

**PERCEPTIONS OF COMMUNITY HEALTH WORKERS REGARDING
THE VALUE AND ROLE PLAYED BY THE GENERAL EDUCATION
AND TRAINING CERTIFICATE IN ANCILLARY HEALTH CARE IN
THE FREE STATE PROVINCE**

by

MS V.V.J. MOTSEPE

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BLOEMFONTEIN

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STUDY LEADER: DR M.P. JAMA

DECLARATION

I hereby declare that the work submitted here is the result of my own independent investigation. Where help was sought, it was acknowledged. I further declare that this work is submitted for the first time at this university/faculty towards a Master's Degree in Health Professions Education and that it has never been submitted to any other university/faculty for the purpose of obtaining a degree.

.....

Ms V.V.J. Motsepe

June 2013

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Ms V.V.J. Motsepe

June 2013

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DEDICATION

I dedicate this script to my late parents (Mme le Tene) and wonderful family, who offered me unconditional love and support.

I would also like to dedicate this script to myself, my husband and best friend Motlogelwa (Papi) Motsepe, my daughter Refilwe and son Kgosi, who have been my consistent inspiration, support and source of wisdom. Without their love and sacrifice this work would never have been possible.

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LIST OF ACRONYMS

ABET:	Adult Based Education Training
AHC:	Ancillary Health Care
AIDS:	Acquired Immune Deficiency Syndrome
ANC:	African National Congress
ART:	Anti Retro-viral Treatment
CBO:	Community Based Organisation
CHAM:	Christian Health Association of Malawi
CHWs:	Community Health Workers
DOT:	Direct Objective Treatment
ECUFS:	Ethics Committee University of Free State
EPWP:	Expanded Public Workers' Programme
FGI:	Focus Group Interview
FHS:	Faculty of Health Sciences
FSDoH:	Free State Department of Health
FSGDS:	Free State Growth and Development Strategy
FSP:	Free State Province
FSPG:	Free State Provincial Government
GETC:	General Education Training Certificate
HBC:	Home Based Care
HCT:	HIV Counselling and Testing
HEW:	Health Extension Workers
HIV:	Human Immuno Virus
HOD:	Head of Department
HRD:	Human Resource Development
HSA:	Health Surveillance Assistant
HWSETA:	Health and Welfare Sector Education and Training
MDGs:	Millennium Developmental Goals
MOHP:	Ministry of Health and Population
NDoH:	National Department of Health

NGO:	Non-Governmental Organisation
NHS:	National Health System
NMCHWA:	New Mexico Community Health Workers Association
NPPHCN:	National Progressive Primary Care Network
NQF:	National Qualifications Framework
NSDS:	National Skill Development Strategy
NSLA:	National Service Level Agreement
PHC:	Primary Health Care
PHW:	Professional Health Worker
PLWHA:	People Living with HIV AIDS
RDP:	Reconstruction and Development Programme
SA:	South Africa
SABS:	South African Bureau of Standards
SAC:	Southern African Countries
SAQA:	South African Qualifications Authority
SDU:	Skill Development Unit
TB:	Tuberculosis
UFS:	University of Free State
UNICEF:	United Nations Children Fund
USA:	United States of America
USAID:	United States Agency for International Development
WB:	World Bank
WHO:	World Health Organisation

SUMMARY

Key words: Community Health Worker (CHW), CHW training programme, South African Qualifications Authority (SAQA), Health and Welfare Sector Education Training (HWSETA), General Education and Training Certificate (GETC), Ancillary Health Care (AHC), qualification, value, experiences, opinions, attitudes, primary health care, focus group interviews, community health needs, health promotion.

In 2004, the Free State Department of Health (FSDoH) trained CHWs in the GETC in AHC qualification and in 2006 Free State Growth and Development Strategy (FSGDS) commissioned the department to conduct a research project to determine the role played by the qualification in improving community health care services and therefore the need for further training. Subsequently, an investigation was done to explore by means of focus group interviews the personal experiences, opinions and attitudes regarding the role of CHWs to: (i) assess and identify community health needs, (ii) execute primary health care talk, (iii) engage in basic health promotion with specific reference to preventing and managing accidents and disasters and (iv) referring clients to the formal health services and other health-related systems. All these four focus areas were used to determine the role and the value of the GETC in AHC qualification in improving community health care services in the Free State Province (FSP).

The aim of the study was to determine the perceptions of CHWs regarding their experiences, opinions and attitudes as far as the value and role played by the GETC in AHC qualification in improving community health care services in the FSP.

The study followed a descriptive, explorative and contextual design using a qualitative approach since the participants described and explored their perceptions in the context of the GETC in AHC qualification. Data were collected

by means of focus group interviews to enable the participants to describe and explore their perceptions.

Based on the literature in this study, it became clear that there are different concepts used to define and to determine the roles and training programmes for community health workers. In South Africa, the GETC in AHC qualification authorised by SAQA is used to empower community health workers with the skills and abilities to assess and provide health care towards community health care needs. In the case of the United States of America (USA) as well as Southern African Countries (SAC), the training of CHWs is determined by the roles they play in the community.

According to the findings of the study it seems as if the training that CHWs received has contributed to the improvement of community health services in the FSP. However, the researcher is of the opinion that if the key role-players such as SAQA, HWSETA, FSDoH and Free State Provincial Government (FSPG) can consider the recommendations made in this study there can be further improvement in the training of CHWs as well as further improvement in the delivery of community health services in the FSP.

OPSOMMING

Sleutelterme: Gemeenskapsgesondheidswerker (GGW), GGW-opleidingsprogram, Suid-Afrikaanse Kwalifikasieowerheid (SAKO), Health and Welfare Sector Education Training (HWSETA), General Education and Training Certificate (GETC), Ancillary Health Care (AHC), kwalifikasie, waarde, ervarings, opinies, houdings, primêre gesondheidsorg, fokusgroeponderhoude, gemeenskapsgesondheidsbehoefte, gesondheidsbevordering.

In 2004 het die Free State Department of Health (FSDoH) GGWs in die GETC in AHC-kwalifikasie opgelei en in 2006 het die Free State Growth and Development Strategy (FSGDS) die departement opdrag gegee om 'n navorsingsprojek te loods om die rol van die kwalifikasie in die verbetering van gemeenskapsgesondheidsdiens en dus die behoefte aan verdere opleiding te bepaal. Na aanleiding hiervan en met behulp van fokusgroeponderhoude is die persoonlike ervaringe, opinies en gesindhede in verband met die rol van GGWs ten opsigte van die volgende verken: (i) assessering en identifisering van gemeenskapsgesondheidsbehoefte, (ii) voer van 'n primêre gesondheidsorggesprek, (iii) betrokkeheid by basiese gesondheidsbevordering met spesifieke verwysing na die voorkoming en hantering van ongelukke en rampe en (iv) verwysing van kliënte na formele gesondheidsdienste en ander gesondheidsverwante stelsels. Al vier hierdie fokusareas is gebruik om die rol en die waarde van die GETC in AHC-kwalifikasie ten opsigte van die verbetering van gemeenskapsgesondheidsorgdienste in die Vrystaat Provinsie (VP) te bepaal.

Die oogmerk van die studie was om die ervarings, opinies en houdings van GGWs ten opsigte van die waarde en die rol van die GETC in AHC-kwalifikasie in die verbetering van gemeenskapsgesondheidsorg in die VP te bepaal.

Die studie het 'n beskrywende, eksploratiewe en kontekstuele ontwerp volgens 'n kwalitatiewe benadering gevolg aangesien die deelnemers hulle persepsie in die konteks van die GETC in AHC-kwalifikasie beskryf en verken het. Data is met behulp van fokusgroeponderhoude ingesamel om die deelnemers in staat te stel om hul persepsies te beskryf en te verken.

Dit blyk uit die literatuur van hierdie studie dat verskillende konsepte gebruik word om opleidingsprogramme vir gemeenskapsgesondheidswerkers te omskryf en te bepaal. In Suid-Afrika word die SAKO-goedgekeurde GETC in AHC-kwalifikasie gebruik om gemeenskapsgesondheidswerkers met die vaardighede en die vermoë te bemagtig om gesondheidsorg ten opsigte van gemeenskapsgesondheidsbehoefte te assesser en te lewer. In die VSA sowel as in ander Suider-Afrikaanse lande word die opleiding van GGWs deur die rol wat hulle in die gemeenskap speel, bepaal.

Volgens die bevindinge van die studie het die opleiding van GGWs tot die verbetering van gemeenskapsgesondheidsdienste in die VP bygedra. Die navorser is egter van mening dat indien sleutelrolspelers soos SAKO, HWSETA, FSDoH en die Vrystaatse Provinsiale Regering die aanbevelings in hierdie studie in aanmerking neem, die opleiding van GGWs asook die lewering van gemeenskapsgesondheidsdienste in die VP verder verbeter kan word.

PERCEPTIONS OF COMMUNITY HEALTH WORKERS REGARDING THE VALUE AND ROLE PLAYED BY THE GENERAL EDUCATION AND TRAINING CERTIFICATE IN ANCILLARY HEALTH CARE IN THE FREE STATE PROVINCE

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION AND BACKGROUND

In this study, the researcher explored the perceptions of Community Health Workers (CHWs) regarding the value of the General Education and Training Certificate (GETC) in Ancillary Health Care (AHC) in improving community health care services in the Free State Province (FSP).

Internationally, the training of CHWs is done in many countries, particularly in sub-Saharan Africa and in parts of South America (SAQA 2004:Online). According to the South African Qualifications Authority (SAQA 2004:Online), in first-world countries, the training is offered as part of their sophisticated integrated health care systems by officials who are mostly graduates in nursing, social work and community development.

In South Africa (SA), CHWs' training is tailored from the unique situation in which the country finds itself where there is an urgent need for Primary Health Care (PHC) provision across a diverse spread rural areas, to large numbers of people, using limited resources and personnel (SAQA 2004:Online). GETC in AHC qualification is important and appropriate for the unique health service requirements in this country, where short courses in community and PHC are offered, *inter alia* by organizations such as the World Health Organization (SAQA 2004:Online). Therefore, CHWs who obtain this qualification will be able to assist communities to better manage their own health and wellness as well

as obtain skills in providing support services within a multidisciplinary health care team (SAQA 2004:Online).

The GETC in AHC is a regular unit standard-based qualification, registered by SAQA identity 49606, with a decision number SAQA 0264/06 and a minimum of 134 credits (Appendix A). The purpose of the qualification is to equip CHWs with competences to perform community health care functions under supervision of a Professional Health Worker (PHW) and provide them with a platform for further education and training in a career pathway towards becoming PHWs (SAQA 2004:Online).

