 1999). According to Rahman et al (2010) in Sylhet region of Bangladesh, CHW candidates were required to have a basic secondary education certificate with an SSC pass and in addition to this they were required to take and pass a general knowledge exam before they could go for an interview and ultimately train to be a CHW.

Chatterjee (1993) highlights that the family planning programs in India carefully recruited males as CHWs in the 1970s and early 1980s. Nevertheless, with the recognition of the significance of child health facilities and need for care, females were considered more appropriate for CHWs (Chatterjee, 1993). Moreover, the plan was changed, and efforts were made to phase out male workers and trainee females were to replace them. In contrast to this, Jobert (1985) found that the government prescribed standards regarding the CHW profile such as minimal education and be willing to dedicate two to three hours a day to community health activities.

2.4.2. Role of (CHWs)

The extent of the health activities of CHW in public grounded health care is quite comprehensive, particularly bearing in mind that in Bangladesh CHWs are not educated or at best semi-literate and are not receiving wages (Perry, 1999). In India, the CHW were expected to know the health requirements of the public and offer elementary health services (Maru, 1993 & Jobert, 1985). This included preventative health services as well as education and link with focused health organizations (Maru, 1983 and Jobert, 1985). In situations where competency lacked, the CHW used resources of the formal health organization to meet needs. The CHWs were expected to advise the community about health programs, for example, household arrangement and individual sanitation (Maru et al., 1983).

2.4.3. Training

In Bangladesh, the CHWs are given basic or upfront preparation on important health care for a duration of twenty-one days, at four days per week at the provincial workplace (Khan et al., 1998). In India, the CHW were accepted and approved by the selection committee; they performed a three-month preparation in simple and basic health attentiveness at the principal health centre (Maru et al., 1983). During the training, the community health volunteer received a normal wage from the government. Moreover, after the training, the CHW spent a minimum of 2 hours a day providing services in the society (Maru et al., 1983). Based on the ideas of Khan et al (1998) and Maru et al (1983), it can be argued that both these countries trained CHWs. However, there is a difference in terms of days, since in Bangladesh, they only trained CHWs for 21 days, whereas in India, they trained CHWs for three months. According to Ahmed et al (2009), in Bangladesh, CHWs were more astute in the knowledge of using medication which included the frequent use of antibiotics for child and in lesser cases the medication for fever and diarrhea.

2.4.4. Incentives

In Bangladesh, there were frequent motivational issues aimed at attracting a CHW, for example, to provide health services for children, to earn a lucrative income, to acquire medical knowledge, to alert individuals about contraception and immunization. According to Maru (1983), in India, from the beginning of the program, the government clarified that the CHWs were volunteers and responsible for serving their communities. However, the society viewed CHWs being primarily employed by the government and they gave CHWs extra responsibilities. According to Chatterjee (1993), the reduction in the involvement by the government in terms of meeting the cost has resulted in withdrawal from other stakeholders.

2.4.5. Monitoring

In Bangladesh, the directors of Building Resources Across Communities' platform assisted management and gave practical guidance to CHWs (Hossain, 1999). The directors managed 25 to 30 CHWs and all the CHWs were called to conduct work two to three times per month. According to Maru (1983), in India, the call of duties of CHWs were managed and ordered by the public. Based on the ideas of Hossain (1999) and Maru (1983), it can be argued that there is difference in terms of monitoring CHWs, since in Bangladesh program organizers are

responsible for monitoring, however in India, the community had the freedom to remove CHWs if they were not performing as expected.

2.4.6. Replication

According to Lovell et al (1993), the BRAC in Bangladesh have pushed for the expansion of health plans. There was a link to qualified, experienced and dedicated human resources to support the program; effective management systems including monitoring and evaluation systems. As identified by Suresh (2003), there was no strategy of stimulating the CHW scheme by the government of India.

2.4.7. Sustainability

By means of developing strong, better educated and empowered village groups, capable of utilizing and making demands on government health services, a higher quality of preventive health measures will be experienced in the community in Bangladesh (Lovell et al, 1993). According to Hadi (2003), the failure to take ownership of the program by the state governments and termination of financial support from the central government, the CHW scheme in due course came to an end after 25 years of functioning.

2.4.8. Challenges

According to Hadi (2003) the most crucial barrier for the BRAC model was that it had to be accepted by the government of India at national level. Furthermore, it is suggested that the successful identification of needs, extensive monitoring and supervision of voluntary programs made it simple for the government of India to institutionalize BRAC and to integrate donation into the agreed health program (Hadi, 2003).

According to Hadi (2003), in India, the CHWs had come across many problems emanating from inadequate backing from the society and the health management. The evaluation of CHW performance found that they were effective for three months, focusing on offering curative facilities thus deserting preventive and health promotion activities. Moreover, the CHWs started to view themselves as community medical doctors, frequently questioning the need of

more training. In contrast to this view, village communities typically regarded the CHWs as "third class doctors" and avoided their services whenever it was possible (Hadi, 2003).

2.5. South African Case Study

According to Swider (2002), in developed countries, the nature of the role of CHWs within health care systems is unclear and is still being revealed (Swider, 2002). Even though efforts have been put in place to officially articulate their title role, CHWs are not yet recognized in the South African health policy.

The Department of Social Development, in particular, has established its own group of community caregivers to address the needs of orphaned and vulnerable children. In 2006, the collective number of public caregivers in health and social development sectors was approximately 62 445 (NDoH, 2006b). National Department of Health (2004b:6) noted that the employment of CHW should be through NGOs funded by government (NDoH, 2004b:6).

2.5.1. Roles of CHWs

According to Lund and Budlender (2009) CHWs have had various job titles. The public councilors and CHWs use the title 'CCG' (community caregiver), whereas the formal DOH 'CHW' (community health worker) has been incorporated within policy and legislation. This difference in title helps to clarify job roles and expectations. The CHWs confirmed that the public had various beliefs of duties that CHWs were supposed to perform which were outside of their responsibilities. These included beliefs of being provided with a meal, prepaid electricity, being able to call CHWs when someone was in labor and expecting massages (Lund & Budlender, 2009).

Moreover, as stated by Lund & Budlender (2009), some of the CHWs were recognized as healthcare experts. They were frequently perceived as doctors or social workers. There was no clear difference in the programme between 'employee' and 'volunteer'. The CHWs receive a stipend, which is in direct violation of the South African labor laws. The full-time employees should receive a monthly salary in agreement with a national standard (Lund & Budlender, 2009). Similarly, Tripathy et al (2016) noted that smaller wages were associated with lack of motivation among CHWs in rural health facilities in India (Tripathy et al., 2016). However, in

South Africa, the motivation was the prospect of education which would allow CHWs to develop a career path (Jinabhai et al., 2015).

2.5.2. Training

According to Jinabhai et al, (2015), the recommended prerequisite for training as a CHW includes an entrance requirement of matriculation. There is a separation between the CHWs' education levels and the feedback received during data collection. Countrywide, CHWs have a low level of education.

2.5.3. Motivations

Being a CHW is not considered as a respected career and a study found that some used the role to utilize free time, or as a bridge to formal employment. In the face of unemployment, the introduction of regular stipends, however small, no doubt played an important role in captivating CHWs (Ngcwabe & Govender, 2013). The stipend amounts were set above the state disability grant level, which has been one of the alternate source of income especially for those CHWs living with HIV/AIDS. Ngcwabe & Govender (2013) found that CHWs are self-motivated and believe chances might open up.

Despite the fact that the prospect of getting steady employment was an important reason for being a CHW, this was not the only motivation for CHWs. Over the course of time, CHWs have established qualified uniqueness, particularly those functioning as social workers, and articulated wishes to progress in that role. For individuals living with HIV, working as a CHW presented an opportunity to become a progressive and non-stigmatized individual (Ngcwabe & Govender, 2013).

2.5.4. Evaluation of CHWs

As stated by Walt et al., (1989), worldwide, medical professionals have been primarily progressive and have recommended the idea of CHWs (Walt et al., 1989). However, in South Africa, the participation of nurses in CHW programs has been insignificant, even though nurses are responsible for staffing public clinics and have close contact with CHWs.

2.6. Historical background of CHWs

2.6.1. The initiation phase

According to Russell & Shneider (2000), at this stage, the nurses were uncertain about the roles of CHWs and perceive them as being risky. CHWs viewed the nurses' lack of knowledge about their training as the most important obstacle to establish relationships with them. The CHWs felt that they were not appreciated and recognized for their contribution (Russell & Shneider, 2000).

2.6.2. Beginning to understand each other

As identified by Russell & Shneider (2000), throughout this stage, CHWs and nurses started to understand CHWs very well, and therefore, there was a decrease of disputes. The nurses had time to work hand in hand with the CHWs and were able to determine that they are knowledgeable and dependable. This has led to the nurses making use of CHWs as an extra help in clinics. Moreover, the CHWs considered an inner struggle, as they had a desire of becoming a nurse but were not able to do so due to shortage of funds (Russell & Shneider, 2000).

2.6.3. Uneasy cooperation

Tollman & Friedman (1994) asserts that, at this stage, the nurses started to look at the CHWs as their link with the public, as a way to get to know the region, people and language difficulties. Nurses started to understand the worth of CHWs, since some nurses reached a point whereby they understand the important role played by the CHW in the community. Moreover, nurses endorsed CHWs to complete their duties without being given inappropriate responsibilities to complete in the health center (Tollman & Friedman, 1994). In contrast to the initiation stage where the nurses were reluctant to agree to take transfers from CHWs, they now welcomed them. This was certainly an indication that nurses started to be familiar with the work of CHWs. Moreover, this showed a change of perceptions by nurses who now viewed CHWs as individuals who are there to support them (Tollman & Friedman, 1994).

2.7. Community perceptions of CHWs

Older literature frequently investigates community perceptions and the quality of care that para-specialists deliver to their patients. A search using the terms 'community health workers' and 'quality of care' using PubMed found the 'challenges facing CHWs' and 'the quality improvement interventions to improve the competence of CHWs' as articles that related to community perceptions. Therefore, the need for local content in this area of research is mandatory (Tollman & Friedman, 1994). According to Condo et al., (2014) in Rwanda, the CHWs were appreciated and acknowledged when they demonstrated high training in health care. The CHWs who did not show confidence in their communication had a very low chance in convincing the community to practice good hygiene and to eat a healthy diet. Generally, the CHWs were viewed as being the main health educators providing valuable knowledge on health such as good hygiene, nutrition, malaria and family planning (Condo et al., 2014). Therefore, this emphasizes that the way the community perceives the CHW is highly dependent on how well the CHWs are trained and how well they can communicate with the community.

2.8. Quality of care

As identified by Bruce (1990), "quality of care has different implications, stretching from technical ability to the interactive proportions of care, and the apparent importance of these dimensions often differs by framework and stakeholder" (Bruce, 1990). The awareness and fulfillment from programs is dependent on the superiority of care, participation and program competence (Gilson *et al*. 1994; Guerrero et al, 2010). Therefore, it is critical to comprehend the advantage of care both from the perspective of maintenance workers and receivers. It can be argued that community health workers provide a quality of care to their recipients which should be based on the feedback of the people. For example, according to Linneman et al (2007), in Malawi, they compared the results of cases of serious malnutrition treated by medical professionals to cases handled by community health workers with no medical training and it was established that there was no difference in rate of relapse.

2.9. Conclusion

The dynamics of societies contribute positively to CHW performance and it is important that the community is involved in the design of CHW programs. The reliability and competence of

the CHWs are important factors to consider in the relationship between the community and CHW. The relationship affects the effectiveness and efficiency of the CHW. Community involvement in the selection and long-term support of CHWs are necessary. However, services provided by CHWs have not significantly affected the quality or results of services in the community.