In 2002, the National Department of Health (NDoH) initiated a strategy to improve community health care service by training volunteers and CHWs in GETC in AHC qualification. Thereafter, in 2004, the Free State Department of Health (FSDoH) embarked on the NDoH's strategy and recruited the first group of 50 CHWs from Xhariep, Motheo, Fezile Dabi and Thabo Mofutsanyane districts respectively, but only 46 managed to register in 2004. Out of these 46 registered CHWs, 44 managed to pass while two failed in 2004. At the moment there are 43 qualified CHWs in the FSP as one has relocated to Cape Town.

Thereafter, in 2006, the Free State Growth and Development Strategy (FSGDS) commissioned the FSDoH to research the need to continue with further training by evaluating whether the training of the CHWs who completed the GETC in AHC qualification in 2004 had an impact on improving community health care service (FSPG 2006:2). Therefore, this study can assist the FSDoH in fulfilling the requirements of the FSGDS.

The aim of this chapter is to provide the introduction and background to the study as explained in the previous paragraphs, followed by the background to the research problem, overall goal, aim and objectives of the study. These aspects are followed by the methodology that includes the study design, study population, focus group interviews as a data collection method, pilot study, data

analysis, reliability, validity and trustworthiness. Thereafter, ethical aspects concerning approval and informed consent are discussed. Following the ethical aspects, a short description on how the findings will be implemented is mentioned. The chapter then concludes with how the script is arranged.

1.2 BACKGROUND TO THE RESEARCH PROBLEM

In 2004, the FSDOH trained CHWs in GETC in the AHC qualification and in 2006 FSGDS commissioned the department to conduct a research project to determine the role played by the qualification in improving community health care services and therefore the need for further training. Since then, the department has not complied with the commission and hence the need to conduct this research.

1.3 OVERALL GOAL OF THE STUDY

The overall goal of the study was to explore, by means of focus group interviews, the experiences, opinions and attitudes of CHWs regarding the value of the GETC in the AHC qualification in improving community health care services in the FSP.

1.4 AIM OF THE STUDY

The aim of the study was to determine the perceptions of CHWs regarding their experiences, opinions and attitudes as far as the value and role played by the GETC in the AHC qualification in improving community health care services in the FSP.

1.5 OBJECTIVES OF THE STUDY

Based on the goal and aim of the study as indicated above, the objectives of the study were to determine whether according to CHWs' experiences, opinions and attitudes, the GETC in the AHC qualification has played a role in the

improvement of community health care services in the FSP based on their ability to:

- assess and identify community health needs;
- execute primary health care talk;
- engage in basic health promotion with specific reference to preventing and managing accidents and disasters; and
- refer clients to the formal health services and other health-related systems.

1.6 METHODOLOGY

1.6.1 Study design

The study followed a descriptive, explorative and contextual design using a qualitative approach since the participants described and explored their perceptions in the context of GETC in the AHC qualification.

According to Ivankova, Creswell and Clark (2007:257) qualitative research is an inquiry process of understanding based on a methodology that explores a social or a human problem. In this study, the social inquiry that was explored was the ability of the CHWs to contribute towards community health care.

Furthermore, Mouton (2003:149) gives the following description: "Studies that are usually qualitative in nature aim to produce an in-depth description of a group of people or community. Such descriptions are embedded in the life-worlds of the actors being studied and produce insider perspectives of the actors and their practices" as was the case with the CHWs who have obtained the GETC in the AHC qualification in 2005. In addition, McMillan and Schumacher (2001:165) noted that the design of a qualitative research project uses data collection techniques such as questionnaires, observations or interviews. In this study, the researcher used focus group interviews to enable

the participants to describe and explore their perceptions based on the stated objectives.

1.6.2 Study population

The population in this study was 43 CHWs who obtained the GETC in the AHC qualification in the FSP in 2005 of which seven (7) are in Xhariep, six (6) are in Motheo, five (5) are in Fezile Dabi and 25 are in Thabo Mofutsanyane districts respectively. According to De Vos, Strydom, Fouchè and Delport (2005:193) a population is a set of entities in which all the measurements of interest to the researcher are represented.

It is usually impossible to include the entire population in a study, the two main restrictions being time and cost (Maree & Pietersen 2007:172). In this study, the researcher did not have any restrictions regarding time and cost as her job allocation allowed her to travel to these districts occasionally. Therefore, the whole population participated in the study.

1.6.3 Measurement

1.6.3.1 *Focus group interviews*

A focus group interview is a carefully planned discussion designed to obtain perceptions on a defined area of interest in a permissive and non-threatening environment (De Vos *et al.* 2005). In this study, focus group interviews were planned and conducted at the venues where these CHWs are working in their respective districts (*vide* 1.6.2), thus making the environment non-threatening.

The researcher conducted seven focus group interview sessions of two hours each to promote self-disclosure among participants. Focus group interviews were conducted in each respective district. In terms of Greeff (2005:299), the researcher's opinion to use focus group interviews was appropriate because

participants had certain characteristics in common that related to the topic and the group was “focused” as it involved some kind of collective activity.

Furthermore, the researcher appointed an experienced and skilled facilitator for the focus group interviews using a focus group interview guide. According to Nieuwenhuis (2007:91), a focus group facilitator must have extensive experience in interviewing and communication techniques. In the case of this study, a nurse educator competent in focus group interviews facilitated the sessions, while independent observers documented the placement, interaction and non-verbal behaviours of the participants.

In addition, participants were provided with an information document explaining what the study entails as well as what its purpose is. These participants were requested to give written consent to participate in the study. The researcher used the assistance of skills development coordinators in the respective districts to hand out these documents to participants as they were in constant contact with them.

According to Nieuwenhuis (2007:92), an audio or video recording can be used to capture data. In this study, an audio recorder was used and the permission of the participants was obtained.

1.6.3.2 *Methodological and measurement errors*

Bias may be a problem with the measurement and to prevent it, small talk should be carried out by the facilitator with the focus group participants to build rapport, establish ground rules and set the tone of the discussions. One of the disadvantages of a focus group interview is that opinions of passive participants may be inhibited or influenced by active participants (Greeff 2005:312). In order to combat such potential bias, in this study, participants were informed about the value of their contribution and were given permission to express themselves without fear that their ideas would be openly criticized.

Furthermore, the facilitator emphasized the fact that there were no wrong answers.

1.6.4 Pilot study

Although pilot testing is a cardinal rule of research, De Vos *et al.* (2005:309) emphasise that a pilot study presents special problems with the focus group interview as the questions used are hard to separate from the environment of the focus group. The true pilot is the first focus group interview with the participants. Therefore, the researcher used the first focus group of participants as a true pilot study for the interviews.

1.6.5 Data analysis

The aim of the analysis in qualitative studies is to look for trends and patterns that reappear within various focus groups. The basis for analysis will be transcripts and tapes (Greeff 2005:311). Firstly, the data were read and re-read in order to immerse oneself with the data. Secondly, focus areas and themes were formed as categories representing the heart of qualitative data. The popular form used was to identify general themes that reappeared in the transcripts. Lastly, this was followed by applying some coding schemes to the focus areas and themes, as explained by Strydom and Delpont (2005:337).

1.6.6 Reliability, Validity and Trustworthiness

1.6.6.1 Reliability

Reliability is a reasonable criterion of quality with regard to qualitative research, though it needs to be applied appropriately. It is the extent of whether a measurement or observation technique would yield the same data if it were to be used several times independently (Babbie 2007:417). Reliability in this study was established by means of using a structured focus group interview guide.

1.6.6.2 Validity

Validity is not a single, fixed or universal concept, but “rather a contingent construct, inescapable, grounded in the processes and intentions of particular research methodologies and projects” as supported by Winter (2000:1). Likewise, Creswell and Clark (2007:134) confirm that qualitative validation is important to establish and assess whether information obtained through qualitative data collection is accurate such that more available strategies can be used to determine validity of qualitative data. In this study, focus group interviews were conducted based on the specific objectives of the GETC in AHC qualification using an experienced facilitator and audio-recording.

1.6.6.3 Trustworthiness

According to Maykut and Morehouse (1994:64) trustworthiness is best defined as the researcher’s belief in research findings. Furthermore, according to De Vos *et al.* (2005:346) there are four criteria available to determine the trustworthiness of qualitative research, namely credibility, transferability, dependability and conformability.

In this study, the researcher enhanced and ensured trustworthiness by using an experienced focus group interviewer who is a nurse educator competent in focus group interviews to facilitate the sessions, independent observers who are professional nurses experienced with primary health care, checking and re-checking of the transcripts and audio-recordings by the researcher with the assistance of the study leader.

1.7 ETHICAL ASPECTS

1.7.1 Approval

Approval to execute the research was sought by submitting a protocol to the Ethics Committee of the Faculty of Health Sciences (FHS), at the University of

Free State while permission to conduct the study (Appendix B) in the FSP was sought from the Head of Department (HOD) Free State Department of Health as emphasised by Silvermann (2001:271).

1.7.2 Informed Consent

Participants were provided with an information document (Appendix C) about the research. A signed voluntary informed written consent (Appendix D) was obtained from the participants as mentioned in Strydom (2005:59). The confidentiality principle of information and participation was observed throughout the study. Also, the participants were reassured that all information will be managed in a strictly professional and confidential manner.

1.8 IMPLEMENTATION OF FINDINGS

Findings of the study will be evaluated according to the responses of the participants in order to identify the areas of concern and focused on the recommendations to address the shortcomings against improvement of CHC service in the FSP. These findings will be communicated to FSGDS committee and distributed via the FSDoH portal, local intranet, help desk review, desk talk and every district managers' office where participants will be able to access the information.

1.9 ARRANGEMENT OF THE SCRIPT

The script is divided into five chapters and the arrangement is as follows:

Chapter 1 discusses the orientation and background to AHC training internationally, in Sub-Saharan Africa, SA and FSP. It further explains the research methodology used for the study.

Chapter 2 reviews the literature on the perspectives of CHWs including aspects such as definitions, roles, duties, training and placement internationally, in Sub-Saharan Africa, SA and FSP.

Chapter 3 outlines the research design and methodology, approach and data collection methods used to determine the experiences, opinions and attitudes of CHWs towards the objectives of the study.

Chapter 4 discusses the data analysis and the findings of data collected according to the focus areas and themes.

Chapter 5 provides the summary, recommendations, limitations and conclusion according to the research findings of the study.

A schematic overview of the study is given in Figure 1.1.