Chapter Three: Research Design and Methodology

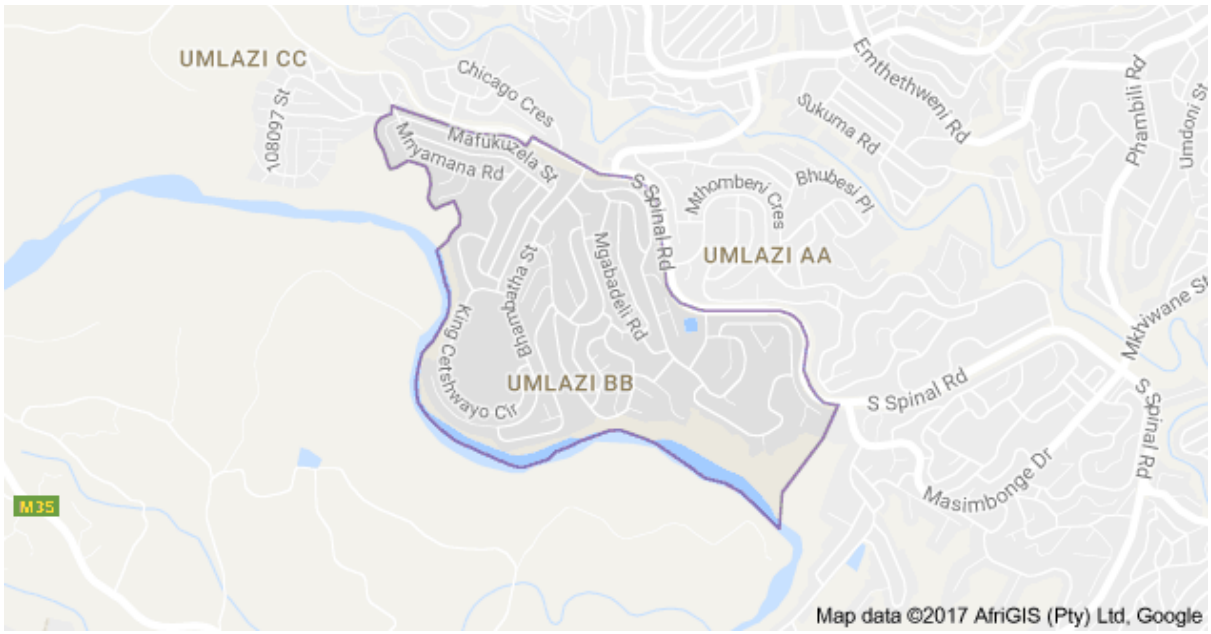
Qualitative methods are useful when studying health and social care settings particularly when exploring concepts, sensitive topics and real life contexts. (Handcock et al., 1998)

3.1. Introduction of chapter

This research study used a qualitative method to collect and analyse data to meet the research objectives and answer the research questions. The rationale behind choosing a qualitative method is that it allows one to gather rich information of traditional and lived experiences as opposed to a quantitative method that aims to generalize and focuses on statistical analysis (Onwuegbuzie et al., 2007). This chapter outlines the methods employed to collect and analyse the data for this study.

3.2. Location of the study

Figure 3.1: A Map of UMlazi showing the location of UMlazi BB Section.



Source: AfriGIS (2017)

The study was conducted in Umlazi BB Section. UMlazi Township is located 17 KM South-West of the Durban's Central business district and immediately West of the old Durban

International airport and the Southern industrial basin (UMlazi Local Economic Development Plan, 2008). The population of UMlazi is estimated to be around 550 000 during the 2011 census (MLEDP, 2008). UMlazi has inherited apartheid planning policies characterized by spatial and economic isolation and as far as development is concerned, the neighbouring townships of UMlazi have lagged behind in the past due to the policies that were in operation (Tshabalala, 1998). UMlazi Township is the second largest township in South Africa which consists of 26 sections. Just over a quarter (26%) of the inhabitants of UMlazi have completed matric, 36% have secondary education, and 15% have some primary education (MLEDP, 2008). The remaining population of this township have attained tertiary or any other form of higher education.

The social healthcare resources available to the population of UMlazi are wide. A total of 7 clinics and 1 hospital serve as immediate responses to the community health needs. The community health centre, also regarded as another primary health care facility, was centrally situated to be convenient for residents of all sections. However, like the hospital in UMlazi V section, this community health centre was not necessarily within walkable distance for all of the catchment population. However, the clinics for each section are a walkable distance. The growing population has also set a demand for an extra 14 clinics to be built across the sections due to the realisation that patients suffering from HIV/AIDS and tuberculosis overwhelm many clinics (UMlazi & Malukazi Local Area Plan & Township Regeneration Stratedgy, 2011).

Three quarters of UMlazi consisted of well-established homes and the remaining quarter consisted of informal settlements that are home to the poorer population and illegal migrants. The informal settlements are characterised by poor living conditions, a lack of basic services such as access to clean water and electricity and moreover, this area is burdened by the ongoing crisis of unattended social services.

3.2. Study Design

A qualitative method was found appropriate for the nature of this study. The qualitative approach offers researchers the opportunity to capture and analyse data that was collected in the field. Qualitative methods employ thick, rich, detailed description in the analysis of written and spoken words, or observations (Taylor et al., 2015). A qualitative approach grants the researcher the opportunity to “ask specific questions to a specific sample at any given time and

environment of exposure" (Ribbens & Edwards, 1998:6). Moreover, interviewees responded to questions asked based on consent and confidentiality reassured by the researcher.

3.3. Sample and Sampling Method

Participant selection is an important component of data collection. The sample selection chosen by the researcher was inclusive of members who are permanent residents of UMlazi BB section. In accordance to Hektner et al., (2007:6), "sampling is a means of collecting information about both context and content of the daily life of individuals".

In this study, the researcher adopted a purposive sampling which is selected on the bases of a populations characteristics and the purpose of the study to ensure the strategy for collecting data provides thick and rich data on their experiences with CHWs. It was also imperative that the participant met the criteria of having received a home-based visit in their homes to ensure that they were able to discuss their perceptions and experiences with CHWs.

Therefore, the conducted research consisted of 12 participants. These participants were chosen as participants that have experienced home visits and received basic services from CHWs. The researcher recruited the participants based on door-to-door visits and presenting the research topic at hand and then asking participants to participate voluntarily on this research and by consent, the researcher scheduled for an interview with the participant at a time that is most convenient for them. Surprisingly, respondents had little or no knowledge of what and who CHWs are, the respondents were unsure of what their actual duties and responsibilities were and whether they are here for a long or short time period. Questions that were uncertain were made clear to the participants at the end of the interview so that information shared before the interview was not jeopardized.

3.4. Description of research participants

A table presenting the sampled population for this research study.

Figure 3.2: Sampled population of UMlazi BB Section.

Sex(M/F)	Age during interview	Educational Attainment	Number of years living in UMlazi BB Section	Number of Children	
F	39	Grade 2	10	6	
F	31	Grade 11	19	2	
M	43	ABET	16	2	
F	41	Grade 3	14	4	
F	40	Grade 7	13	3	
F	28	Grade 12	10	1	
F	30	Grade 12	13	1	
F	65	Teacher	30	6	
F	38	Grade 6	20	4	
F	34	Grade 11	15	4	
F	40	Grade 12	32	2	
F	59	Nurse	32	2	
Total Participants		**12**			

Source: Researcher (2018)

In total, the study was conducted among 12 participants aged between 28 and 65 years. This sample was made up of 10 young adults and two elderly members. Further to this, of the 12 sampled population , 5 have attained their matric pass and 2 of the 5 went to tertiary level and studied for a profession. The remaining 7 participants had a primary level of education and

without high school completion; it becomes difficult to find employment and to make appropriate decisions on health seeking behaviors.

Pertaining to the number of years that these participants have lived in UMlazi BB, results have showed that all the participants have lived for more than 10 years in this area. The rationale behind their arrival and their survival in this area draws back on their challenges of getting employment due to their level of education.

In understanding behavioral norms, Hurst & Kelly (2006) assert that poverty, vulnerable livelihoods and illiteracy are some of the determinants that are associated with poor health and social decision making. Particularly, understanding basic health care services enables participants to actively integrate with the services provision accessible to them. In essence, the sampled population met the eligibility requirements for this research study. The eligibility criteria for this study was aimed at participants who resided in UMlazi BB section and have received basic health service from CHWs and were willing to share their experiences with the researcher.

3.5. In-depth interviews

The in-depth interviews were conducted amongst participants in UMlazi BB Section within different age groups who received basic health care services from CHWs. Johnson (2002) implies that in-depth interviews seek to unpack deep information and understanding about meanings in context; meanings that share the deep knowledge and understanding of the participants being interviewed. He further stresses that this research instrument positions one to subject to his or her own self and reflect on ones' concerns, personal matters and ones lived experiences (Johnson, 2002: 104).

The motivation behind in-depth interview was for the researcher to understand, hear and represent the participant's perceptions of the quality of care provided by CHWs. Also, in-depth interviews allowed the participants to share and present their experiences on the quality of care received by CHWs.

3.6. In depth Interview guides

The interview guide consisted of 13 questions attempted to capture perceptions, attitudes and experiences of community members that received these basic services from CHWs. The study

sample consisted of females and males who have received care from CHWs deployed at UMlazi BB section.

Prior to the start of the scheduled interview, a short interview guide was shown to the participants. This practice enabled participants to ask questions about the questions that they were uncertain of and share their views or fears pertaining the interview that was going to be conducted. During the interview, participants were asked questions about the kind of services that the CHWs provided to them, whether CHWs present themselves appropriately to them and whether participants were comfortable to speak to CHWs about their health issues (appendix I). This kind of role-play enabled the researcher to note carefully on the respondent's body language, facial expressions and the choice of words used in response to the questions asked by the researcher.

3.7. Data collection process

The data was collected between October and November 2017. Prior to data collection the researcher made posters that were put up in the public areas in the UMlazi BB section informing the public of the research that was going to be conducted and clearly stating that participation towards this research was voluntarily. The posters that contained a brief idea of the research that was going to be conducted was put in the sections clinic, rank and as well as outside the known spaza shops.

Fieldwork preparations included translating the interview guides to IsiZulu to accommodate the participants that wished to participate in their home language. The researcher hired a tape recorder that was used during the interview conducted in the participant's home. Other preparations for fieldwork included the researcher referring back to the grounded theoretical framework to check whether the designed research questions were going to be suitable to answer to the questions that are required by this study.

Before interviews began, the researcher presented herself and described the purpose of the research study, the research objectives as well as the significance of the contribution of their interviews would bring to the improvement of CHW programs as well as of the academic worldview in ought of their perceptions of the quality by these semi-skilled workers.

During the interviews some participants were reluctant to talk and asked questions on whether they would get into trouble for speaking to me about the CHWs of their area. Another

participant asked how they would be sure that I would not take what they have shared and inform the CHWs that visit their homes. It was for this reason that the consent form was explained clearly to the respondent and that what is reported in the interview and after the interview remains confidential. In addition, I guaranteed them that they will remain anonymous participants throughout this study and that the information of what they shared on my data analysis will not reflect or link back to them.

The researcher ensured that at the start of an interview, consent was attained. The researcher attained full consent from the participant and full consent meant that the participant agreed to be part of this study voluntarily, allowed that they be interviewed and recorded by the researcher and also agreeing that this is a voluntary study and there are no direct benefits for their participation. This was clearly understood by all participants and interviews resumed accordingly.

3.8. Data analysis

For the purpose of this study, a thematic analysis technique was utilized to sort and analyse data collected into relevant themes. Daly et al (1997) notes that a thematic analysis emerged as an important description of a phenomenon that is idealised in search for themes. It is a technique in data analysis that utilizes the identification of themes through carefully reading and re-reading of the data transcribed (Rice & Ezzy, 1999:258).

The interview recordings were played each day to enable the researcher to listen and note on the rich data that the researcher would use as points of emphasis in the results write up section. This process entailed word-for-word transcriptions of each interview conducted in IsiZulu and in English. Thereafter, the researcher encoded data according to the identified themes and coded from the theoretical framework used for this study. The researcher constantly referred back to the literature review and the objectives in order to get a sense of the themes that kept emerging from the interviews.

3.9. Ethics

Prior to the data collection, the researcher attained ethical approval for this study from the University of KwaZulu-Natal's Humanities and Social Sciences Research and Ethics Committee and data collection commenced when the researcher was given consent to proceed with study at Umlazi BB section. Issues surrounding confidentiality and privacy were

addressed and respondents were assured that any information they provided will remain private, anonymous and will be protected. The researcher visited the homes of those respondents that received services from CHWs and interviews were conducted in IsiZulu. All interviews were recorded using a voice recorder with the consent by the respondents. The interviews recorded were all transcribed and translated into English.

Conclusion

Chapter 3 reviewed the research design and methodology that was used to carry out this study. This study used a qualitative methods approach to enable the researcher to hear and present the participants perceptions on the health care provision by CHWs. The data collected enabled the researcher to seek knowledge of the participant's experiences with CHWs and the

quality of care that they provide to them. This chapter illustrated the characteristics of those that participated and their level of education that conferred their health seeking behaviors.

Chapter Four: Data Analysis

4.1. Introduction of the chapter

This chapter will present a qualitative analysis of the information obtained from the in-depth interviews conducted amongst participants in UMlazi BB section. The following themes are detailed in the chapter: perceived accessibility of health care services, availability and quality of staff and resources, community perceptions of community health workers, perceived quality of care, and recommendations made by community members.

4.2. Availability of Health Care Services

The health care services that were available to the community were provided by public clinics in the area, public clinics in other areas, public hospitals, private hospitals, mobile clinics, NGOs and CHWs. Participants were asked about the health care services available in their locality and they reported the following:

"Eeeh, in the area in which we live in here at UMlazi BB…We have a clinic and in the clinic we have nurses that we get assistance and help from" (Participant 1).

"We have a hospital named King's Memorial eMshiyeni also here in UMlazi but situated in V section. And then we have iThembalabantu, a clinic in our area that health services specifically to HIV/AIDS and TB patients" (Participant 2).