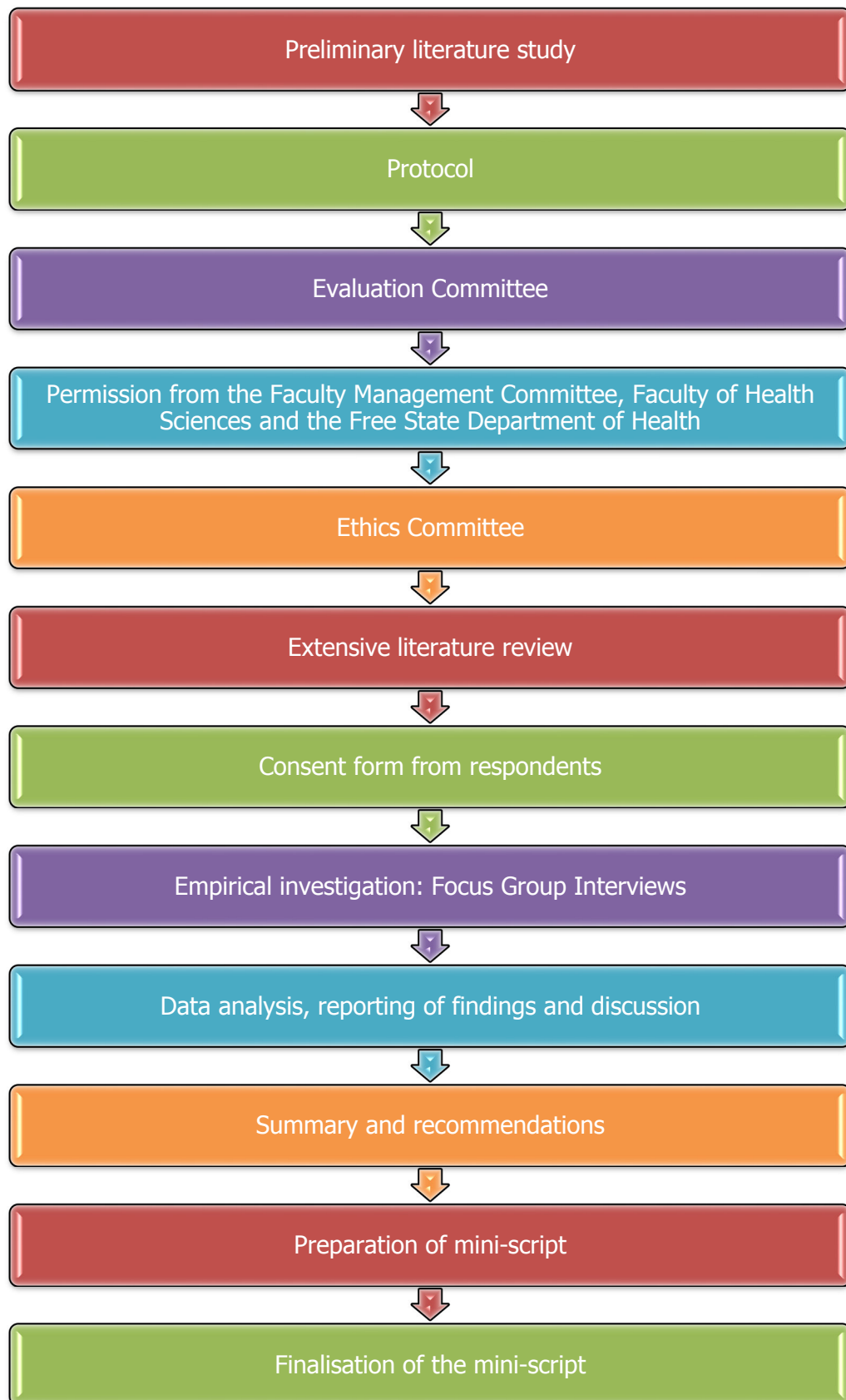


FIGURE 1.1: A SCHEMATIC OVERVIEW OF THE STUDY
[Compiled by the Researcher, Motsepe 2012]

1.10 CONCLUSION

This chapter provided an introduction and background to the study. Furthermore, the chapter outlined the problem, goal, aim and objectives of the study. In addition, the chapter outlined the research methodology and concluded with how the script will be arranged.

The next chapter, Chapter 2, titled **Perspectives on Community Health Workers**, will be a literature review focusing on relevant international, national and local perspectives.

CHAPTER 2

PERSPECTIVES ON COMMUNITY HEALTH WORKERS

2.1 INTRODUCTION

This chapter deals with the different definitions of Community Health Workers (CHWs), their roles, duties and training programmes internationally, in the Southern African Countries (SAC), nationally and locally. Kahssay, Taylor and Berman (1998:1) define CHWs as individuals who provide help in the maintenance of health and treatment for people in their home environment as well as providing health education to prevent diseases and prolonging life. Friedman, Ramalepe, Matjuis, Bhengu, Lloyd, Mafuleka, Ndaba and Boloyi (2007:5), define CHWs as people who service the consumer to access health care nearest to their home. Their service encourages traditional community life and participation by the people and responds to the needs of the people.

The focus internationally is on some programmes in the United States of America (USA) mostly concentrating on the United States Agency for International Development (USAID), United Nation Children Fund (UNICEF), World Health Organisation (WHO), World Bank (WB) and Alma Ata reports. In the case of the SAC, the focus is on Malawi, Zambia, Kenya, Uganda and Ethiopia because these are the countries that mostly rely on CHWs in the provision of Primary Health Care (PHC), especially in deep rural communities. Nationally the focus is on South Africa (SA) with specific reference to the policies, directives and reports on CHWs. Lastly, in the local perspectives the focus is on the five districts of the Free State Province (FSP) namely Xhariep, Motheo, Lejweleputswa, Fezile Dabi and Thabo Mofutsanyane. The reason for focusing on these districts is because the researcher is involved in the training of CHWs in all the districts but also liaises with the standard-setting bodies regarding CHW's issues. The main focus will, however, be on the FSP.

2.2 GENERAL PERSPECTIVES

The importance of PHC and the following roles of CHWs were highlighted as early as the 1970's during the Alma Ata Conference of 1978:

- Education on prevailing health problems;
- Methods of preventing and controlling health problems;
- Promotion of food supply and good nutrition;
- Adequate supply of safe water and basic sanitation;
- Maternal and child health care, including family planning;
- Immunisation against major infectious diseases;
- Appropriate treatment of common diseases and injuries;
- Provision of essential drugs; and
- Provision of basic curative care (Friedman *et al.* 2007:20).

In short, the above-mentioned information indicates that the participation and roles of CHWs in the provision of PHC has been reported earlier with evidence showing that they can significantly add to the efforts of improving the health of the population, particularly in the settings with the highest shortage of motivated, capable health professionals.

Lomax and Mametja (1995:4) also emphasise that information on CHWs is mostly based on the roles they play in the improvement of PHC. For example, the following roles were identified:

- Linking the community with resources and services;
- Spreading health information;
- Mobilising people to determine health needs and to take health into their own hands;
- Raising awareness about disease and carrying out health-promotion activities;
- Identifying and treating minor illnesses and referring chronic illnesses;

- Acting as agents of change for development; and
- Carrying out specialist activities in areas such as malaria and tuberculosis control, rehabilitation, hypertension and diabetes.

Also, according to Friedman *et al.* (2007:4), the activities of CHWs not only have an impact on the health status of the communities they serve but also influence social factors such as referrals for grants and the overall development of the community.

A popular development in many CHW's programmes around the world has been the extension of CHWs' role to specific community health needs such as:

- Rehabilitation;
- Environmental health;
- Women's health;
- HIV/AIDS education; and
- Prevention and control of malaria and tuberculosis.

Therefore, governments have a vital role in supporting the development of CHW initiatives (Cruz 1997:20).

It is important to note that according to Walt (1990:19), by the end of the 1970's, over thirty countries were training middle-level health workers (variously called medical assistants), medical aids and physician assistants in CHW's programmes. These CHWs' training programmes were indigenous attempts to meet the local needs by training relatively large numbers of health workers quickly and inexpensively to care for communities that are otherwise badly served by the health services. In 1977, the WHO produced an experimental manual on the strengths and weaknesses of existing CHW training programmes (Walt 1990:19).

According to a World Bank report published in the Health System Trust in 1995, “if CHWs have no clear connection to the existing health system, they are often bypassed by household members who consult providers at the first level of the formal system.” It is therefore important to link the health services with CHWs’ programmes for the success of an efficient health system (Lomax & Mametja 1995:5).

2.3 INTERNATIONAL PERSPECTIVES

Internationally, particularly in the USA, CHWs are referred to according to the role they play in facilitating health care access through outreach and health care promotion and disease prevention services to the underserved communities with high-risk populations. Hence, according to Witmer, Seifer, Finocchio, Leslie and O’Neil (1995:1056), the role of CHWs in education and outreach contributed significantly to increased detection of breast and cervical cancer, improved childhood immunisation rates, decreased rates of infant mortality and low birth weight, hypertension control and smoking cessation.

Also in the USA, CHWs are referred to as health guides who are high school graduates trained for six months to encourage preventive behaviour among hypertensive patients (Walt 1990:19). Goodwin and Tobler (2008:2) describe CHWs as clinic-based workers who are typically working in hospitals, community health centre (CHC) and health departments, performing tasks such as patient registration, translation, health education and basic health assessments.

In further defining CHWs, the WHO states that these are workers who live in the community they serve are selected by that community; are accountable to the community they work within; have received a short, defined training and are not necessarily attached to any formal institution (Bhutta, Lassi, Pariyo & Huicho 2009:12). Witmer *et al.* (1995:1057) also argue that it is essential to provide CHWs with opportunities for continuing education, professional

recognition and career advancement programmes. Likewise, Goodwin and Tobler (2008:5) advocate for a standardised training and certification for the CHWs workforce to enhance recognition and provide greater opportunities for reimbursement through state Medicaid programmes and third-party insurers. These standardised training programmes can increase the skills of CHWs and ensure a high quality of care.

Still in the USA, in 1993, the New Mexico Community Health Workers Association (NMCHWA) was informally developed under the University of New Mexico Prenatal Care Network. The development of the association was aimed at providing a venue for CHWs to gather information regarding health and social service resources, share information on CHWs programme best practices, education, legislative updates, peer support, political power for the CHW model and networking (NMCHWA 2010:1 of 4).

In the case of Russia, a training programme for CHWs was also started in the 19th century. The aim of the programme was to train school leavers who provided care to the rural population. According to Walt (1990:88), in the mid-70, the WHO and the UNICEF had already started promoting discussions about CHW's programmes. As a result, a number of international meetings were held with countries that were training CHWs to exchange information.

2.4 SOUTHERN AFRICAN COUNTRIES' PERSPECTIVES

Most of the literature on CHWs in the South African Countries (SAC) focuses on perspectives obtained from the studies conducted in Ethiopia, Malawi, Namibia and Uganda (Celletti, Wright, Palen, Frehywot, Markus, Greenberg, de Aguiar, Campos, Buch & Samb 2010:45). The specific focus in these studies is on planning, standardised training, recruitment procedure, career path and adherence to the government ministries' minimum requirements for CHWs (Celletti *et al.* 2010:45).