"There are clinics around UMlazi and the closest one is the clinic here at AA. We also have hospitals and our CHWs and they are the ones that really help us a lot" (Participant 7).

"*We have clinics here where people get help. We also have NGOs, crèches as well as churches where people can get help. However, we work more closely with clinics and NGOs and of course the CHWs" (Participant 12).*

"By the way, they are also private clinics and hospitals that are fancy" (Participant 10).

"They also provide mobile clinics that move around in the community" (Participant 11).

What can be noted from the above illustrations is that UMlazi provides a variety of healthcare services including the care of lay counsellors and during fieldwork, respondents admired the work that CHWs provide more than of the higher medical institutions as evidenced in the following responses:

"These CHWs are hardworkers they treat us better than in the clinics and hospitals, I am really happy with their work" (Participant 10).

"The clinics and hospitals are really frustrating sometimes but the CHWs always take care of us and are easier to talk to" (Participant 12).

The perceived accessibility of the health services was found to be mainly affected by distance to the services, and the cost of covering that distance.

4.1.1. Perceived accessibility of the service

The public clinics were the main health institutions used by most respondents. This is also evident from the GHS survey carried by StatsSA in 2015 which shows that slightly over sixty percent of the respondents used public clinics (StatsSa, 2016). The hospital was less likely to be used as it was very far and also, it is expensive to travel to the clinics. Furthermore, individuals had to get a referral from a clinic before they can go to a hospital. The clinics were not easily accessible to most people as they were far from most people in the community and it was very difficult for vulnerable groups such as the elderly and those that are very sick to reach them. With regards to the accessibility to health services, respondents expressed this in comments such as:

"*We have to walk a long distance to get help" (Participant 1).*

"*Clinics and hospitals are far" (Participant 5).*

"*We need to wake up very early to walk to the clinics and get care" (Participant 3).*

"*It is difficult for us to go to them because we do not have money to travel to them" (Participant 3).*

According to StatsSA (2016), more than ninety percent of the respondents in the GHS survey used the nearest health facility. This shows that distance is a major factor that determines the health facility which a person would visit.

The CHWs were more accessible to the community as they stayed in the community. They have increased the reach of the medical services to vulnerable people such as the elderly and the very sick. They also provided a door to door service where they checked up and delivered medication to members of the community. This is evident in the comments such as:

"*They come to fetch our appointment cards and go and fetch our pills for us" (Participant 3).*

"*You get help from them immediately as they stay closer to us and I do not need to worry that I would have to wake up early and queue for one at the clinic" (Participant 4).*

"*They are closer to us and the clinics and hospitals are far" (Participant 2).*

A longer distance to the health facility seems to make the health facilities less accessible to the community members. The CHWs remedy this situation by bringing the health services to the homes of the community members. Therefore, this represents an advantage in the use of CHWs. They indirectly reduce the physical burden and cost of the community member going to a health facility therefore this is beneficial to the community member.

4.1.2. Availability and quality of staff and resources

The staff in the public clinics were mainly nurses and doctors that attend to patients. The respondents in the research reported that the clinics in the areas seemed to be understaffed which resulted in congestion and queues. A respondent reported that the clinics and hospital seemed have a low number of doctors and nurses. The shortage of staff has reached an extent that it is clearly visible to the community members. This issue was reported by participant 3 as follows:

"In some clinics there are not a lot of nurses and doctors" (Participant 3).

The respondents also reported that there were long waiting times for people that needed to receive medical care. This was expressed in the words of participant 11 who stated as follows:

"I feel as if the clinic takes a very long time to attend to us if we are sick, they take their own time" (Participant 11).

According to StatsSA (2016), a survey found that the respondents usually complained about the long waiting periods at medical facilities in South Africa. This shows that this a common problem within the medical facilities in South Africa.

A respondent also expressed that there was no guarantee that after waiting for long periods of time that you would get to see a doctor. The uncertainty of getting assistance and the long waiting times in these institutions has a negative effect on the quality of service and leads to community members who are not satisfied by the medical services offered.

"Sometimes in hospitals, you will have to wait long queues just to have your file taken out and then have to wait more hours just to see a nurse and if you are lucky you get to see a doctor" (Participant 5).

4.1.3. Attitude of the nurses

The respondents also reported that the nurses were harsh and were easily angered by requests from community members. The respondents reported that the nurses were not patient and that they did not give patients adequate attention.

The large numbers of patients that nurses have to serve seem to have a significant effect on their attitude as respondents reported that when the clinic is busy, the nurses were more likely to be harsh. The respondents also reported that there were no nurses available to serve them during the lunch breaks. This means that the service in the clinics is not continuous and can result in longer waiting times. The nurses also seem as if they did not communicate well and show empathy for the patients as they prioritised their lunch breaks. The respondents reported having to ultimately leave the clinic after waiting for long periods of time.

Furthermore, the nurses are not able to spend sufficient time due to the high number of patients that they have to serve. This was one of the major concerns reported by study participants as highlighted below:

"In the clinic it is busy, the nurses are busy and also the nurses are harsh towards us. Sometimes you come in and they will tell you they are taking lunch now and then you get fed up and leave" (Participant 1).

"In public hospital and clinics they have attitude……. They tell us they busy and its full so when we get to see a nurse it's not for long" (Participant 6).

According to StatsSA (2016), it was found that patients usually reported that medical staff were usually rude in health facilities in South Africa and where likely low levels of care for the patients and even turn them away. This seems to indicate that the behaviour of medical staff is a common occurrence in South Africa.

4.1.4. Availability of doctors

The respondents also reported that at times they would fail to find a doctor who treats a certain disease. This would mean that a patient would have to leave without getting appropriate treatment or would have to travel to another health facility. This represents an inconvenience to the patient as expressed in the following remarks:

"*...maybe the doctor that deals with the illness you are suffering from is not available to examine you on that day therefore you will not get assistance and medical care at that time" (Participant 2).*

4.1.5. Availability of medication

The respondents also reported that at times they would not be able to get the medication that they required at the health facilities. This represents another inconvenience to the patient as they have to go elsewhere to seek the medication. According to StatsSa (2016), it was found that respondents would complain about drugs were unavailable at the closest health facilities. Likewise, participant 3 reported the following regarding access to medication:

"Also, we sometimes do not get medication because they are out of stock" (Participant 3).

4.2. Community Perceptions on Community Health Workers

There were various perceptions about CHWs in the community. The perceptions could be classified into initial perceptions at the introduction stage and the long-term perceptions after getting to know the CHW.

4.2.1. Initial Perceptions

The initial perception about CHWs were that they were similar to nurses. The CHWs were perceived to be similar to the nurses because they provided similar services. It seemed that the community viewed CHWs as being unable provide medical services that required more qualified medical professionals such as general doctors and specialists.

"They provide help like the nurses at the hospital" (Participant 3).

"They are doing what the nurses are supposed to be doing at the hospitals" (Participant 9).

4.2.1.1. Perceived skills

However, the community members also recognised that CHWs were less skilled than the nurses. According to Lehmann & Sanders (2007), CHWs are less trained than health professionals, this also seemed evident to most of the community members at the first instance as reported here:

"CHWs are our helpers here in our community and we sometimes mock them and call them our 'our almost nurses to be" (Participant 1).

"*But sometimes we ask ourselves whether they know everything because we know that they are not nurses but just as community care givers (CHWs)*" *(Participant 6).*

4.2.1.2. Perceived trustworthiness

Initially, there was also a perception that the CHWs could not keep the illness of the patient confidential. At this stage, community member feared that since the CHWs were part of the community, they would tell other people in the community about their illness especially in the case of HIV. This concern was reported by participant 1 and participant 5 as follows:

"*The first time when they assisted me I was scared as some of the CHWs are people that stay in this community and especially here in the location, people love other people's news" (Participant 1).*

"I used to choose what I tell them because you can never trust a person" (Participant 5).

4.2.2. Long Term Perceptions

The long-term perceptions arise after the community has had the chance to get to know the CHWs. Below responses reflect some of the long-term perceptions of community members regarding CHWs:

"After getting to know them and watching how they would treat everyone at the household I knew that they could be trusted" (Participant 9).

"It took a while for me to be convinced that they meant well but this is normal because you cannot just trust anyone that you do not know" (Participant 11).

4.2.2.1. Perceived skills

The community members reported that with time they were convinced that the CHWs were suitably trained and therefore had the skill and competency to assist them with their health issues as indicated in the next remarks:

"They are obviously very smart as they would know what to do every time you tell them about your health problems" (Participant 11).

"Eventually they proved me wrong as they would do things for your health that you did not know about they were very sharp and clever…… they also gave good advice on how to stay healthy and eat well" (Participant 12).

4.2.2.2. Perceived trustworthiness and confidentiality

After a period of initial uncertainty, the CHWs were generally perceived to be trustworthy people by the community members. The community members reported that it was generally easier to communicate with the CHWs and have a conversation about their health problems. This is in contrast to the experience that they would have with nurses who were usually rude and did not have time to have a long conversation with the community members regarding their health issues. This seems to indicate that the community was less guarded about discussing issues that required confidentiality. This contrasts with the initial perceptions where community members showed great concern about the CHW keeping their health issues confidential.

This increased level of trust by the community members over the longer terms was evident in comments like:

"*As time went on, it was easier speaking to them about my health problem" (Participant 1).*

"*I am comfortable talking to them my child because I believe they are trained to do the work that they do. I trust them. They are trustworthy" (Participant 2).*

"*I take CHWs as my own children and as members of my broken family because my life, health and trust lies in their hands" (Participant 3).*

"Yes, I am comfortable with their help because they have helped me out a lot and I am grateful. With no resources to assist us like before, we appreciate anything and everything because we trust them" (Participant 12).

According to Lehmann & Sanders (2007), the CHWs should be selected from the community that they will be serving. Although the initial perceptions indicating a lack of trust may suggest that this may not be a good idea, it is the long-term perceptions that matter. In addition, the CHWs from the community will understand the culture, norms and habits of the community that they are serving which makes it easier for them to develop trust and communicated with community members

The respondents also reported that the fact that CHWs belonged to the community which they served made them more reliable and trustworthy. In their responses, they indicated the following sentiments:

"*We know some of these CHWs from around here so we know that whenever we need them they will come and assist us quickly" (Participant 10).*

"*The CHWs are from here so we can trust them as they understand the issues that we deal with everyday" (Participant 8).*

According to Gilson et al (2005) the communities that are served by CHWs would eventually find them acceptable and credible. The community members in this instance seem to show a level of accepting the CHWs and trusting them as credible providers of health. This is in contrast to the short-term perception that they could not be trusted since were part of community and could easily spread rumors in the community. Furthermore, this supports the idea that the selection of CHWs should be done from the communities that they serve. The

community members seemed to indicate that they had a strong relationship with the CHWs comparing them to their own family and children. This indicates a strong bond on which trust can easily be built.

The CHWs were perceived as being patient with community members. The community members also reported that even in the cases were the CHWs were faced with adverse behaviour such as violence from someone that was mentally ill they showed endurance and patience. This seems to indicate a high level of dedication and persistence, which are necessary qualities in handling mentally ill community members as stated by participant 4:

"*CHWs will be patient with him even when he wants to physically fight with the CHWs" (Participant 4).*

Furthermore, the community members reported that the CHWs would spend long periods of time with community members. They (CHWs) would give the community members adequate attention and time. They would not rush the community members and they would carefully listen to all their requests. This was in contrast to the nurses who did not give the patients adequate time and were impatient. This seems to indicate a preferable quality of CHWs in comparison to the nurses. In this regard, participant 4 and 10 indicated that:

"Give off their time on you without worrying about anything else unlike the hospitals where the nurses get impatient when they are a lot of patients waiting to be seen by them" (Participant 4).

"The CHWs are very patient even though we keep on bothering them with all our requests and needs they never loose their temper and try their best" (Participant 10).

This also seemed to make it easier for the community members to confidently communicate as they perceived CHWs as good listeners who would carefully listen to all their health problems. In addition, the respondents perceived the CHWs as being easily approachable making it easier to ask them questions. It seemed that the CHWs showed a high level of dedication to addressing and giving well thought out responses to the questions from the community members. This is also in contrast to the nurses at the hospitals who did not give the patients enough time to ask all the questions and a low level of dedication. The respondents seemed to consider CHWs as individuals who truly cared about their well-being as shown in the following responses:

"Their patience and care during the time I was ill was unbelievable" (Participant 5).

"They have a passion for this work if it was me I would not be able to be as committed as they are" (Participant 9).

"They made me feel special and cared for and I was really grateful for their kindness" (Participant 10).

The respondents also reported that the CHWs were perceived as dedicated as they would stay overnight so as to address a community member who needed continuous assistance and motivation. They would do this so as to ensure the wellbeing and health of the patient. They would motivate and encourage the community member to take their medication.

"They will stay up all night and make sure that I am fine and that I take my pills" (Participant 4).

"They would always insist that I take my pills on time" (Participant 10).

The perceptions of CHWs as being patient, attentive, giving all their time and highly dedicated to the wellbeing of the community makes them preferable in comparison to nurses in the clinics and hospitals. This makes the community feel comfortable to talk to them and be satisfied with their service. Correspondingly, participant 3 and participant 4 reported that:

"they take their time with me unlike the nurses in the clinics and hospital" (Participant 3).

"they take their time with me and give me the best service and they don't rush to finish. They are better than the clinic and hospital nurses" (Participant 4).

4.3. Experiences of Community Members with CHWs

The experiences of community members with CHWs vary and can be organised in the categories listed in subheadings below.

4.3.1. Providing Medication

The CHWs played a crucial role in the delivery of Antiretroviral drugs to the community members that found it difficult to access health facility, this is enabling them to get adequate treatment for HIV/AIDS. In cases where women were pregnant and could not easily travel to

the clinics, they would provide medication to them. In reference to the role of CHWs, participant 1 expressed the following:

"When I was pregnant, the CHW helped me by getting pills as I was in a bad luck when I was pregnant that I also found out that I had the virus" (Participant 1).

In addition to the assistance of delivering pills, they would check on the wellbeing and health of the community members regularly. The CHWs would carefully check and ensure whether the community members were taking their medication correctly and appropriately.

"They fetch my tablets and they check that I take them by counting how many are left every time they visit me" (Participant 3).

The respondents also reported that CHWs would also provide health education to them about their diseases. They would provide useful information in controlling diseases of the respondents. They indicated the following:

"They teach me how to control my TB and go to the clinic when I feel that I am really sick" (Participant 3).

"They would tell me about other diseases I could get if I did not follow their advice properly, the information was new to me" (Participant 9).

"They showed me ways I could get relief when I was feeling very sick" (Participant 11).

The CHWs also provided treatment to the elderly who are commonly affected by non-communicable diseases (NCDs) such as diabetes and hypertension. These interventions of providing treatment for the elderly group were beneficial as these were the group of people that would find it difficult to travel to the nearest clinics or hospitals to seek treatment. The interventions by the CHWs meant that the elderly community members could receive the treatment in their homes and could get regular check-ups from the CHWs visiting their homes as evidenced in the following responses:

"They are very helpful especially with older people, they check up on them regularly as they usually get sick and cannot go the hospital" (participant 10).

"They administer medication to the elders and they also do tests to check if they are healthy" (Participant 12).

According to Alaofè, et al (2017), CHWs had a positive effect on the treatment of NCDs such as increasing the knowledge of the diseases and promoting actions that increased prevention and control of the disease. In this research, similar findings were found as CHWs made the elderly community members more aware of the diseases and ensured the control of these diseases.

4.3.2. Reminders of Appointments and Constant check ups

The respondents reported that the CHWs would constantly remind them of appointments and follow up visits that they needed to make. This ensured that the community members had sufficient treatment and were always in good health. This was especially necessary for pregnant women during and after the pregnancy. The CHWs would ensure that there was sufficient and appropriate health care for pregnant women during and after the pregnancy. They constantly checked up on the well-being of the mother and baby. After the mother had given birth they would continue to check up on the well-being of the baby. This was supported by most study participants with some indicating the following:

"*They told me to go for my neo-natal care visits to check how big the baby is and also told me what foods to give my baby when he starts teething and eating" (Participant 1).*

"And also, the CHW came to check up on me and remind me that I have to go for my clinic check-ups because I am pregnant because it is important to know how the baby is growing" (Participant 7).

4.3.3. Wound Care

The respondents also reported CHWs as giving adequate and careful treatment to the wounds. The respondents reported that the CHWs would clean the wounds of diabetics. This seemed to be necessary in ensuring that these wounds would not get infected. They would also administer medication that would remedy the pain for the wound and thus providing relief and comfort to the community member. The direct administering of treatment to the wounds by the CHWs meant that they could ensure that it was done correctly and appropriately. Furthermore, they provided a clean environment that was suitable for the treatment of wounds. The CHWs would provide gloves to be used when bathing and cleaning sores by other people in the household so

as to prevent any spread of sores to others. In relation to this type of caring, some participants reported the following regarding the role of CHWs:

"*They would bathe the sick, clean our diabetic sores" (Participant 2).*

"They would often give you gloves to protect yourself when bathing and cleaning their sores because we don't even know whether these sores can pass on to us or whether they have HIV……would wash and clean it, put Betadine [1] on it and bandage it nicely without me feeling any pain" (Participant 3).

The respondents also reported that the CHWs would advise them on the appropriate environment that they needed to provide so that their wounds could heal. It seemed the CHWs advised the community members to maintain a clean environment so as to reduce the chances of further infections that could make the wound worse or slow down the healing process as reported by participant 2:

"*They say that in order for my sore to heal, I need to be in a clean environment"*

(Participant 2).

4.3.4. Providing a Clean Environment

The respondents reported that the CHWs would provide and ensure a clean environment. This ensured that there was good hygiene which is necessary for recovery from an illness and prevention of further infections. They would carry out tasks around the household such as cleaning, washing, cooking and they bathe the community members. The community members show a high level of gratitude for this assistance, they even felt that the CHWs are doing more than what they are supposed to. This action of providing a clean environment goes beyond what clinics and hospitals can provide and therefore makes the CHW more preferable as highlighted in the next responses:

"They even go beyond their duties and clean my home …… the CHWs then come to assist the man bathe and clean the women. They would come with napkins and gloves for protection and then perform their duties with care" (Participant 1).

[1] This is a brand name for an antiseptic ointment

"They clean the house for us and also do our beds and also wash for us when necessary. And on the following day they would come to see you and also change your bedding"

(Participant 4).

"They like checking the environment in which your living in, whether it's dirty or clean and they will clean it if it is dirty and tell you that it should always be clean so that you don't get sick all the time" (Participant 5).

4.3.5. Health Education

The respondents reported that the CHWs would give them advice on how to stay healthy. They would advise them on how to regularly exercise so that they stayed fit. The CHWs seemed to also advise that the community members should do a reasonable amount of exercise, which seems to indicate that they were well aware that heavy exercising is inappropriate in some cases such as with pregnant women. According to the respondents, the CHWs would also give them information on how to eat healthy food. This seems to indicate that the CHWs were well aware of the healthy food that provided healthy nutrients to the community member given their health situation. Through teaching and giving advice about eating healthy and exercising regularly the CHWs seemed to promote a healthy lifestyle within the community. According to Condo et al (2014), CHWs are usually viewed as being the main health educators that provide valuable information about good hygiene and nutrition. Similarly, participant 7 stated that:

"They teach us about eating healthy and exercising, just walking around the house and outside my yard now and again and not too far because I am pregnant" (Participant 7).

The respondents also reported that the CHWs would also provide valuable information about diseases that could possibly affect them. The CHWs would continually provide the community members with new information regarding the diseases. It seems by passing this information the CHW increased the knowledge of the community about the disease and empowered them to handle the health situation in an appropriate manner as indicated by the following participants:

"*They also bring me updates about the illness that I have and other things that they feel I should know" (Participant 2).*

"They also teach us about the different illnesses that are there" (Participant 4).

The respondents also reported that the CHWs would teach them how to respond to emergency health situations such as fits. It seems the CHWs would provide the community members with appropriate knowledge so that they could carry out the necessary steps. This seems to have empowered community members and enabled them to confidently handle the emergency health situation should they be faced with such a situation. The corresponding response is from participant 4 who stated that:

"They also inform us what to do when we experience someone with fits" (Participant 4).

The respondents also reported that the CHWs would advise them on how to have safe sex and on the use of birth control. The CHWS would advise the use of condoms as a form of birth control and prevention of sexually transmitted diseases. The CHWs would also give information on where the community members could get certain contraception that would reduce their chances of falling pregnant. It seems that by promoting and educating the community on the safe sex the CHWs could possibly reduce the chances of STDs and unwanted pregnancies. This was highlighted in the words of participant 7 as follows:

"Also tell us about important things that we need to know for example how to protect yourself when having sex like using a condom and also going to the hospital to get contraceptives and not fall pregnant" (Participant 7).

4.3.6. Providing Condoms

The respondents reported that the CHWs would provide them with condoms. By providing condoms and promoting their use the CHWs could reduce the rate of unplanned pregnancies and the spread of HIV and STDs. The community members expressed a great concern with the high rate of pregnancies amongst their children. The high number of children that need to be taken care of in the household appears to be a burden to community members, especially the elderly. The CHWs could assist in reducing these high levels of pregnancies by distributing and promoting the use of condoms as evidenced in the following response:

"They also bring condoms and give these children here in our streets who keep falling pregnant" (Participant 3).

4.3.7. Emotional Support

The respondents reported that the CHWs would provide them with emotional support that kept them motivated that they would recover from the disease. The CHWs were friendly and would listen to all the issues that affect the community member and would give empathetic counselling. The qualities that the CHWs showed seemed to make the community feel comfortable to tell them about personal issues that the CHWs. It seems the CHW would have gained the trust of the community member for them to divulge personal issues to the CHWs and also take the advice from the CHW into consideration. When asked about the role of CHWs, participant 1 also highlighted emotional support:

"Even started speaking to them about issues about my baby daddy and him being sick…That he infected me with the virus and them we would fight about it, I would sit with my CHW and she would advise me on how to respond to this issue and not stress about that as it will also affect my baby" (Participant 1).

The CHWs also demonstrated a friendly attitude through their facial expressions. They would smile and show that they care for the well-being of the community member. This made the community feel comfortable and also feel a sense of friendliness and empathy from them:

"I love the smiles from the ladies that have helped me here at home. I have even called them back because they care" (Participant 4).

"I know the ladies that came to help me by name (and then he names them) and these ladies were from Siyaphambili from Mam Shezi group" (Participant 5).

The CHWs would also act as a friend who motivated the community member that they would getter better and they gave the community member hope. They made the community member have a feeling that they were not alone in fighting the disease by giving emotional support. The CHWs could also form a personal connection with the community member. The community member would get to know them (even by name) and gets used to them as participant 3 state:

"CHWs gave me a lot of hope. When I was sick, they motivated and even prayed with me" (Participant 3).

According to HRSRA (2017), CHWs provide friendly and easy going professional help. This is evident in the experiences that the community members have expressed above which are in line with these findings.

4.3.8. Social Service Information

The respondents reported that the CHWs would provide them information about social services. It seems that some community members perceived the CHWs as social development workers, mainly due to the link that the CHWs had to social services. The CHWs were closely linked to social services, social workers, home affairs and the Department of Health. They would provide the community members with important information about social services that seemed to increase their access to these services. The CHWs would also ensure that community members were always updated on information regarding social services. In addition to this it seems that the CHWs would communicate with social workers such that they could provide assistance to the community members. Therefore, it seems that the CHWs provided a communication link between the community members and the social workers as shown in the following remarks:

"Help you get assistance from social workers because mainly our issue now is not health related but social development related……..Instead of having mini nurses to take care our health issues, we have mini social workers that take care of our social issues" (Participant 1).

"They are social development CHWs and they have not stopped serving us" (Participant 6).

The respondents reported that the CHWs would inform about government initiatives from government departments such as home affairs. It seems the ability to be mobilise and reach a large population in the community enabled to spread the information effectively and efficiently. In her response, participant 6 indicated that:

"Tell us when home affairs and social development will be around to take down our names for ID's and grants" (Participant 6).

According to Dick et al, (2007), CHWs should be involved in the social development of the community. The CHWs in this study demonstrated to be beneficial as a link to social services and improve communication about government initiatives within the communities in which they serve.

4.4. Quality of Care

It is important to differentiate between quality of care based on how the CHWs competency and interpersonal skills when delivering the service and how it is based on the availability of resources to deliver the service.

4.4.1. Competency and Interpersonal skills

The respondents reported that they were generally satisfied by how the CHWs deliver the service using their intellectual knowledge and their interpersonal skills. They felt that the CHWs were doing their work as best as they could with the amount of resources that they had. The CHWs seemed to demonstrate a high level of competency and were knowledgeable on how to provide medical care. It also seems that they demonstrated a high level of care and patience compared to the hospitals and clinics. These services were in line with the level of care that the community expected the CHWs to deliver given the constraint of resources that they had. As mentioned earlier the CHWs provided a better quality of service than the nurses at the hospitals. The CHWs would also act immediately to deliver the adequate care to the community members which was in contrast to the hospital or clinic where the service is slow. When asked regarding the competency and interpersonal skills for CHWs, participant 1, 3 and 4 reported the following:

"They handle us with care and they are not rough. Their care is better than the nurses at the clinics" (Participant 1).

"There is a lot of improvement in my state after their help. I know I will be fine because they leave me in a better and clean state……the quality of care offered by the CHW satisfies us because we do not really know much on health and the things that affect our health. They are the ones that take care of us. They are the nurses of this community" (Participant 3).