In some of these countries which are severely affected by HIV/AIDS, shortages of health workers present a major obstacle to scaling up HIV services. As a result, CHWs have been deployed to ensure a sustainable provision of quality services by delegating specific tasks to cadres of CHWs with limited training thereby increasing access to HIV services particularly in rural areas and among underserved communities (Celletti *et al.* 2010:45).

Unfortunately, according to Bhutta *et al.* (2009:22), many sub-Saharan African countries are off target for reaching the Millennium Development Goals (MDGs) set for 2015, possibly because of the following factors:

- inadequate human resources especially workforces who are dying of HIV/AIDS;
- lack of supervision;
- lack of equipment and drug supplies needed to provide essential maternal, child and reproductive health services; and
- lack of drug supply required to control and treat potentially preventable infectious diseases.

In the case of Ethiopia, CHWs are referred to as Health Extension Workers (HEW) assigned in health posts and community-level programmes. The discussions and planning on CHW programmes occurred among the Federal Ministry of Labour and Social Affairs, Federal Ministry of Education, other councils of ministers, regional governments, professional associations, Community Based Organisations (CBOs) and NGOs. Students are selected within the community by the community and are required to have middle school education. The HEW training programme is a one-year training that prioritises prevention and control of communicable diseases like HIV, tuberculosis (TB) and malaria, with the goal of providing equitable access to the health service. The programme includes both in-class and practical sessions concentrating on training in hygiene and environmental sanitation, family health services, health education and communication. Upon completion of the programme, the Ministry

of Health certifies the HEW. All the stakeholders who collaborated in the planning incorporated defined career structure promotion and continuous training into the HEW programme (Celletti *et al.* 2010:51).

In Malawi, CHWs are referred to as Health Surveillance Assistants (HSA) who, over an extended period of time, were developed to respond to numerous public health emergencies. Compared to Ethiopia, no collaboration in planning and establishing CHWs programmes has occurred between the NGOs, Ministry of Education, Social Services and the Ministry of Health in Malawi. Hence, HSAs are trained over a 10-week period by the Malawian Ministry of Health for a wide range of primary prevention and clinical care areas alone. Upon completion of the training, HSAs receive a certificate of attendance from the Christian Health Association of Malawi (CHAM). They are, however, not recognised as health care providers by any of the regulatory councils or provider associations in Malawi. Instead, the Ministry of Health and Population (MOHP) in Malawi directly recruits the HASs into the civil service structure in order to provide HIV Counselling and Testing (HCT) services, Home-Based Care (HBC) services such as adherence, monitoring and dispensing Antiretroviral Treatment (ART) (Celletti *et al.* 2010:50).

In Namibia, CHWs exist outside the regulated system and their establishment and management generally occur without the same level of collaboration. The training of CHWs is conducted by NGOs that support the community volunteers and this training differs in durations of a few days, a week or two weeks depending on the type of volunteer. Again, there is no clear certification process or continuous follow-up education system on CHW programme in Namibia (Celletti *et al.* 2010:S49)). CHWs are volunteers who are affiliated with the local and international NGOs. Although CHWs are trained and recruited by NGOs, supervision is performed by civil servants at the regional level. Subsequently, in April 2007, the Ministry of Health and Social Services (MOHSS), drafted a policy for community-based health care, outlining the guidelines and standards on training and accreditation, supervision and

compensation of CHWs. These discussions were held to allow for the incorporation of community counsellors into the public sector (Celletti *et al.* 2010:51).

According to a report by Celletti *et al.* (2010:S51), focus group interviews were held with CHWs in order to find out their expectations as well as assessment of their contribution to the health care of the community they service. In the report, CHWs stated their willingness to assume more extended tasks even though some of their senior cadres felt threatened. Professional health workers like nurses and doctors supported the role of CHWs and recognised that their services allowed them to concentrate on the more complicated tasks. Also, focus group discussions with People Living With HIV/AIDS (PLWHA) concluded that CHWs who are themselves living with HIV can make a noticeable contribution by addressing issues such as prevention, disclosure, adherence, self-care, stigma and discrimination in HIV. Moreover, PLWHA often show a preference for CHWs who are also living with HIV/AIDS to counsel them.

In Uganda, CHWs are described as Nursing Assistants (NA) or Auxiliary Nurses (AN). Similar to Malawi, no collaborative planning and discussions take place especially not as far as the Nursing and Medical Councils are concerned. The lack of collaboration and discussions resulted in the high level of Ministry of Health in Uganda supporting the task shifting in the NGO sector, thus contributing in CHWs providing HIV and non-HIV clinical services. Although the provision of HIV and non-HIV clinical services are essential in meeting the needs of the communities, concerns have been raised about the level of standard training that is competency-based and the extent of supervision provided to CHWs. Finally, the Ministry of Health in Uganda stopped the training of AN or NA and directly recruited and incorporated the cadre into the civil service structure (Celletti *et al.* (2010:48).

After a multi-country research study that was done on CHWs' contribution in improving PHC services, Celletti *et al.* (2010:S55) also attest to the fact that

there was sufficient evidence to convince policy makers that CHWs make a significant contribution to reinforcing and overstretching the health workforce in the SAC.

In summarising the SAC perspectives, evidence shows that employing CHWs can benefit access to quality, especially in the provision of HIV services. The successful and sustainable training and efficient services provided by CHWs depends on the existence of an enabling environment that includes a supportive regulatory framework, functioning referral systems, and quality assurance mechanisms, such as standardised training and supportive supervision.

2.5 NATIONAL PERSPECTIVES

Nationally, perspectives on CHWs' will focus on SA with specific reference to policies, directives and reports from the National Department of Health (NDoH), South African Qualifications Authority (SAQA) and Non-Governmental Organisations (NGOs).

According to literature, there was no chance for CHWs' programmes to succeed in a politically, economically and socially oppressive country like SA that lack support and interest at regional levels. Hence, in 1978, the Alma Ata Declaration on PHC included generic CHW programmes despite the exclusion of SA in the 1980s from all the decision-making and planning of CHW training programmes due to schemes that failed to reach its participatory objectives during the apartheid era (Walt 1990:27).

Even so, according to Frankel (1992:20), the training needs of CHWs should be regularly evaluated by training staff or external evaluators so that programmes can be adapted accordingly. Therefore, for the qualification to become effective, surveys and home visits should be carried out during CHWs' training to familiarise them with the health priorities (Cruz 1997:80). The performance, knowledge, skills and impact of training as well as the attitudes of CHWs during and at the end of their training should be evaluated at regular intervals. Hence,

the training programmes of CHWs were promoted and became part of many developing countries' health systems (Schneider, Hlophe & Van Rensburg 2008:180).

In 1994, when SA became a democratic country, the NDoH and the Reconstruction and Development Programme (RDP) embarked on programmes to resuscitate CHW programmes to improve PHC in rural communities (Schneider *et al.* 2008:181). Still in 1994, the RDP document produced by the African National Congress (ANC) and the National Qualifications Framework (NQF) integrated all elements of education and training systems to allow learners to progress between the different levels of education, which resulted in the development of a unique General Education Training Certificate (GETC) in Ancillary Health Care (AHC) qualification with 134 credits (Appendix A). No other country has yet generated a full and formal qualification in AHC at NQF level 1: ABET level 4 like SA. This integration assisted learners in obtaining recognition and credits for qualifications, thus proceeding towards obtaining a qualification (SAQA 2009:Online). This qualification is important and appropriate for the unique health service requirements of the country (SAQA 2009:Online). Furthermore, the qualification enables CHWs to assist communities in managing their own health and wellness better as well as in obtaining skills in providing support services within a multidisciplinary health care team (SAQA 2009:Online). Moreover, CHW's training programmes in SA have placed more emphasis on maximum local flexibility on empowering CHWs with skills to respond to the health needs and priorities of their communities (for example cf. Point 2.5 & 2.6).

According to Friedman (in Schneider *et al.* 2008:181), despite considerable political support for the concept PHC, a national programme was not part of the health reform instituted by the new democratic government immediately after 1994 and only one CHW programme associated with the former Kwa-Zulu Natal homeland survived the transition post-1994, keeping alive earlier models of CHWs and later helping to shape the CHW policy which emerged further in

2004. As early as the 1990's, Cruz (1997:16), recommended that PHC Training Boards should have overall responsibility for CHW's training programmes and should ideally include:

- Assessing the needs and recognising where the CHW's trainees come from;
- Laying down guidelines for content, according to adult education methods;
- Controlling standards;
- Provision of training centres and materials; and
- Planning for on-going training.

In practice, trainers or facilitators of CHWs training programme are nurses or people who have been promoted from being CHWs. However, doctors and nurses need re-orientation to gain insight into PHC and learn new methods and skills in communicating CHWs' programmes.

For instance, the health professionals should have:

- Good experience of PHC in the District Health Service (DHS);
- Training and experience in adult education; and
- Experience in community development, so that these CHWs can become experienced, good trainers even though they will need additional training in adult education and "up-grading" with health knowledge (Cruz 1997:15).

Following the recommendation by Cruz (1997:16), CHWs need to be consistently evaluated to improve their training and performance. At present, this is not done systematically in SA as the development of a National Core Curriculum and a working group has been set up to develop "competency testing" which could be used by an "accreditation body" to ensure that training is of an adequate standard. Despite this encouraging start, most of the larger NGOs' programmes floundered and struggled to sustain themselves when the new democratic Government's legitimacy led major international donors to switch their funding priorities. Eventually, larger NGOs weakened gradually and

were replaced by numerous small Community Based Organisations (CBOs) projects that had less coherence and insecure funding (Friedman *et al.* 2007:4). Since 1999, the development of hospices and similar institutions became increasingly overburdened and unable to cope with the number of patients in their care. As a result, a need arose to introduce and formalise CHWs' training in order to increase the number of home-based carers so as to assist and support families caring for their sick and frail aged in their homes (Friedman *et al.* 2007:4).

Subsequently, in 2000 the SA government introduced a policy framework for the training and remuneration of CHWs (Friedman *et al.* 2007:6). The government also began to provide increased funding to small organisations that were undertaking home-based care. For example, a 59-day training course for home-based care workers was developed by the Hospice Association of South Africa (HASA) jointly with the NDoH. Moreover, in the 2000's, a Standard Generating Body (SGB) from SAQA developed unit standards and qualifications for four NQF levels of CHW. The first NQF level, which is foundational for the AHC, allows the learner to function as a basic Home and Community-Based Caregiver (HCBC). The second and third NQF levels provide for the cadre known as the Community Care Worker (CCW), with level 4 being a fully-fledged CHW (SAQA 2009: Online). Thereafter, in 2001 National Guidelines for Community and Home Based Care were published. At the same time, CHWs were emerging to service new HIV initiatives and the National government declared 2002 as "the year of the volunteer". Therefore, volunteers were expected to work half a day and 20 hours per week. A rapid growth was seen with the range of lay workers, home-based carers, lay counsellors and Direct Objective Treatment (DOT) supporters (Friedman *et al.* 2007:4).

Again, in 2002, the NDoH initiated a strategy to improve community health care service by training volunteers, home-based carers and DOT supporters in General Education Training Certificate (GETC) in Ancillary Health Care (AHC) qualification at NQF Level 1: ABET level 4 (SAQA 2009:Online). Furthermore,

Fox (2002:7) emphasises that structures such as Community Health Committees (CHCs), CHW coordinators and managers should be trained to ensure that CHWs are adequately supported in their work places.

Following that, in 2003, according to NDoH Community Health Directory, individual programmes by provincial training centres such as the National Progressive Primary Care Network (NPPHCN) in the Western Cape and the *Medecins sans Frontiers (MSF)* programme in Lusikisiki in the Eastern Cape were started. As the need for training grew further, Regional Training Centres (RTCs) were also established in every province, while national debates were continuing around the standardisation and accreditation of CHW's training programme to fit in the NQF (Cruz 1997:14).

Since SA had an urgent need for PHC provision across vast and wide-spread rural areas, a qualification that includes all aspects to a large number of people, using limited resources and personnel as discussed earlier on was started. The urgent need influenced the first important step of the development of a standardized CHW's training curriculum (SAQA 2009: Online). Hence, two learning manuals, "Health for All Series" that includes a guide for CHWs and "Child Health" were published in 2003 to cater for the AHC workers (Clarke, Knight, Prozesky, Van Rensburg, Hutton & Walton 2003:20).

Already in 2004, there was an estimated 40 000 lay workers in SA, nearly equal to the number of professional nurses working in the public sector mentioned by Day and Gray (in Schneider *et al.* 2008:180). As in other countries, different terms have been used for CHWs. The term CHW was introduced as an umbrella concept for all the community or lay workers in the health sector in SA. Also, a National CHW's Policy Framework was adopted (Schneider *et al.* 2008:182).

The different terms such as the following are used:

- Community Care Workers (CCWs);
- Ancillary Health Workers (AHWs);

- Lay Health Workers (LHWs);
- Home Community Based Workers (HCBWs) and
- Direct Objective Treatment (DOT) supporters.

Although the generic term CHW embraces a very wide range of different types of workers of uneven competence and relevance as mentioned earlier, in 2004 the SA National Minister of Health encouraged provincial departments to rapidly establish CHW's programmes within the disadvantaged communities throughout the country (Friedman *et al.* 2007:5). The late Minister of Health, Manto Tshabalala Msimang, in her speech at the launching of the CHW's Programme in 2004, firstly reiterated the following important imperatives for the CHW's programme:

- The President's articulation of a people's contract to create work and fight poverty;
- Government's commitment to improve service delivery;
- The national human resource and skill development strategies;
- The increasing complexity of the burden of diseases and poverty-related challenges;
- The increasing need for health promotion activities, community and home-based care (Schneider *et al.* 2008:182).

Secondly, she highlighted an important feature in CHW's policy framework stating that although the CHWs' infrastructure is a direct consequence of the state investment, the government has avoided becoming an employer of CHWs. Therefore, government was funding the NGOs to employ CHWs and letting them fall outside of the public service regulatory processes governing employment in SA (Schneider *et al.* 2008:182). All the CHWs were brought under the banner of an Expanded Public Workers Programme (EPWP), which is one of the government's poverty alleviation strategies for the country. The EPWP is tied to the Department of Labour's National Skill Development Strategy

(NSDS) and it includes accreditation of community-based training through structured learnerships (Schneider *et al.* 2008:181).

The curriculum standards for CHWs mentioned above have all been approved by SAQA and registered with the NQF in January 2005. Over the past years, a programme to fast-track the training of CHWs set at level 3 has been undertaken (Friedman *et al.* 2007:6). In 2005/06, according to Schneider *et al.* (2008:182), the NDoH allocated R68 million to provincial NGOs involved in HIV/AIDS and TB care training support activities. Fourteen (14) CHWs were linked with each PHC facility in their communities, supervised by nurses and their incentive was a R1000 per month from the NGOs (Bhutta *et al.* 2009:167). Thereafter, the NDoH registered four CHWs qualifications in terms of the NQF, creating the possibility of career pathways for CHWs as mid-level health workers. Recruitment and selection of CHWs occurred mostly through calls for volunteers, sometimes via community-based organization and often through the involvement of health facility staff (Schneider *et al.* 2008:181).

According to the EPWP quarterly report of 2005, despite the progress made with the development of a standardized curriculum by SAQA, problems still existed in communities and a rapid move to establish an effective national CHW's programme was needed. Hence, very few agencies that had the capacity to undertake CHWs' training were accredited by SAQA for both their own workers as well as those of other agencies (Friedman *et al.* 2007:22).

The longstanding programmes with hundreds of trained CHWs remained unrecognized. For instance, in a paper presented by W. Southgate at a CHWs' Conference in Qwaqwa in 2005, the speaker highlighted that there are 2,100 CHWs who completed Community Based Health Programmes (CBHP) in Kwa-Zulu Natal. But, the comprehensive CHW training programme remains unaccredited. Therefore, accreditation of CHWs' training programmes and roles within the PHC structure were reinforced both in relation to the communities they serve and to the health staff they work alongside (Friedman *et al.* 2007:4).

According to Friedman *et al.* (2007:8) some of the CHWs that have been trained as caregivers face day-to-day challenges of caring for the helpless, vulnerable and dying patients; only to discover later that this is not the type of work they wanted to embark on as a career. The move of accreditation of CHWs' training programmes opened career pathways that hardly existed for CHWs who would seriously like to practice and carefully consider it a wise step to proceed towards a formal career in recognized professional disciplines such as nursing, medicine and pharmacy (SAQA 2004:Online). Subsequently, according to Friedman *et al.* (2007:8), there has been a proliferation of pseudo voluntarism where volunteers hoped for jobs in the community, while others aimed at simply obtaining training that would increase their likelihood of finding formal employment.

During 2006, a series of five manuals adding to the two that were already mentioned earlier on (set at level 3) were again published, thus providing learning about PHC, health and common diseases, personal development, community development and social care. All the training materials were based on the new outcomes-based education framework and included a range of participatory learning exercises (Friedman *et al.* 2007:8). Thereafter in 2007, the WHO reported that the role of CHWs in many countries has contributed a lot in improving health outcomes. However, CHW's programmes have found immense bureaucracy of formal SAQA accreditation by the Health and Welfare Sector Education and Training Authority (HWSETA) making it almost impossible for most NGOs to obtain accreditation and many stakeholders felt that CHWs should form a specific category of their own as multi-purpose PHC workers. However, according to Cruz (1997:16), the NDoH did not share the above-mentioned view as there were only five (5) of the 84 projects in SA that were included in the National Review of Community Health Worker Programmes who had any form of accreditation.

In two of the projects, nursing tutors assist CHWs to complete the basic Nursing Assistant (NA) course recognised by the South African Nursing Council

(SANC). Hence in 2010, the Minister of Health, Dr Aaron Motswaledi, and MEC's visited Brazil and learnt that re-engineering PHC is of significant importance in improving the health outcomes as mandated by the National Health Council (NHC) 10-point plan. Thereafter, the Minister established a team to elaborate on a SA model to strengthen PHC. The team reported the first narrative document to the NHC meeting in November 2010 where debates took place, and thereafter it was adopted. Restructuring the health system is one of the 10 points noted in the five year Health Sector 10 Point Plan 2010-2015 emphasising "overhauling the health care system" and strengthening its effectiveness (RSA DoH 2011:3).

According to RSA DoH (2011:5), there are three stream approaches to PHC re-engineering that must be implemented by the NDoH, namely:

- A ward based PHC outreach team for each electoral ward;
- Strengthening school health services and
- District-based clinical specialist team with an initial focus on improving maternal and child health.

According to above-mentioned, the stream that interests the researcher is a ward- based PHC outreach team that includes CHWs. Supported by Sepulveda *et al.* 2006 (in RSA DoH 2011:5), the contribution of CHWs in many countries indicated that home and community-based health services that are linked with the fixed PHC facilities in particular, are critical to good health outcomes. Also, the ward-based PHC outreach team is designed to correct the limitations in the way community-based health services are currently provided in the country. The ward-based PHC outreach team is composed of a professional nurse as a leader; environmental health practitioner, health promotion practitioner and five (5) CHWs.

The roles of CHWs as part of the PHC outreach teams include the following:

- Conducting community, household and individual health assessments; identifying health needs and risks (actual and potential); and facilitating the family or an individual to seek the appropriate health service;
- Promoting the health of the households and the individuals within these households;
- Referring persons for further assessment and testing after performing simple basic screening;
- Providing limited, simple health intervention in a household (e.g. basic first aid, oral rehydration and any other basic intervention that she or he is trained to provide);
- Providing psycho-social support and managing interventions such as treatment defaulter tracing and adherence support (RSA DoH 2011:19).

Recently, the DoH is finalising a curriculum for CHW's training and outreach team orientation. The curriculum and training material will be made available to the provinces in due course (RSA DoH 2011:19).

According to NSDA (2011:11), the NDoH with its stakeholders supported the achievement of the four outputs stipulated towards PHC re-engineering, namely:

- Increasing life expectancy;
- Decreasing maternal and child mortality;
- Combating HIV and AIDS and decreasing the burden of diseases from TB;
and
- Strengthening Health system effectiveness.

The NHA has provided the legislative background for the new categories of health professionals in SA under the regulations relating to Human Resources in Chapter 7, Section 52 (c) and (d) of the Health Act No. 61 of 2003. There is

also a need to develop regulations regarding Human Resources within the National Health System (NHS) in order to create new categories of health care personnel to be educated or trained for-example CHWs. The regulations shall identify shortages of key skills, needed expertise and competencies within the NHS by the restructuring of the health system into one that is based on PHC approach (NSDA 2011:21).

Finally, it is important to point out that CHWs in SA represent the most formalised end continuum of community participation around HIV/AIDS, from treatment literacy training programmes for people living with HIV, to members of their social networks volunteering to become TB or Antiretroviral 'treatment buddies', and they participate in rights-based activists network (Schneider *et al.* 2008:182).

2.6 LOCAL PERSPECTIVES

Locally, perspectives on CHWs will focus on the FSP with specific reference to FSDoH guidelines and policies as well as research articles. The FSP CHW's programme has its origin in a contract signed in 2001 between two large NGOs, namely the Cancer Association of SA (CANSA) and Hospice (Schneider *et al.* 2008:182). Furthermore, the FSDoH Strategic Plan of 2003 outlined plans to develop and implement strategies for the deployment of CHWs to assist in HIV/AIDS interventions. Subsequently, in 2004, a policy was drafted on relationships of NGOs to cater for expanding activities and a growing number of NGO contracts (Schneider *et al.* 2008:182).