"CHWs are just fast, very fast and they attend to me immediately" (Participant 4).

4.4.2 Availability of Resources

However, the quality of services offered based on the resources available to the CHWs offered has declined. The lack of resources greatly limited their quality of service and most of the members in the community had noticed this trend and they also acknowledged that the lack of resources had greatly reduced the quality of service. There was also a lack of team work from the CHWs which limited their ability to share the limited resources they had. They no longer offered food, they did not provide medication for pain, and they did not have equipment to test

for blood pressure and blood glucose levels. Most elderly people in the community had a high chance of having hypertension and diabetes and this meant that they would have to go to the clinic or hospital to test for blood pressure and blood glucose levels. When reporting on the availability of resources, participants had the following remarks:

"The care that they provided was of a very high standard and the reason behind this is that CHWs use to work as a team and they were given resources that they needed to be able to perform their duties well" (Participant 1).

"The quality of care has decreased I do not want to lie. And I think the reason for that is not because they do not want to work as health care workers but because they do not get given the resources that will protect and enable to give us the best of care that they use to give us before" (Participant 5).

"They cannot wash and clean my sore without providing pills to numb the pain. They should at least give them pain blocks to give to us when we complain of pain" (Participant 2).

"But right now, they do not have resources so they come and to look at me and help where they can" (Participant 3).

"Also they need to have BP machines to check our BP as well as prick test to check our blood levels" (Participant 4),

According to Kalyango et al (2012) the performance of CHWs has been reduced by the lack of resources. The accessibility of medicine and cost of transporting the medicine is another key determinant in the performance of CHWs.

The CHWs responded that the reason for their lack of resources was that the Department of Health was not able to provide them with these resources any more due to financial constraints. Pertaining this issue, participant 1 stated that:

"They respond by saying that the department does not have money and also mention other problems that make it difficult for them to provide the care that they use to provide for us" (Participant 1).

4.4.3. Relieving Current Health Services

The community members also acknowledged that CHWs have an indirect effect of reducing pressure on the hospitals and the clinics. The door to door service that they offer reduces the amount of people that have to go the clinic to seek help. They help in minimising the queues at the hospitals and provide relief for the nurses at the clinics. The following remarks reflect the critical role of CHWs in the provision of health services:

"The CHWs assist the nurses and minimize their duties in the clinics and hospitals. Because sometimes there is no need… For example, the granny's are sick and they are expected to fetch medication for BP only and they is no need for them to see the doctor and the nurse to ask them unnecessary questions" (Participant 2).

"There are no nurses so in a way they have helped clinics and hospitals with their problem of having no nurses to help the sick (Participant 3).

4.5. Recommendations

The recommendations by the community members were divided into different subthemes. These included the physical appearance of CHWs, the attitude of CHWs, provision of resources, ongoing training and development of CHWs and compensation of the CHWs.

4.5.1. Physical Appearance

The respondents had expectations on the ideal physical appearance of CHWs. They expected a CHW to be very neat, presentable, and clean. This seems to be necessary as being neat and presentable would give the community confidence in trusting that the CHW is a serious health worker. In addition, the CHW being clean could be necessary if the CHW is meant to promote and convince the community member to maintain a clean environment. CHWs being clean makes it easier to promote and encourage good hygiene as they could lead by example. The respondents also expected the CHWs to wear a visible badge, and a uniform. This was expected as CHWs had to identify themselves since they go into people's homes as the community generally fears for their safety due to high crime in the community. The following is what the interviewed community members had to say regarding the physical appearance of CHWs:

"A CHW must have a badge (signals where the badge should be), so that I can see who she is because they are a lot of thieves out there and we don't know whether they are here to help us or rob us" (Participant 1).

"The CHWs in this area have uniforms and in the uniforms, it is written clearly as to where they coming from" (Participant 4).

4.5.2. Attitude

The respondents also recommended that CHWs should have good interpersonal skills. It seems that the CHWs is expected to have the ability to hold an intelligent conversation, show a high level of social awareness and demonstrate empathy and sympathy to the community members. The CHWs were expected to be polite and show that they are happy to serve the community members when they enter their homes. The community members seemed to expect that the CHWs should demonstrate a high level of dedication and passion to serving the community. It seems that CHWs were expected to demonstrate dedication and care by being aware of problems that the community members may face and recommend a solution. This was reported by some participants as follows:

"CHWs should always be ahead of us and must be able to provide the help that is needed by us in our homes" (Participant 2).

"And also, the way they present themselves when they are welcomed into our homes. That they smile" (Participant 4).

'Their ability to conduct a knowledgeable conversation with me and also able to advise me and also understand my situation that the person that they helping comes from which situation and whether they sympathize or empathize" (Participant 1).

4.5.3. Provision of Resources

As mentioned earlier the greatest constraint to the CHWs in delivering quality service was their lack of resources. Therefore. the community members strongly recommended that the CHWs be given enough resources to carry out their work. The ability to perform all the necessary duties at the homes would greatly reduce the people that had to visit the clinic and will therefore

reduce pressure on the nurses in the clinic. Participants therefore reported the need for the provision of resources:

"The CHWs be given the resources they need to perform their duties in our homes" (Participant 1).

"They must have at least pain blocks, bandages and BP machines so that before they can help you with anything they have checked your BP" (Participant 3).

"We ask the department responsible in issuing resources to them to issue resources to CHWs so that they can provide us with the care that they use to back in the years" (Participant 4).

According Greenspan et al (2013), the provision of financial assistance, resources and assistance in their work-related tasks can be a source of motivation to the CHWs. Therefore, it is important that CHWs are provided with resources so that they are also motivated to keep serving their community.

4.5.4. Ongoing Training and Development

The respondents in the research recommended that more people should be trained to be CHWs so as to create employment. It seems that the community view CHWs as providing benefits to the community and as a viable source of employment. In addition, they also recommend continual training and development of CHWs. The respondents seem to recommend that the training provided should be able to develop their skills and knowledge on emerging diseases and effective methods in pregnancy prevention. It seems that the community members view the job role that is progressive and could generally lead to other more competent roles in health care such as being nurses. Earlier in this chapter CHWs were perceived to be similar to the nurses but being less competent therefore the community members seem to believe that if CHWs receive more training they can easily transition into nurses. Furthermore, continual development and review also means that the CHWs are up to date on information regarding diseases that affect communities and enables them to give appropriate recommendations and accurate information. Earlier in this chapter CHWs were found to provide community members with up to date information on diseases affecting the community, therefore continual development regarding diseases that affect communities is necessary in order for the CHWs to accomplish this. According to Pinto et al., (2012) and WHO (2007), CHWs should always update their training through continual development and should also revise older training

material. This was evident in the recommendations made by community members in the statements above. According to Kalyango et al (2012) continual review and development of knowledge and training were important factors that affected the performance of a CHW. Training and development of CHWs was emphasised by most participants as equally significant, they stated:

"Also educate them not only to remain as CHWs but also to become nurses and sisters so that they make way for the next CHWs to continue with the work that they do for the community……I believe that if their training also improves with the current time, they will be able to assist us with the new diseases that are troubling us today. And also have them trained on teaching and showing us effective prevention methods to use so that we can plan for our pregnancies" (Participant 1).

"They should hire more CHWs to work in Umlazi and also provide them with more training so that they can keep up with the illness that they are facing in our homes" (Participant 2).

"Having CHWs in our community was the best way of giving jobs to the unemployed in our community" (Participant 3).

The respondents also recommended that CHWs should be trained in skills beyond just providing health care. The CHWs were expected to have an ability to do social development work within the community. It seems that community members found the services that the CHWs provided as being similar to those provided by social workers. Therefore, it seems that the community members believe that CHWs can easily equipped with skills of providing social work and make an easy transition to being social development workers. The respondents also suggested that CHWs should be involved in the distribution of food to those that were hungry and in need. It seems that community members have the ability to assume other duties to serve the community that go beyond health services. In this regard, participants had the following remarks:

"CHWs must be trained more so that they are able to help us beyond health services. For example, the ones in Siyaphambili use to work as health now they are social development CHWs and they have not stopped serving us" (Participant 3).

They can assist in giving food parcels because people in this area need food and health care more than clothes (Participant 4).

4.5.5. Compensation

The respondents recommended that CHWs should be financially compensated for the services provided to the community. It seems that community viewed a financial compensation as way to keep them motivated and for the CHWs to have the ability to provide for their homes. As mentioned earlier being a CHW was viewed as a source of employment, therefore a financial compensation is necessary. Furthermore, it was mentioned earlier that CHWs showed a high level of dedication and were motivated, therefore providing a suitable service seemed to be a way to ensure that they stay dedicated and motivated to carry out their work. According to Kironde & Klaasen (2002) it was found that financial compensation was found to provide real motivation to CHWs in South Africa.

4.6. Conclusion

Public clinics were found to be the health facilities that were used more frequently, and their distance and accessibility were key in the availability of these institutions. CHWs were found to increase the reach to communities and most of the community members were grateful for their services. The long-term perceptions showed that CHWs were trustworthy, credible and patient with community members. CHWs provided reliable treatment of diseases to vulnerable groups, educated and promoted healthy lifestyles for community members they treated, were a friend and helper who assisted in the household and also provided a link to social services and public organisations. The community members were satisfied with the level of service that CHWs provided but they also acknowledged that the service was limited by lack of resources. Therefore, a key recommendation was that CHWs had to be provided with more resources to carry out their work. In addition, it was also recommended that CHWs have a clean presentation, have good social and interpersonal skills and continually revise and update their training.

The next chapter presents the conclusion and recommendations based on the findings presented in this chapter.

Chapter Five: Discussion, recommendations and limitations

5.1. Introduction of chapter

Chapter 5 will present the discussion of the findings from the analysis of the data in Chapter 4. Furthermore, this chapter will outline the recommendations based on the findings, problems experienced during the research, the limitations of the qualitative study, suggestions for further research and the contribution of the research. The objectives of the research from the first chapter will be reviewed and related to the findings. The recommendations based on the findings are outlined. The problems and limitations that were experienced in conducting the research are outlined and suggestions for further research are given. Finally, the contribution of the research will be outlined.

5.2. Discussion

This section provides a discussion of the main objectives and the findings relating to these 3 objectives as a result of the qualitative analysis.

5.1.1. Discussion pertaining to the experiences of community members when visited by the CHW

The first objective was to explore the community member's experiences when they received a visit from the CHW. Firstly, CHWs provided medicine to the community. They collected and delivered antiretroviral drugs to the community members. In this case, CHWs are seen to increase the reach of AIDS/HIV treatment and being distributors of the medicine to those that need it the most. According to Schneider et al., (2008), there is a significant number of CHWs whose main purpose is to provide treatment for HIV and TB. The training of CHWs has been linked with programs for HIV treatment and prevention. According to Mukherjee & Eustache (2007), CHWs are trained on how to educate the community on HIV and TB prevention and to reduce stigmatization. They also act as a link between the clinics and the community members affected by HIV and TB.

In particular, this study noted that the CHWs were perceived as instrumental in the prevention of the spread of HIV from the mother to the child during the pregnancy. Similarly, in Malawi, the Tingathe program uses the services from CHWs to prevent transmissions from the mother to the child (Kim, et al., 2013). The CHWs provided support for the mother during the pregnancy and after the child is born. The CHW are useful in ensuring that mothers get ARV treatment on time so that they prevent transmission to the child.

The CHWs were also found to provide medical services for community members suffering from Diabetes and testing the Blood Pressure. According to Norris et al (2006), diabetes should be properly treated at the early stages for the prevention of morbidity. There is also a concern that most people do not get enough guidance on how to manage the disease on their own. The dissertation research showed that CHWs provided aid in the treatment of diabetes and facilitated a suitable environment for the patient. The research also found that the CHW would provide care for the wounds of community members. It is important to carefully treat a diabetic wound so as to enhance healing, reduce infections and ensure that moisture is properly regulated (Advanced-Tissue, 2016)**.** They would clean the wounds of the community member which prevents any infections. The community members demonstrated a high level of care by cleaning the wound of the patient.

The CHWs provided health education and promoted a healthy lifestyle. Correspondingly, Tsolekile et al., (2014) found that CHWs offered advice to patients on which food to eat and which places patients should go to get medical assistance. CHWs can deliver health education and nutrition advice through support groups and at home. In addition, Tsolekile et al (2014), suggests that it is preferable for health education and advice to be given at a support group rather than at home since the advice given at the home is a response to a question asked by the community member. However, the research findings of this dissertation showed that CHWs provide health education based on the health condition and situation of the community member rather than just responding to questions.

In addition to this, they would continually keep the community member informed on new information on diseases. The findings show that the CHWs are generally aware of the community member's health situation and provide the relevant information and advice. It also shows that the CHWs continually improve their knowledge about new disease and they are also keen to pass the information to the community members.