In mid-2004, when an inventory was made in the 16 PHC facilities in the FSP for the antiretroviral treatment (ART) programme, there was an average of just over 14 CHWs linked to each facility. The rest of the CHWs were trained as single purpose workers such as lay counsellors, DOT supporters or home-based carers. Recruitment and selection for further training occurred through calls for

volunteers sometimes via CBOs and often with the involvement of local health facility staff (Schneider *et al.* 2008: 183).

Still in 2004, the FSDoH embarked on the NDoH's strategy mentioned in the national perspectives (*vide 2.5*) stating that training programmes for CHW's should be resuscitated to improve PHC in rural communities. What followed was the recruitment of the CHWs to the programme. The recruitment was liaised with the district managers and district coordinators in partnership with NGOs and CBOs. The entry requirements of the candidate to the programme were a standard six (6) or grade eight (8), two years of continuous voluntarism to the FSDoH and residence in the FSP.

There were, according to Schneider *et al.* (2008:185), concrete perceptions by CHWs about the opportunities available to be recruited in a CHWs' training programme. These perceptions were accompanied by considerable uncertainty and mistrust. For example, one CHW indicated that a selection criterion for further training was in some instances unfair and was quoted *"I volunteered myself for more than 5 years now, when there is a post, they take somebody from outside, not you because you are a volunteer. Does it make sense? Now we are applying for learnerships, they say we are going to give volunteers first priority. Unfortunately, they take somebody with standard two or eight sitting in the township doing nothing and you find out that his/her mother is head or something in the Department of Health"*.

According to Schneider *et al.* (2008:183), in 2006 the number of CHWs linked to the PHC facilities did not change much. However, there was a clear investment in the training of CHWs with a shift towards more multi-skilled and multi-purpose HIV/TB workers rather than generalist CHWs. Moreover, the combination of further training and the new tasks of the ART programme created the impetus for a reorganisation and expansion of job descriptions for CHW, as quoted by one CHW in the Schneider *et al.* (2008) article: *"We now have patients on ARVs, so we are able to do follow-ups for those who miss*

return dates. We also do counseling, home based care and drug readiness (training). We rotate, for example if I do home based care today, I do counseling tomorrow, just like that”.

In line with Frankel’s (1992:20) recommendations, regular monitoring of CHWs’ performance, knowledge, skills and the impact of training on their attitudes towards PHC should be done. Therefore, in 2006, the FSPG commissioned the FSDoH to conduct research on the necessity of continuing with further training of CHWs in the GETC in AHC qualification and evaluate the impact of the training on improving PHC in the FSP (FSPG 2006:2). Hence, this study that focused on exploring the experiences, opinions and attitudes of CHWs who completed their training in 2006.

In 2011, the NDoH mandated the FSDoH to embark on PHC re-engineering, especially where CHWs form part of the PHC ward outreach teams that are assigned to a geographic area or to a number of families in the districts’ rural communities (RSA DoH 2011:7). According to RSA DoH (2011:6), the involvement of CHWs as part of the outreach team of health workers (*doctors, nurses and CHWs*) will improve access to health care. Also, social mobilisation will be strengthened with basic public health education being the major community activity.

2.7 CONCLUSION

In general, the most important aspect highlighted in this chapter is the 1978 Alma Ata Conference Report which emphasised the importance of the role of CHWs in the improvement of PHC. It is also clear that by 1970s, over 30 countries were training middle-level health workers with different names being given for CHWs. Also, in 1995, the World Bank reported the importance of linking health services with CHWs’ programmes for efficient health systems.

In the case of the USA, the most important roles of CHWs identified are health promotion and disease prevention in high risk populations-especially

hypertension. The most profound definition of CHWs is by the WHO that states that these are the workers living in the community, selected by the community and accountable for the community. Of note again is that in the mid-70s, the WHO and UNICEF emphasised the importance of standardisation of CHWs' training programmes and certification. During that period, discussions for encouraging collaboration between countries were held.

According to literature, there are severe challenges of taking care of PLWHA in SAC. Some of the challenges are shortage of CHWs and material resources for providing quality care in rural communities, thus a possible inability to meet the 2015 MDGs on HIV. In addressing the shortage, countries such as Ethiopia, Malawi, Namibia and Uganda also embarked on training CHWs, especially to support people living with HIV and AIDS. Also, there is sufficient evidence to convince policy makers to continue further training of CHWs.

In SA, bodies and organisations such as ANC, NQF, NDoH and SAQA developed policies and directives to formalise training of CHWs and home-based carers. As a result, 2002 was declared a "year of the volunteer" by the National government leading to an increase in the number of lay counsellors, home-based carers, lay-workers and DOT supporters. Subsequently, in 2003, provinces such as KZN and EC established CHWs' training programmes. These programmes were guided by PHC manuals published by SAQA and this resulted in SA having about 40 000 lay-workers by 2004. Moreover, in 2010-2011, the DoH developed a new model to strengthen PHC v.i.z "overhauling the health care system", finalising a curriculum for CHWs and ward outreach teams in re-engineering PHC.

Locally, in the FSP the development of CHWs' programmes originated in 2001, with FSDoH signing contracts with NGOs to train CHWs. Thereafter, in 2003, the FSDoH Strategic Plan emphasised the necessity of deploying CHWs to assist in HIV and AIDS interventions. Subsequently, in 2004, the NDoH mandated FSDoH to train CHWs in a two-year GETC in AHC qualification and they completed in 2006. As in other Provinces, in 2011, the NDoH mandated FSDoH

to implement PHC re-engineering programme especially where CHWs form part of ward outreach teams to improve access to health care and strengthening basic public health education.

The GETC in the AHC qualification is a National Certificate with its main focus on Primary Health Care (PHC), within the framework of community development, with health promotion as a vital aspect. On completion, the learner is expected to play a pre-emptive role in the assessment and identification of health needs as well as to intervene in PHC activities collaborating with and referral to the formal health and other health related systems (SAQA 2009:Online).

Furthermore, preventive measures for the management of disasters and accidents from important aspects of the qualification. Hence the researcher has based the study mainly on the four outcomes namely, (i) assess and identify community health needs, (ii) execute primary health talk, (iii) engage in basic health promotion with specific reference to preventing and managing accidents and disasters (iv) refer clients to the formal health services and other health-related systems.

With regard to the Free State Province and according to the Free State Growth and Development Strategy, a recommendation was made to utilise CHWs who have obtained the GETC in AHC to assist with the improvement of PHC services in the FSP (FSPG 2006). Therefore, information with regard to the role and value the GETC in AHC has played in capacitating the CHWs were needed, hence the study.

The next chapter, Chapter 3, titled: **Research Design and Methodology**, will be the description of the study design and approach of the literature review, the population in the study, sample selection, pilot study, focus group interviews as a data collection method, data analysis, ethical aspects and how quality was ensured.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

This chapter deals with the research design and methods that were used to conduct the study. Firstly, the description of the study design is provided. Thereafter, the following aspects of the methodology are described: literature review; the population and sample in the study; focus group interviews as a data collection method; data analysis; ethical aspects and how quality was ensured.

According to Joubert, Bam and Cronje (2008:2) research is defined as a collection and interpretation of information (data) according to certain structured guidelines so that valid conclusions can be reached. Likewise, Denscombe (2007:8) defines research as a systematic investigation into existing or new knowledge. The latter author further states that research is used to establish or confirm facts, reaffirm the results of previous work, solve new or existing problems, support theorems, or develop new theories.

3.2 THEORETICAL PERSPECTIVES ON THE RESEARCH DESIGN AND APPROACH

This study followed a descriptive, explorative and contextual design using a qualitative approach. According to Joubert *et al.* (2008:15-16), a descriptive study is characterized by describing a specific group, prevalence and incidences. Furthermore, a descriptive study is usually the first step in the exploration of a field of research. This was the case in this study in which the perceptions of CHWs regarding the exit level outcomes of the GETC in the AHC qualification were described and explored. Ivankova, Creswell and Clark (2007:257) define a qualitative research approach as an inquiry process of understanding based on a methodology that explores a social or a human

problem. In this study, the social inquiry that was explored was the ability of CHW's to contribute towards community health care service.

In addition, Mouton (2003:149) states that studies that are usually qualitative in nature aim to produce an in-depth description of a group of people or a community. Such descriptions are embedded in the life-worlds of the actors being studied and produce insider perspectives of the actors and their practices as was the case with the CHWs who have obtained the GETC in AHC qualification in 2006 in this study.

Another definition by Denscombe (2007:333) regards qualitative research as an umbrella term that covers a variety of approaches to social research drawing on disciplines such as sociology, social anthropology and social psychology. The author further identifies the following common approaches that are used in qualitative research:

- The use of the text and images as the basic data;
- An interpretive approach that regards knowledge as socially constructed;
- A concern with meanings and the way people understand things;
- An interest in the activities of social groups (such as rituals, traditions and relationships);
- An interest in patterns of behavior, cultural norms and types of language use.

The use of the above approaches in this study will be discussed in the next chapter.

3.3 RESEARCH METHODS

Research methods are tools that help the researcher get a clearer picture of things, and an accurate measurement of things, facts and evidence about the subject matter (Denscombe 2007:133).

The research methods that were used and formed the basis of this study comprised a literature review, study population, sample selection, pilot study, focus group interviews (FGI) as a data collection method and data analysis. Equally important, ethical aspects and quality assurance methods were included.

3.3.1 Literature review

The literature review that informed this study was discussed in Chapter 2. The aim of this review was to place the planned study in the context of the subject and formulate a clear research problem. According to Joubert *et al.* (2008:67), when the researcher has read broadly about the subject, certain aspects about the study are addressed.

The literature review helped to contextualize a problem against related theory and research, and ensured that the study had a specific aim of describing and exploring the experiences, opinions and attitudes of CHWs regarding the exit level outcomes of the qualification. Also, the literature review provided the basis for the development of a FGI guide based on the specific objectives of the study.

3.3.2 Study population

A study population is a set of entities in which all the measurements of interest to the researcher are represented (De Vos *et al.* 2005:193). In this study, all 46 CHWs who were involved in the GETC in AHC learning programme in 2004 were the study population.

3.3.2.1 Target population

The target population in this study was 46 CHWs who obtained the GETC in the AHC qualification in the FSP in 2006. However, three of the 46 CHWs passed

away before the FGIs were conducted. Therefore, the target population was 43, of which seven (7) were in Xhariep, six (6) in Motheo, five (5) in Fezile Dabi and 25 in Thabo Mofutsanyane districts respectively. Table 3.1 portrays the target population and districts.

TABLE 3.1: TARGET POPULATION PER FSP DISTRICTS

DISTRICTS	TARGET POPULATION
XHARIEP	7
MOTHEO	6
FEZILE DABI	5
THABO MOFUTSANYANE	25
TOTAL	43

3.3.2.2 *Sample selection*

According to Denscombe (2007:13), there are basically two kinds of sampling techniques that can be used by researchers. The first one is known as probability sampling and the second one as non-probability sampling. As the name suggests, "probability sampling, is based on the idea that people or events that are chosen as the sample are chosen because the researcher has some notion of the probability that these will be a representative cross-section of people or events in the whole population being studied and non-probability sampling is conducted without such knowledge about whether those included in the sample are representative of the overall population". For instance, the target population selected in this study was likely to produce the most valuable data needed.

3.3.2.3 *The pilot study*

Pilot testing is a cardinal rule of research (De Vos *et al.* 2005:309). Yet, a pilot study presents special problems with focus group interviews like in the case of this study where the questions used are difficult to separate from the environment of the focus group. Therefore, in this study, the first focus group interview was used as a true pilot study. The findings of the pilot study were not included in the final study.

3.3.3 Focus group interview

McMillan and Schumacher (2001:165) state that the design of a qualitative research project uses data collection techniques such as questionnaires, observations or interviews. In this study, focus group interviews (FGIs) were used to enable the participants to describe and explore their perceptions based on the study objectives (*vide 1.5*). Also, an audio recorder and transcripts were used to capture data and permission was obtained from participants to do so (Nieuwenhuis 2007:92).

In a FGI, discussions are carefully planned and designed to obtain perceptions on a defined area of interest in a permissive and non-threatening environment (De Vos *et al.* 2005). In this study, FGIs were planned and conducted at the venues where these CHWs are working (*vide 1.6.2*), thus making the environment non-threatening. The researcher booked a conducive board room at the respective district facilities for the FGI to take place.

The use of FGIs for this study was appropriate because according to Greeff (2005:299), participants had certain characteristics in common that related to the topic and the group was “focused” as it involved some kind of collective activity. The researcher conducted seven focus group interview sessions of two hours each to promote self-disclosure among the participants. These FGIs were conducted in each respective district using a FGI guide. Table 3.2 portrays the number of FGI sessions per district.

TABLE 3.2: FGI SESSIONS PER DISTRICT

DISTRICT	FGI SESSIONS
Motheo	1
Fezile Dabi	2
Thabo Mofutsanyane	3
Xhariep	1
TOTAL	7

3.3.3.1 *Response rate*

According to Babbie and Mouton (2001:261), a question most novice researchers ask concerns the percentage return rate that should be achieved from the respondents. In most cases, not all members of the population respond. Nevertheless, the overall response rate is a guide to the representativeness of the population. If a high response rate is achieved, there is less chance of significant response bias than in low response rate. The consensus is that a response rate of 50% is adequate for analysis and reporting. A response of 60% is good, whilst a very good response rate is 70%. These are just rough guides that do not have statistical value. However, a demonstrated lack of response bias is far more important than a high response rate.

In this study, 35 out of the 43 CHWs participated in the FGI sessions. The reason being, eight (8) participants got sick (*vide 3.3.2.1*). Therefore, there was an 81% response, which according to Babbie and Mouton (2001:261) is a very good response rate. It is important to note the discrepancy in the population and respondents in Motheo and Fezile Dabi districts, as the participants swapped their attendance of FGI sessions. Hence, the change in numbers of response rate on both districts in the table below. Table 3.3 portrays the response per district, population and sessions.

TABLE 3.3: RESPONSE RATE PER DISTRICT, POPULATION AND FGI SESSION

DISTRICT	RESPONSE RATE	POPULATION	SESSIONS
Motheo	7	6	1
Fezile Dabi	6	5	2
Thabo Mofutsanyane	19	25	3
Xhariep	3	7	1
TOTAL	35	43	7

3.3.3.2 Focus group interview guide

A FGI guide (Appendix E) was developed according to the principles of focus group interviews. Greeff (2005:308) reasons that a guide should have an easy beginning, be sequenced, move from general to specific and use the time available wisely. In addition, the structure should include both questions and facilitator style. Hence, the FGI guide that was developed for this study contained prompts that focused on the aim of the study generally and specific questions related to the objectives of the study (*vide 1.5*).

According to Nieuwenhuis (2007:91), a focus group facilitator must have extensive experience in interviewing and communication techniques. The facilitator for this study was a qualified nurse educator managing the Skill Development Unit (SDU) in the Human Resource Development (HRD) Directorate for FSDoH. This facilitator has obtained a Master's degree and has experience in conducting interviews. Furthermore, an independent observer was appointed per session to document the interaction and non-verbal behaviour of the participants. The independent observers were the skills development coordinators in the respective districts (*vide 1.6.2*) working together with the HRD Directorate at the FSDoH Provincial Office. The use of these coordinators as observers enhanced the FGI as they are experts in the field of PHC.

3.3.3.3 Focus group interview questions

Questions for the facilitation of the interviews were reflected on PowerPoint slides (Appendix F). These questions were formulated according to the FGI guide, with the time allocated for each question. The FGI questions focused on the reflection and discussion on personal experiences, opinions and attitudes of CHWs towards the set objectives of the study (*vide 1.5*). According to Greeff (2005:309), the general rule of thumb is to maintain as much consistency as possible throughout the series of focus groups, for it is in comparisons and

contrasts that themes and patterns emerge from the data. In this study, the experienced facilitator maintained consistency by adhering to the time allocated for each question and by projecting the same PowerPoint slides in all the FGI sessions in the respective districts (*vide 1.6.2*).

3.3.4 Data analysis

The researcher analysed the data using qualitative scientific methods to identify trends and patterns that reappeared within the various FGIs. The bases for analysis were notes from the independent observers and transcripts from the audio recording (Greeff 2005:311). Firstly, the data was read and re-read from the transcripts, audio recordings played, rewinded and replayed in order to immerse oneself with the data (De Vos *et al.* 2005:337). Secondly, categories, themes and patterns were formed as they represented the heart of qualitative data. The popular form was to identify recurrent patterns in the transcripts and audio recordings and to apply some coding schemes (Strydom & Delpont 2005:337).

Two types of coding schemes were used in this study to analyse data; namely, open coding and axial coding. According to De Vos *et al.* (2005:338) as well as Nieuwenhuis (2007:105), during open coding, data are broken down into parts, closely examined, compared for similarities and differences and questioned in terms of phenomena reflected in the data.

In this study, the researcher broke down the data into parts by grouping data according to the required responses to the questions. A xial coding was also used, which is done by putting data back together in new ways after the process of open coding. Therefore, connections were made between the focus areas and themes using the responses. Hence, in this study both coding methods were applied as the themes and focus areas were consistent with the FGI questions and the objectives of the study.

3.4 ETHICAL ASPECTS

Ethical aspects were considered before the study was conducted. According to Joubert *et al.* (2008:9) all research projects must be approved by the ethics committee of the relevant institution before the study commences. Approval for the execution of the study was obtained from the Ethics Committee of the Faculty of Health Sciences (FHS), UFS and ECUFS nr 49/2011 was allocated to the study. Likewise, permission to conduct the study in the FSP was obtained from the Head of Department (HOD) in the FSDoH (Appendix B).

In further adhering to ethical principles, participants were provided with an information document about the research (Appendix C). Also, an informed consent form (Appendix D) with an emphasis on confidentiality principle of information and participation was provided (Strydom 2005:59). The researcher used the assistance of the district coordinators to hand out the consent forms to the participants as they were in constant contact and nearer to them. Participating was voluntary.

In order to protect the rights of participants, the researcher provided the participants with the contact numbers of the Secretariat of the Ethics Committee of the FHS, UFS for enquiry.

3.5 RELIABILITY, VALIDITY AND TRUSTWORTHINESS

To ensure quality in the study, reliability, validity and trustworthiness criteria were applied.

3.5.1 Reliability

According to Babbie (2007:417), reliability is a reasonable criterion of quality with regard to qualitative research, though it needs to be applied appropriately. It is the extent of whether a measurement or observation technique would yield the same data if it were to be used several times independently. In this study,

reliability was established by using a FGI guide (Appendix E) with the FGI questions (Appendix F). The facilitator also assisted with the formulation of the FGI questions to meet the set objectives of the study. All the sessions were facilitated by the same experienced FGI facilitator who is knowledgeable in CHWs learning programme outcomes. During facilitation, the same questions were projected on the PowerPoint slides in all the sessions in the respective districts.

3.5.2 Validity

Validity is not a single, fixed or universal concept, but “rather a contingent construct, inescapable, grounded in the processes and intentions of particular research methodologies and projects” (Winter 2000:1). Likewise, Creswell and Clark (2007:134) confirm that qualitative data validation is important to establish and assess whether information obtained through qualitative data collection is accurate; thus, more available strategies can be used to determine validity of qualitative data.

According to Denscombe (2007:297), validity or credibility of qualitative data is the extent to which researchers can demonstrate that their data are accurate and appropriate. Researchers do this by offering reassurances that the qualitative data have been produced and checked in accord with good practice. It is on this basis that judgements can be made about credibility of the data. Again, validity of findings in social research can be checked by using different sources of information (data triangulation), by comparing data from different informants or using data collected at different times (Denscombe 2007:136).

Therefore in this study, validity was ensured by conducting FGIs based on the same specific study objectives of the GETC in AHC qualification, using the same FGI questions, facilitated and projected by the same experienced facilitator and using an audio-recorder at the respective districts.

3.5.3 Trustworthiness

According to Maykut and Morehouse (1994:64), trustworthiness is best defined as the researcher's belief in research findings. In this study, the researcher enhanced and ensured trustworthiness by using an experienced facilitator and independent observers.

In this study, the researcher enhanced and ensured trustworthiness by using an experienced focus group interviewer who is a nurse educator competent in focus group interviews to facilitate the sessions, independent observers who are professional nurses experienced in primary health care, and checking and re-checking of the transcripts and audio-recordings by the researcher with the assistance of the study leader.

3.6 CONCLUSION

Chapter 3 outlined the research design, approach and methodology. The methodology covered a literature review, study population, sample selection, data collection methods used, data analysis and ethical aspects, as well as quality assurance criteria that were considered.

The next chapter, Chapter 4, entitled **Data Analysis, Findings and Discussion**, will focus on how data were analysed and a discussion based on the findings that emerged from the data collection.