The research also found that CHWs also provided emotional support to the community member. The CHW facilitated a helpful relation that gave the community member hope and demonstrated a care for the welfare of the community member (Maes & Kalofonos, 2013). The emotional support built trust and distinguished the CHW from just being a medical service

provider. There was also a positive emotional connection with the community member remembering the names and friendly expressions of the CHWs that assisted them.

The fact that the CHWs came from the same community made it easier for them to identify and have positive relations with the community member. This reinforces the importance of the CHWs belonging to the community which they served (Bender & Pitkin, 1987; Lehmann & Sanders, 2007; Werner, 1977). The community members could share personal issues and trust that the CHW would listen and give positive feedback to them. This interaction with CHW gives the community member that they have someone who can support them when they are experiencing problems. The CHWs played an important role in reducing the isolation and stress of the community member through this interaction.

The CHWs actively encouraged a clean environment and good hygiene for the community members. The research also found that CHWs would clean the environment which the community member resided in. They would conduct households such as washing, cooking and cleaning. This is a distinct service that most clinics and hospitals would not be able to serve to the households. Therefore, this is an extra value that the CHWs bring to the households and is a result of their ability to go to the actual household which the community member resides in (Oliver, et al., 2015). The community members felt a high level of care for their welfare as a result of the actions of CHW to clean the environment. This may also be a result that this level of care goes beyond what clinics and hospitals would normally do for the community member. The cleaning of the environment requires an initiative and awareness by the CHW to carry out rather than doing what they asked to do by the community member. In addition to just cleaning the environment, the CHWs would also demonstrate personal care by bathing the community member. This demonstrates a high level of commitment to ensure that the community member is clean. This can also be helpful to vulnerable groups of people such as elderly and those that are too weak to bath themselves and it promotes good hygiene within the community.

The CHWs were also found to provide information about social services. The CHWs would normally work in partnership with government organizations such so as to get important information about social services to the community (Spencer, et al., 2010). The CHWs is considered effective in getting the information as they would actually visit a community member and have a verbal conversation with community member. The CHWs played a role of connecting social workers to the community. According to Spencer et al (2010), CHWs are

essential in connecting the community to the social workers. Generally, the CHWs and Social workers have similar goals such as serving and empowering the community, care for the well-being of the community member and incorporating the culture and living environment into the provision of their services.

These similarities in their service provision has resulted in the community referring to the CHWs as social development workers. The fact that CHWs are from the same community makes them have a strong ability in engaging with the community on social issues that affect them. The interaction between the community members and the CHW is also effective due to similar language, culture and race (Spencer, et al., 2010).

5.1.2. Discussion pertaining to how community members perceived CHW

The second objective of this study was to explore the perceptions that the community had about the CHW. The research found that there was a different perception in the short term when the community member initially meets the CHW and in the long term when the CHW and the community member get to know each other. The level of trust between the community member and the CHW differed in the short term and the long term. Initially, the community member would not trust the CHW to keep the medical condition and issues discussed confidential. The expectancy from the community member was that CHW would spread rumors about the community member's conditions such as HIV/AIDS or TB to people in the community.

The fact that CHWs belonged to the community made it less comfortable for community members to share confidential information with them. In the mind of the community member, this made it easier for the CHW to identify them to others in the community and talk about their medical conditions. The initial perception emanated from a reputation of spreading rumors by people in the community and this greatly affected the level of trust that the community member had for the CHW. According to Schultz et al (2002), the level of trust that the community has for the CHW is strongly dependent on the reputation that is attached to the CHW. In the research, it was found that the reputation of the community was attached to the community member on the initial visit. The skills of the CHWs were also perceived to be similar to those of nurses. This is expected as both provide health services that assist people and they are less trained than doctors. However, the community members were also aware that

CHWs have received less training and that they were more informal than nurses (Lehmann & Sanders, 2007). The community did not consider the CHWs as health professionals with a wide range of medical knowledge but rather as having limited knowledge just enough to be an extension to the provision of medical services.

The research also found that in the long term, the CHWs became more credible and trusted by the community. The community members now attached the actual reputation to the CHWs based on their experiences with them. The level of trust between the CHW and the community member seemed to increase due to the good reputation that the CHW had built with the community member. This reinforces the fact that a good reputation will lead to a higher level of trust from the community. The level of care for the well-being and empathy that the CHW demonstrated also influenced the level of trust. The ability for the CHW to listen and give positive feedback to the community member seemed to influence how much information the community would share with the CHW.

The research also found that the community perceived CHWs to have a high level of dedication to their work in the long term. This seemed to indicate that the CHWs actions may be influenced by intrinsic needs such as a strong desire to assist community members and pride in their work as well as altruism such as working hard to serve the needs of the community member (Mpembeni, et al., 2015).

The research also found that CHWs were perceived to be patient and they would take their time with the community members. This was contrary to the service offered at the clinics and hospitals where the nurses were impatient and would easily get frustrated. Therefore, the ability to be patient by the CHWs seems to make them more desirable than the nurses at the clinics and the hospitals.

To strengthen this section, researcher notes the links to the following concepts in the theoretical framework.

Assurance refers to courtesy and the ability to convey trust and confidence by keeping to privacy and confidentiality of their patients matters. In the results section where respondents shared their experiences pertaining CHWs, we observe that CHWs were truly trusted by community members and community members felt a sense of openness in discussing their

health issues as well as their personal issues at home because CHWs seemed to maintain confidentiality on their issues.

Empathy refers to caring and giving individualized attention to their patients. This was quite evident in responses given by community members where CHWs went beyond their duties of providing basic health care to extending their services even after work hours. Because of the kindness, care, attention and hope that their patients will heal faster given the amount of quality of care they received, CHWs were always at their service.

5.1.3. Discussion pertaining to perceived quality of care provided by CHW

For this section, the researcher refers back to the concepts in the conceptual framework which included the following:

Reliability which refers to the ability to provide services accurately and dependently; CHWs tried to be at community members service even when faced with the lack of resources to execute their duties, CHWs were available to provide services to community members.

Responsiveness which refers to readiness or quickness in responding to customers' needs. This was also evident in research that the training given to CHWs equipped and prepared them to execute their duties efficiently by responding to immediate health care issues that a community members were in need of. Moreover, results derived from the analysis has emphasized that when CHWs arrive at participant's households, they begin giving care where they can and where they cannot, CHWs refer patients to relevant institutions.

Tangibles refers to the physical items such as medication and equipment. Given the challenges faced with resources in executing CHW services, the physical items needed by respondents CHWs fetched for them in their designated areas. CHWs ensured that community members receive their medication when it was due and made it their duty to fetch medication for them when they monthly supplements have run out.

The third objective of this was to explore the quality of service that was offered by the CHWs. The quality of care seemed to be influenced by the interpersonal skills that facilitated a desirable social interaction with community members. The capability of CHWs to conduct

desirable social interactions encourages and reinforces relationships that are based on trust (Kok, et al., 2017). The findings from the research seemed to indicate that it was more desirable to interact with a CHW who demonstrated a high level of care, patience and empathy. These desirable qualities of the CHW seemed to enhance the quality of service of the CHW and made them more credible to the community member. These qualities made the CHWs more desirable than the nurses in the hospitals who had undesirable social interactions such as showing less empathy and less patience. The qualities above demonstrate the concept of reliability of the CHWs to community.

The research also found that community members seemed to be satisfied with speed of the service of the CHW was considered faster as they would usually get an immediate response from the CHW. This may be due to the fact that the CHW is only attending to one patient at a time compared to the nurses who deal with many patients and cannot respond to all the patients immediately. The research also found that the quality of service was influenced by competency of the CHW. The demonstration of knowledge in health education seemed to enhance the quality of service offered by the CHW. Knowledge and skills of the CHW influence their performance when they render a service to the community member (Kok, et al., 2017). The continual development of knowledge and skills is also necessary for the CHW to maintain a good quality of service.

The research also found that the service was affected by the amount of resources that that the CHW had to carry out their tasks. The lack of resources seemed to reduce the quality of service rendered to the community members. According to Kok et al (2017) the availability of resources affects the performance and motivation of the CHWs. This seemed to be evident in the research as most of the community members expressed concern about the lack of resources and were aware that this was limiting the services that the CHWs could render. The CHWs lacked resources to provide tests of blood pressure and glucose levels for the elderly who were vulnerable to hypertension and diabetes. This is a cause of serious concern as the elderly find it difficult to travel to distant clinics and hospitals to get these tests. However, it seems that even though the CHWs were limited by the availability of the resources they still have intrinsic motivations and demonstrated a high level of dedication to their work. The community members seemed to be aware that they were performing at optimal levels given the resources that they had. The CHWs also seemed to indicate that the main reason for the lack of resources was due to financial constraints by the Department of Health to provide them with resources.

Communities tend to link the government to provision of medical service and any weakness in the government also influences the CHWs (Nxumalo, et al., 2016). The research also found that the community members were aware that the services that CHWs also provided a relief to the clinics and the hospitals that were understaffed. According to Rouxa et al (2015) the transfer of responsibilities and medical care from nurses is imperative in meeting the demand for medical services.

5.1.4 Discussion pertaining to recommendations made by community members about CHWs

The fourth objective of the study was to explore recommendations made by community members about CHW. The research found that community members recommended that CHWs should be clean at all times. The CHWs are supposed to provide and promote a clean environment therefore it is necessary that they are also clean at all times. The cleanliness of the environment also reduces the risk of infections to the community members. The research also found that the CHWs needed to be identifiable to the community members. The CHWs needed to wear an appropriate badge and uniform that allowed members of the community to trust them. The community members identified that high crime rates in the community meant that they could not just trust anyone to enter their households. As mentioned earlier, the initially the community members do not trust the community member, therefore positive assurance and identification that he is a health service worker is key requirement.

The research also found that the community members recommended that the community members should have good social and interpersonal skills. As mentioned earlier, a good social interaction with community members increases the level of trust that the community has for the CHWs. There was also a need for the CHWs to have a high level of social awareness of the environment of the community members. The CHWs should be proactive in developing solutions for the community member. The research also found that community members recommended that CHWs should be motivated through fair financial compensation of their services. The motivation of the CHWs influences their performance and attitude towards their work. Therefore, for the CHWs to stay motivated it seems a fair financial compensation is necessary.

The community members also recommended that the CHWs should receive ongoing training and development. Continual training and development ensures that the CHWs maintains a high level of service and remains knowledgeable about new health developments. Continual training also ensures that the CHWs refresh the knowledge that they have acquired from previous training. The community members also recommended that the CHWs should receive more training in conducting social work. The integration of social work as part of the CHWs role could increase the benefits to the society. Similarities in the goals and objectives of the social worker and the CHW makes it easier to train CHWs workers to social work. It seems the similarity is evident as community members have referred to CHWs as social development workers. However, integrating the two roles means that the CHW has more tasks and more responsibilities. This may become problematic if there is not enough compensation that can motivate the CHWs to accept more tasks. The community also recommended that the CHWs should hand out food especially to those that are hungry. This is highly dependent on whether there are enough financial resources to purchase the free food. The research findings have shown that CHWs usually lack enough resources which is mainly due to financial constraints by the government. Providing food introduces another financial responsibility to the government which is already struggling to provide resources.

5.2. Recommendations

The findings of the research have indicated a low satisfaction with clinics and hospitals. These government facilities have been found to be understaffed and have been unable to keep up with the demand of the services. The community members also have to travel long distances to get to the clinic and hospitals. This shows it is important to increase the training of CHWs so as to increase the reach of health services (Rouxa et al., 2015). In addition to just increasing the number of the CHWs, there is also a need to ensure that the CHWs are effective and they provide a good quality of service. CHWs can be made more effective through careful planning and developing strategies to maximize their effectiveness. It is necessary that the number of CHWs that are deployed is sufficient to serve the community.

In terms of designing CHW programs, it is necessary that there is community participation (Schultz et al,, 2002). This reduces the gap between the expectations of the community and the actual services that are rendered. This will enable CHWs to tailor their services such that they are suitable for the community that they serve. The community participation would also help

in building trust between the CHWs and the community (Kok, et al., 2017). In the research, it was found that initially the community members would not trust the CHWs to keep their health issues confidential. However, if the CHWs build trust by engaging the community during the design process of the programs they can greatly reduce the level of distrust between the community and the CHWs. The community should also be engaged when monitoring and evaluating the performance of CHWs. There should be surveys that rate the different drivers of performance of the CHWs. Benchmarks should be established for evaluation of the performance of CHWs.

CHWs also need to plan and co-ordinate effectively so that they maximize the use of the few resources that they have. They need to identify which community members need the resources. It is unnecessary to carry equipment to a community member who does not need it. A quick survey to identify the needs of the households is necessary prior to the actual visit. The CHWs could then use this data for the allocation of resources and plan on how to maximize the use of the limited resources. The CHWs should also share this information with stakeholders such as NGOs and the government to inform them on the need of the community. These stakeholders can greatly assist in logistical planning and developing strategies for implementation. According to Massis, et al., (2018) community embeddedness is helpful in working with limited resources. Building good quality relationships with the community is important. CHWs can use their knowledge of the community and build long lasting networks that can assist them in the provision of health services to the community members (Balcazar, et al., 2011). Furthermore, the CHWs need to start planning for the long term and have achievable goals on how they can be more efficient. They should use failures as lessons on how they can improve their services. They should work on improving their efficiency in the long term. In the process of selection, it is important to select CHWs with desirable social characteristics such as empathy, patience, being proactive and the ability to listen and communicate effectively.

A CHW who shows a high level of empathy gives the community member hope that they will recover and can greatly reduce the depression as a result of the illness (Pinto, et al., 2012). Identifying these social characteristics during the recruiting of the CHWs will enhance the quality of CHWs who are produced by a training program. The training should also address the development of the CHWs emotional intelligence. The CHW should develop capabilities of dealing with stress and anger. The CHW should be able to manage these emotions and keep a positive attitude towards the community members. The research showed that the nurses were

perceived as impatient, not being able to deal with stress and easily frustrated. This greatly reduced the quality of service that the clinics offered. Therefore, good management of emotions by the CHWs is an important factor in maintaining a good quality of service. The CHWs should also be assisted in developing their interpersonal skills with community members. They need to have a high level of social awareness; empathy and they should also be able to control their emotions. The fact that CHWs were patient and calm with community members, increased the level of satisfaction of the community member with the service rendered by the CHW.

The CHWs should also be able to maintain good relationships with the community members. They should foster relationships that ensure that community is free to express themselves. The research showed that members of the community were satisfied with the service when they could confide in the CHW about other issues affecting them. The CHWs should also be able to communicate, listen and give counselling the community member. The CHWs should have an ability to maintain communication channels with the community members that require constructive feedback (Haq & Hafeez, 2009). It is also necessary that the CHWs have good relationships with health facilities. The CHWs are a link between the community members and the health facilities, therefore it is necessary that there are good relationships with both parties.

The CHWs should receive continual training and refreshing of knowledge and skills. Governments and other sponsors of CHW programs need to facilitate and finance the continual training and development of skills. The CHWs must be motivated to take up the training programs and develop their skills. The training should also integrate social development skills so that the role of the CHW can be broad. In the research, it was found that community encouraged the training of CHWs to engage in social work. The ability to carry out social work will increase the benefits from the CHW and will improve the quality of service from the CHW.

The CHWs should be motivated to continually perform their duties. They need to be rewarded and acknowledged for the tasks that they carry out. In this research, it was found that community members perceived that it was necessary that CHWs are financially compensated for their work. In the case where limited financial resources are available the efficiency of the CHWs should be increased. Increasing the efficiency of a CHW means that a lower number of CHWs should be used and which means that less financial resources are required to compensate the CHWs. Efficiency can be increased by clearly outlining the tasks that CHWs normally carry out and developing strategies to improve the speed and effectiveness of these tasks. Discussions and brainstorming sessions should involve CHWs and use their experiences to develop

strategies to improve the efficiency of the CHW. They should be encouraged to be more efficient through incentives that reward the CHW from being efficient. The process of discussion, brainstorming and planning can also provide insights on how to efficiently use limited resources.

CHWs should be monitored and their performance should be evaluated. This process can be useful in finding the gaps where the CHWs are underperforming. This process should involve community members being asked about the quality of service they received from the CHW and how this service can be improved. The strengths and weakness of the current service by the CHWs should be identified. The constraints such as the amount of resources and competency that the CHWs have should also be assessed. Finally, it is important to use all this information to find ways of improving the quality of service and incorporating these solutions in the design of CHW programs.

Investigations and data should be regularly collected on the operations of CHWs. This information should be reported and the insights from the data should be used to improve the operations of CWHs. The CHWs should also be trained in producing reports on medicine that they supply and identifying any shortages. The environment and conditions that the CHWs operate in should be assessed. The programs should be designed such that there are a strategic fit to the particular environment. The competence of the CHW should be flexible enough to adapt to the needs of that particular environment. Resource allocation should be adjusted to fit the needs of the community. The CHWs should be aware of the dynamics of the environment and varying needs of the community. The community members in the research recommended that CHWs should be aware of the needs of community member in advance and should be proactive rather than reactive. This can be achieved if the CHWs is aware of the environment that they are operating in.

The CHW programs should seek strategic partnerships with other organizations that have a social responsibility. They should seek partnerships both in the private and the public sector. This will increase the amount of resources and financial funding the CHWs have. The skills and competency of these organizations could also assist in improving the operations and design of the CHW programs. The CHWs should raise awareness on the needs of the community and the benefits of assisting the community through CHW programs. These organizations could also assist in providing food for the community.

The CHWs should also have the ability to give advice and assistance that will result in a decrease in the demand of health services. Ensuring a clean environment and promotion of good health practices help in the reduction of serious infections that could result in the patient demanding more health services. The CHW should be able to assess the situation and establish the necessary steps that will help reduce the chances of serious illnesses and infections. The CHW should be able to provide the correct medicine to reduce the chances of a community member going back to the clinic. It may also be necessary for the CHWs to keep proper records for the needs of the community member to reduce any errors.

The CHWs should also follow up on community members prior to the visit. They should assess the patient in the long term and document their experiences. These experiences can provide information on how to improve or maintain a good quality of service. If the CHW once encountered adversity or a problem and managed to find a solution which worked, this solution could be used by other CHWs under similar circumstances. Inspirational experiences about how CHWs have assisted community members and inspired them to recover can also motivate other CHWs who want to assist the community. These experiences could also be used to raise awareness of the benefits of CHWs and could possibly result in more financial funding for CHW programs. Increased financial funding can assist in procuring more resources and better equipped CHWs.

5.3. Problems

This section looks at the problems that were encountered during the research. It looks at the problems associated with difficulty in data collection and those that are associated with the research design that was chosen.

5.3.1. Problems arising from Data Collection

There were several challenges that were encountered during the process of data collection. The first problem was that there was no method of checking whether the respondents were truthful and not biased in the responses that they gave. The data was collected at one point of time and there was no way the opinions could be checked for consistencies. The research also did not capture the living conditions and environment of the community members.

The questionnaire took a relatively long time to complete and this meant that some respondents were no longer willing to give full responses towards the end of the questionnaire. The respondents would give short answers and some of them had to be probed to get more information from them. The sample used to collect data was not randomly selected, it was a convenience sample. The selection of community members to be interviewed was based on whether they would agree to answer questions. The environment of collecting the data was not always suitable for holding an interview. The flow of the discussion was usually interrupted by the presence of other family members and noise from the outside.

5.3.2. Problems arising from the research design

The information that was collected using audio recordings that were then transcribed for analysis. Facial expressions and emotions could not be captured by using audio recordings. Therefore, these aspects could not be analysed as they could not be observed. The actual interactions that the community members had with the CHWs could not be directly observed. The information used was based on the description that the community gave of its experiences with the CHW. There was also a chance that respondents would change their responses and behaviours since they were being observed and interviewed by the interviewer. The extent to which the presence of the interviewer affected the response from the respondent was uncertain.

5.4. Limitations

Upon arrival at the participant's home, what was noticed is that some participants were reluctant to part take in the research study because of their underlying assumptions whilst some participants welcomed the researcher and allowed for an interview to be done because of how it sounded interesting to some and also to find out what this 'young girl' is doing in our area.

The sample size was limited to 12 participants and was explorative as it is a small sample size. This increases the possibility of accepting a result that is biased and could not be necessarily true for a larger population. The sample only consisted of black respondents and was only representative of this single race. This means that the results cannot be generalised for other races. The data that was collected was cross sectional as it was collected at one single point of time. The respondent was not interviewed at a different point of time to check whether his opinion had changed. The study was conducted in a single area of a township, UMlazi BB

section. This sample only represents the opinions of those that stay in that specific area. The opinions do not represent a wider population and area. This means the information could be biased to the views of the community of UMlazi BB section. The small sample size and the fact that respondents were from UMlazi BB means that the information cannot easily be generalized for other areas or settings.

Some of the experiences in the field were challenging and if accepted, would have impinged on the true reflections of the results and the sampled population that should have consisted of participants that have received care from a CHW. With that mentioned, two participants shared of their parent's experience when their late parents experienced care from the CHWs of this area. Politely, the researcher listened to the shared memories and took part in an open conversation had thereafter, but mentioned that these experiences could not be documented as this research was aimed at interviewing those that received the care initially.

Having to walk to and from participant's houses was exhausting however, the motive behind this was to have community members share some of their experiences with the researcher. The data that was collected was in the form of voice recordings and could not capture facial expressions and other social cues that could provide more insight to the response given by the respondent. The information that was captured was also limited to the questions that were posed to the respondent and was not based on observation. Observation would have allowed more information and insights to be obtained about the interactions and relations between the CHWs and the community members. The themes that were discussed are also based on the responses from the small sample of the respondents. The themes were also subjective as they are based on the researcher's view of the transcribed data.

Not forgetting, the time in which this data collection took place, the community of UMlazi was mourning the death of one of its famous gang kingpin Sandile 'Chillies' Bhengu who was a famously known hijacker in the community of UMlazi. Chillies was shot dead by the police force, and in his attempt to escape from the police after these law enforcements found him removing a tracking device off a stolen car (The Mercury, 2017). The area at that time was a labelled as 'no go area' and collecting data was dangerous. Therefore, what was decided by the researcher was to suspend all data collection until the area was resumed to be safe for research interests.

5.5. Suggestions for further Research

This research was only explorative in nature and was limited to a small sample size. The themes that were established could be used to develop a quantitative survey that can consider a larger sample. The quantitative survey is quicker to carry out and can provide insights that are supported by sound statistical analysis. The large sample could provide more robust findings that are representative of the community. The sample was also limited to a single area in the township. Therefore, future research could consider other areas so that a wider population is considered. The sample can also be expanded to consider other races and not just a single race. The suggestions that have been mentioned will also reduce the bias and enable the results to be generalizable to a larger and wider population.

The study could also be designed to be longitudinal in nature which means that data can be collected at different points of time for the respondents. This will enable changes in responses with time to be identified. This would also allow any inconsistences in the responses to be identified. The research could also be enriched by gathering information based on observing interactions between the CHWs and the community members. This would enrich the study by capturing the behaviours of the community members and the CHWs whilst they are not being interrupted. The research could also be further enriched by interviewing the CHWs as well. The comparison of the responses can reveal some inconsistencies within responses and similarities in responses will make the insights obtained more credible.

5.6. Contribution of Research

The research project has important contributions in the literature regarding the role, perceptions and quality of service of CHWs. Firstly, the respondents in the research were community members in the township who are vulnerable to low quality health service from clinics and hospitals. There is a limited amount of research that focuses on the urban area townships in South Africa. Therefore, this research contributes in understanding the health services and perceptions of CHWs within the township setting in South Africa. The participants in the research were also those individuals that were most vulnerable to low quality health services and had contact with CHWs, therefore, their insights were valuable to improving the quality of CHW programs.

The research contributed by demonstrating the necessity to integrate both social and health services. The research showed how the community found social work and services offered by the CHWs as being correlated and how the two can be combined through training in both. The research shows that the services CHWs offer can be extended beyond just health services and that there is a capability of continually developing the services offered to produce a better quality of service that embodies most of the needs of the community members.

The study also contributes through themes that would be useful in the design of quantitative questionnaire. The research is a starting point that provides insight into larger research projects. The sub themes could be incorporated in quantitative studies and can easily be rated by the participants. Finally, the research contributes to the available literature on community health workers that can be used for reference by other academics and researchers in further research. The recommendations in the paper can be used in planning and design of CHW programs by governments and other stakeholders.

5.6. Autobiographical Reflection

The researcher experienced a valuable lesson whilst conducting the research. The researcher gained knowledge into the process of research and the difficulties in carrying out a full research dissertation. The researcher learnt that the implementation of research does not always go according to plan. The researcher had to develop strategies to work around the problems encountered in carrying out the research. The researcher gained insights into the difficulties of health provision in the township areas. The experiences that were outlined by the participants gave the researcher a new perspective about the quality of health services in South Africa.
The researcher now recognizes the contribution that CHWs have on the provision of health services and their positive impact to community. The researcher has gained an appreciation how the CHWs complement the health services and how their roles extend beyond just provision of health care. The researcher has also learnt that engaging the community is necessary in finding solutions into the provision of health care services within the community. It is necessary to gain their perspectives and their ideas on how services can be improved in the community.

The researcher has gained insights into the difficulties that the CHWs face in their work. The ability and resilience to work with limited resources has shown how resilient they can be. The

researcher recognizes the dedication that the CHWs have in carrying out their tasks and how they are patient even in difficult situations. This is beyond the roles that are usually explained in literature.

5.7. Conclusion

The research achieved all the objectives that were outlined in Chapter 1. The CHWs played important roles to the community members such as providing treatment, providing health advice, emotional support, enabling a clean environment and being a valuable link to social and government services. The research showed that in the long term, CHWs were viewed as trustworthy, patient and dedicated which enabled them to build a good reputation in the community. The main limitation to the quality of service that CHWs provided was the lack of resources they had to carry out their tasks. The lack of resources requires the CHWs to learn how to work with limited resources and still continue to be effective. Continual training and development of skills was very important in maintaining a good quality of service in the community. The integration of social work and the roles of the CHW was also found to be important in satisfying the needs of the community members. Community engagement was found to be important in the design of CHW program and selection of CHWs.

It is also important to note that the research findings were limited to a small sample of respondents of the black race within the township of UMlazi BB and data was collected using audio recordings at one point of time. This means that the research was explorative in nature, was cross-sectional and could not easily be generalized beyond the sample. The research however presents themes and findings that could be used as a foundation for future research and larger quantitative surveys.

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Appendix I: Interview Guide in English and IsiZulu

1. What are the health care services people living in your community can get?

2. How do community members feel about the health care services they get?

3. Do you know or ever heard about CHW?

4. What services are offered by CHW?

5. What is your experience with CHW?

6. Are you comfortable talking to CHW about your health problem?

7. Do you believe the services you get from the CHW are enough?

8. Are you comfortable with the help of CHW?

9. What do you need on a CHW that will make you certain that he/ she knows their job?

10. How do you feel about the quality of care you get from a CHW?

11. Do CHWs working in your area come back and check on you or your problem?

12. Do you think that giving people jobs as CHW was a good way to make the basic services to the community better? (Merges with question 13: However, we are looking at the evaluation of cm on offering jobs such as CHW. And then link with the recommendations made by them).

13. What do you think needs to be done to improve the quality of service received from CHW? (Recommendations)

1.Yiziphi izinsizakalo zokunakekelwa kwezempilo abantu abahlala emphakathini wakho abangazithola?

2. Amalungu omphakathi azizwa kanjani ngezinsizakalo zokunakekelwa kwezempilo abazitholayo?

3. Uyazi noma uke wezwa nge-CHW?

4. Yiziphi izinsizakalo ezinikezwa yi-CHW?

5. Isiphi isipiliyoni sakho nge-CHW?

6. Ingabe ukhululekile ukukhuluma ne-CHW mayelana nenkinga yakho yempilo?

7. Uyakholelwa ukuthi izinsizakalo ozitholayo ku-CHW zanele?

8. Ingabe ukhululekile ngosizo lwe-CHW?

9. Yini oyidingayo kumsebenzi we-CHW ezokwenza uqiniseke ukuthi yawazi umsebenzi wakhe?

10. Uzizwa kanjani ngezinga lokunakekelwa olithola ku-CHW?

11. Ingabe ama-CHW asebenza endaweni yakini ayabuyela futhi ahlole wena noma inkinga yakho?

12. Ucabanga ukuthi ukunikeza abantu imisebenzi njenge-CHW kwakuyindlela enhle yokwenza izinsizakalo eziyisisekelo emphakathini zibe ngcono?

13. Ucabanga ukuthi yini okudingeka yenziwe ukuze kuthuthukiswe izinga lezinsizakalo ezitholakala kuma-CHW?

Appendix II: Ethical Clearance Approval

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

2 August 2017

Ms Ziphezinhle Londeka Precious Mpanza 213503073
School of Built Environment and Development Studies
Howard College Campus

Dear Ms Mpanza

Protocol reference number: HSS/0480/017M
Project title: Community perceptions of the quality of care provided by community health workers.

Full Approval – Expedited Application

In response to your application received 4 May 2017, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol has been granted **FULL APPROVAL.**

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

.....

Dr Shenuka Singh (Chair)
Humanities & Social Sciences Research Ethics Committee

/pm

cc Supervisor: Kerry Vermaark
cc. Academic Leader Research: Professor Oliver Mtapuri
cc. School Administrator: Ms Nolundi Mzolo

Humanities & Social Sciences Research Ethics Committee
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Appendix III: Informed Consent

UKZN HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE (HSSREC)

APPLICATION FOR ETHICS APPROVAL
For research with human participants

INFORMED CONSENT RESOURCE TEMPLATE

Isaziso kulabacwaningi: Kungakhathalisekile ukuthi kunesidingo sokuqinisekisa ngokwesayensi nangokomthetho, kufanele kwenziwe umzamo wokukhiqiza idokhumenti yokuvuma ecacile ngezilimi futhi elula ngangokunokwenzeka, ngaphandle kokushiya imininingwane ebalulekile njengoba kuchazwe ngezansi. Izinguqulo ezihunyushiwe eziqinisekisiwe zizodingeka uma inguqulo yokuqala ivunyiwe.

Kunezimo ezicacile lapho imvume yokuvuma ngomlomo ingase yamukeleke, futhi izimo lapho imvume yomuntu enolwazi ingasuswa yi-HSSREC.

Ishidi Lolwazi kanye Nemvume Yokubamba iqhaza Ocwaningweni

Usuku:

Mnumzane/ Nkosazane ethandekayo

Igama lami nginguZiphezinhle Mpanza ovela eSikoleni Sokuvakasha Nezokuthuthukiswa Kwezemvelo ngaphansi koMnyango Wezezibalo Zabantu ku-University of KwaZulu-Natali. Ngingaphansi kokuqondwa kukaDkt. Kerry Vermaak osebenza kule nyuvesi. Uma ufisa ukuxhumana naye ungase uthintane naye ku-031 260 2285 futhi nange-imeyili ethi *vermaak@ukzn.ac.za*.

Uyamenywa ukuba ucabange ukuhlanganyela ocwaningweni olubandakanya ucwaningo ngemibono yomphakathi ngezinga lokunakekelwa okuhlinzekwa abasebenzi basezempilo bomphakathi emphakathini. Inhloso nenjongo yalolu cwaningo ukuphenya ukuqonda komphakathi mayelana nabasebenzi bezempilo emphakathini kanye nokwandisa ulwazi mayelana nendlela umpakathi osizakale ngayo nokunthi ngabe bayakwazisa noma cha. Ucwaningo kulindeleke ukuthi lubhalise abahlanganyeli abangu-15-20 esigcemeni saseMlazi kwa-AA futhi naphakathi kwalaba bahlanganyeli abalinganisiwe, lolu cwaningo luhlose ukuheha kanye nabahlanganyeli besilisa ocwaningweni. Isikhathi sokubamba iqhaza kwakho uma ukhetha ukubhalisa futhi uhlale ocwaningweni kulindeleke kube cishe amaminithi angu-30 ingxoxo ngayinnye.

Ucwaningo lungabandakanya ubuzingozi obulandelayo kanye / noma ukuphazamiseka. Ukufunda kungadinga ukuthi usho ngokugcwele okuhlangenwe nakho kwakho ne-CHW futhi uveze ukuthi ngabe uzizwe ubandlululeka noma unqatshelwe nganoma iyiphi indlela ngemuva kokubonwa yi-CHW. Ngalokho osekushiwo, siyaqinisekisa ukuthi lonke ulwazi olunikezwe kulolu chungechunge locwaningo luzogcinwa luyimfihlo futhi ngeke uze uxhunyaniswee nanoma yiluphi ulwazi olunikezele kulolu cwaningo. Ulwazi oluqoqiwe luzosetshenziselwa ngendlela enosizo ngaphandle kokuhlanganisa amagama noma izindawo futhi kulungile ukuthi lolo lwazi olunikeziwe luzovikelwa.

Sithemba ukuthi isifundo sizodala izinzuzo ezilandelayo:

- ukuvumela ukutholakala kwemibono yomphakathi ngabasebenzi bezempilo emphakathini kanye nokunakekela abakunikezayo.
- Ukuqonda indima yabasebenzi bezempilo emphakathini ekuhlinzekeni ukunakekelwa kwezempilo okuyisisekelo.
- ukunikeza imifanekiso echaza ukuthi imiphakathi izwa kanjani ngempela ngale ndlela eyinhloko yokunakekelwa kwezempilo.
- Futhi kuzosebetshenziswa lemiphumelaeyotholakela ukuze kuvalwe igebe ezincwadini ezivela ku-CHW.

Uma ucwaningo lungase luhileleke ebungozini noma olungathandeki, abahlanganyeli bavunyelwe ukuyeka ukubamba iqhaza kwabo ngokushesha. Lokhu kuzosho ukuthi bazohoxa kulolucwaningo futhi noma yiluphi ulwazi olutholwa ngaphambi kokuqedwa luzopheliswa.

Lolu cwaningo luye lwabuyekezwa ngokomthetho futhi luvunyiwe yiKomiti Yezokuziphatha Zokucwaninga Kwezenhlalakahle ne-Social Sciences yase-UKZN (inombolo yokugunyazwa_____).

Uma kwenzeka kuba nanoma yiziphi izinkinga noma ukukhathazeka / imibuzo ungaxhumana nomcwaningi ku-076 70 58 157 noma iKomiti Yezokuziphatha Yokucwaninga Abantu E-UKZN, ngemininingwane yokuxhumana elandelayo:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION
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Sicela uboniswe ukuthi ukubamba iqhaza kwakho kulolu cwaningo kungokuzithandela futhi uvunyelwe ukuhoxisa ukuhlanganyela kwakho kulolu cwaningo nganoma yisiphi isikhathi.. Uma kwenzeka unokwenqaba / unokuhoxa ekubambeni kwakho iqhaza , ngeke uthole sigwebo noma ukulahlekelwa ukwelashwa noma enye inzuzo onelungelo lokuyithola.

Esimweni sokuhoxa kwakho kulolu cwaningo, amrekhodi kanye nokurekhoda kwananoma yiluphi uhlobo lokuthathwa kwemizuzu yemhlangano kuyomiswa futhi lonke ulwazi olutholiwe kuze kube ngalesosikhathi luyobhujiswa unomphela futhi akukho bufakazi obuyokuxhumanisa nengxoxo eqhutshiwe.

Ngokwemvelo yalolu cwaningo, azikho izikhuthazo, isinxephezelo noma ukubuyiselwa ngokubamba kwakho iqhaza kulolucwaningo. Ukubamba iqhaza kungokuzithandela nokuhoxiswa kulolu cwaningo kungenziwa nganoma yisiphi isikhathi noma ngemva kokuphela kwengxoxo.

Ulwazi olutholakele ezingxoxweni ezibanzi luyophathwa futhi lugcinwe endaweni ephephile. Zonke izingxoxo zizoshiselwa kwi disk ezogcinwa ehhovisi lomphathi. Uma kwenzeka noma yiziphi izimo ezingalindelekile izingxoxo eziqhutshwayo nazo ziyogcinwa kwi –drive yangaphandle eyogcinwa ehhofisini lomphathi ikhiyelwe ekhabetheni lapho kufinyelela khona kuphela, umphathi kanye nabacwanigi.

IMVUME (Lungisa uma kudingeka)

Mina (Igama) ngiye ngaziswa mayelana nesifundo esihlosiwe (nikeza imininingwane) ngu (unikeza igama lomcwaningi / umsebenzi wensimu).

Ngiyaqonda injongo nezinqubo zesifundo (engeza lezi futhi uma kufanelekile).

Nginikezwe ithuba lokuphendula imibuzo mayelana nalesifundo futhi ngibe nezimpendulo ngokwaneliseka kwami.

Ngiyazisa ukuthi ukubamba iqhaza kwami kulolucwaningo kuphelele kungokuzithandela nokuthi ngingaohoxa nganoma yisiphi isikhathi ngaphandle kokuthinta noma yiziphi izinzuzo engivame ukuzithola.

Ngiye ngaziswa nganoma yisiphi isinxephezelo esitholakalayo noma ukwelashwa uma ukulimala kwenzeka kimi ngenxa yomphumela wezinqubo ezihlobene nalesifundo.

Uma ngineminye imibuzo / ukukhathazeka noma imibuzo ephathelene nokucwaninga ngiyaqonda ukuthi ngingathintana nomcwaningi (ukunikeza imininingwane).

Uma nginemibuzo noma ukukhathazeka ngamalungelo ami njengomhlanganyeli wesifundo, noma uma ngikhathazekile ngesici sesifundo noma abacwaningi ngingaxhumana

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Imvume eyengeziwe, lapho kufanele khona

Nginikeza imvume yoku:

Ukurekhodwa komsindo kwengxoxo yami / ingxoxo yeqembu lokugxila YEBO / CHA
Ukurekhodwa ngokwevidiyokwengxoxo yami / ingxoxo yeqembu lokugxila YEBO / CHA
Ukusetshenziswa kwezithombe zami ngenhloso yocwaningo YEBO / CHA

_____ _____
Isignesha yomhlanganyeli Usuku

_____ _____
Isignesha kaFakazi Usuku
(Lapho kusebenza khona)

_____ _____

Isignesha yomhumushi Usuku
(Lapho kusebenza khona)