CHAPTER 4

DATA ANALYSIS, FINDINGS AND DISCUSSION

4.1 INTRODUCTION

This chapter deals with how data were analysed, the findings and thereafter discussion of the findings. This is the data collected by means of Focus Group Interviews (FGI) using a FGI guide (Appendix E) with the focus on prompting the participants to think back and reflect on their personal experiences, opinions and attitudes regarding their ability to: (i) identify and assess community health needs; (ii) execute primary health care talk; (iii) engage in basic health promotion by means of preventing and managing accidents and disasters and (iv) refer clients to the formal health services and other health-related systems.

4.2 DATA ANALYSIS

As described in Chapter 3 (*vide 3.3.4*), data were analysed from the transcripts of the audio recordings and notes of the independent observers. The basis of the analysis was on a single question used to prompt and encourage the participants to think back and reflect. The question was "*Reflect on and discuss your experiences, opinions and attitudes regarding the value and role played by the GETC in AHC in the Free State Province*". In further analysing the data the researcher used the objectives of the study to formulate four major focus areas namely:

- Identification and assessment of basic community health needs.
- Execution of primary health care talk.
- Engagement in basic health promotion with specific reference to prevention and management of accidents and disasters.

- Referral of clients to formal health services and other health-related systems.

In further analysis of the data, different themes were identified in each focus area. Table 4.1 portrays the focus areas and themes.

TABLE 4.1: IDENTIFIED FOCUS AREAS AND THEMES

FOCUS AREAS	THEMES
1. Identification and assessment of basic community health needs	<ul style="list-style-type: none"> • Shelter • Food • Water • Health care • Education
2. Execution of primary health care talk	<ul style="list-style-type: none"> • Nutrition • Food groups • Functions of food in the body
3. Engagement in basic health promotion with specific reference to prevention and management of accidents and disasters	<ul style="list-style-type: none"> • Burns • Fractures • Drowning • Paraffin poisoning
4. Referral of clients to formal health services and other health-related systems	<ul style="list-style-type: none"> • Clinics • Community Health Centres • Social and Welfare Departments

4.3 FINDINGS AND DISCUSSION

The findings and discussion thereof are according to the prompts in the FGI guide (Appendix E). For the purpose of discussing the findings from the seven FGI sessions in the districts, the researcher attached the following labels to identify each FGI session:

- Motheo [Motheo]
- Fezile Dabi (1) [FD1]
- Fezile Dabi (2) [FD2]
- Thabo Mofutsanyane (1) [TM1]
- Thabo Mofutsanyane (2) [TM2]
- Thabo Mofutsanyane (3) [TM3]
- Xhariep [Xhariep].

The above-mentioned labels will be used in the discussion. Furthermore, these labels will be used as references in the recommendations in the next chapter.

4.3.1 Focus area 1: Identification and assessment of basic community health needs

This focus area is based on the participants' reflection on their experiences, opinions and attitudes regarding their ability to identify and assess basic community health needs.

The following five (5) themes were identified during the discussion.

4.3.1.1 Theme 1: Shelter

According to the responses from the seven (7) FGI sessions, shelters were identified mostly as shacks which are small and overcrowded. According to the participants, these types of shacks predisposes families to lack of privacy and unhygienic conditions. For example, one participant remarked: "*...most of these shelters look like match boxes and pig sties.....it is really heart-breaking to see such conditions...*" [Xhariep]. In addition, participants from the other two FGI sessions at Thabo Mofutsanyane and Fezile Dabi districts remarked: "*...shacks are without windows to allow ventilation and this result in stuffiness and droplet infections like TB*" [TM1]. Also, "*...municipality should speed up RDP houses allocation to the people*" [FD2].

According to the discussions above, it is clear that the status of shelters is unfavourable as a basic need for the community. In addition, the researcher witnessed these small, overcrowded and leaking shacks during community health awareness campaigns and training, particularly in the rural areas of the Free State Province. These shacks are erected at close proximity to each other with more than six people staying in a one-roomed small shack. These conditions are reported regularly in the media with shack dwellers reporting

that they become sick and lose property due to improper infrastructures. Hence, the participants recommended that to the government must speed-up building and allocation of proper RDP houses to the needy as was promised during the 1994 municipal elections.

4.3.1.2 Theme 2: Food

In the second theme, the participants' responses were based on their ability to identify and assess food as a basic community health need. According to their responses, unemployment and poverty were the major sources of lack of enough food. In fact, one member from Thabo Mofutsanyane district believed that Orphans and Vulnerable Children (OVC) should be assisted with grants to obtain food as they are the mostly affected group. An expression made was: *"...OVCS are neglected, malnourished, eat unbalanced diet and people are poor, have no skills to prepare and cook food properly"*[TM1].

In addition, the other participants remarked as follows:

- *"Feeding schemes should be available at the rural schools"* [Motheo]
- *"Health talks should be emphasised on nutrition at the clinics and schools"* [FD2]
- *"People should be encouraged to erect food gardens to obtain nutrients"* [TM2]
- *"Social workers to supply OVC with food parcels on daily basis"* [FD1].

According to the remarks above, it is clear that unemployment leads to poverty and in turn difficulty to obtain food. For example, it is known that the country has a challenge to create jobs for its people, hence so many riots and demands for services. There are regular reports in newspapers about the shortage and escalating prices of food that are making it more difficult for people to obtain food. Therefore, food is one of the basic needs for human survival. Another challenge is the influx of foreigners into the country making job creation and

food shortage an even bigger problem. Again, the idea is for the government to revisit their 1994 and 2000 manifestos on job-creation and poverty alleviation.

4.3.1.3 Theme 3: Water

In their responses regarding their ability to identify and assess water as a basic health need, the participants indicated that improper sewerage system infrastructures particularly in rural areas are the result of communities drinking polluted water.

Hence they made the following remarks:

- *"Ahh... there is no running tap water in the settlements thus people drink water from the dams"* [Motheo]
- *".....it is people's right and basic need to drink clean water, not to share water with animals....."* [TM3]
- *"Our people lack information on how to disinfect water before drinking. It is our responsibility as CHWs to teach the community on water purification methods"*[Xhariep]
- *"Municipality should supply clean water with tanks to the communities"* [FD2]
- *" Municipality to install proper sewerage system and cover water reservoirs"* [FD1]
- *"...people should be educated not to urinate in the water reservoirs as this cause water pollution"* [TM3].

The participants stated that local government delays to erect proper sewerage and sanitation infrastructure, thus forcing the community to drink polluted water. However, local government can argue and debate the issue based on high influx of people to informal settlements where pipes cannot be installed. The researcher recently witnessed a riot due to water shortage at two rural

towns of Thabo Mofutsanyane district where residents destroyed water tanks and burnt municipal offices because of poor water service delivery. However, the Free State government expressed their disappointment in the local newspaper stating that there was no need for these communities to destroy property. It appears that people are tired of empty promises made by the government. Therefore, the idea is for government to consider water as a basic need and appoint appropriately qualified people to erect proper sewerage system and supply clean water to communities.

4.3.1.4 Theme 4: Health Care

Participants' responses towards their ability to identify and assess health care as a basic health need were based on lack of information about health care in the community, as one participant from Fezile Dabi district voiced it out as follows: *"...neglect proper health care due to poverty and overcrowding...think communities should be taught on how to maintain surroundings clean"* [FD1]. The other participants indicated determination to take the health talk forward to the community on proper health care. At Thabo Mofutsanyane district, one member [TM3], stated that: *"people staying in close-by shacks, spill dirty water in-between the shacks and this cause water-borne diseases"*. In Xhariep, one participants' remark was: *".....flies infestation all over, uncovered food and body hygiene negligence....."* [Xhariep] Only one participant from Motheo district had a different view on assessment of the lack of health care and remarked: *"...lack of mobile clinics at the deep rural areas and farms contribute to poor health care of these communities"* [Motheo].

In addition, the following statements were made:

- *"Enough mobile clinics should be available to supply proper health care to the rural and farm communities"* [Motheo]
- *"Health-awareness campaigns should be done randomly"* [FD2]

- *"...we (CHWs) should continue with home visits and emphasise good health to the community"* [Xhariep]

According to the participants, it is clear that the community lacks information on proper health care and there are insufficient mobile clinics to attend to the health care of deep rural-based areas. Hence, the Free State Department of Health (FSDoH) has allocated PHC roving teams of health care workers made up of doctors, nurses and CHWs to provide PHC to the rural local municipal areas. The researcher observed the work done by these teams at one rural district where there was improvement with regard to follow-up of patients on chronic medication.

4.3.1.5 Theme 5: Education

The discussions with regard to their ability to identify and assess education as a basic health need were also based on unemployment and poverty that is prevailing. Participants viewed the latter as reasons for communities not receiving education. For example, reference was made to the current incident where the government has failed to distribute textbooks to the schools, thus disrupting learning. This appeared in the media and no one wanted to take the responsibility. Participants were of the opinion that the government should take the responsibility of solving the problem by charging those who were involved. However, the community should not display their dissatisfaction by burning and destroying the schools and books as this adds to the delay of the progress to improve the current situation in education.

Furthermore, the participants raised a concern that teenage pregnancies and abuse of drugs also interrupt school programmes. For example, one participant from Fezile Dabi district identified poor attendance of school by pregnant young girls and by those abusing dagga. Lack of Adult Based Education and Training (ABET) in the community was identified and members commented as follows: *"...government and departments should come with strategies to facilitate ABET*

programme particularly in the rural communities” [FD1]. Whereas participants from Thabo Mofutsanyane viewed the need differently and voiced out as follows: “...presence of crèches and early learning centres have improved the level of education in our communities...” [TM2].

To support the quotations above, the following were also added:

- *“...compulsory education to all school-age-going people” [FD1]*
- *“Our government to provide free education to the impoverished” [Motheo]*
- *“... department of eh??... to continue with ABET to improve literacy” [FD2]*
- *“There should be continuous skill development in entrepreneurship and learnership to the communities” [TM1].*

The participants noted that education is the key to better life and it is important for survival of the communities. In 2002-2003, the researcher coordinated an ABET programme for FSDoH to all personnel who were previously disadvantaged. The programme improved literacy within the communities as the adults could count and use numbers. As far as reduction of teenage pregnancies, the government has embarked on resuscitating integrated school health programmes where nurses are visiting schools and attending to the health needs of pupils as well as providing family planning service to the young girls. Of note is that the Minister for Basic Education, Ms Angie Motshekga, in her speech recently at Oudtshoring Department of Education (DOE) emphasised the importance of distributing and supplying condoms to schools as a means to reduce sexually transmitted infections and teenage pregnancy. Therefore, the government and other responsible departments should attend to education as a basic need for a better life for all.

4.3.2 Focus area 2: Execution of Primary Health Care (PHC) talk

In this focus area, the reflections were based on the participants’ experiences, opinions and attitudes with regard to their ability to execute a PHC talk. From

these responses, three (3) themes were identified, namely nutrition, food groups and functions of food in the body.

4.3.2.1 Theme 1: Nutrition

According to responses of the participants' ability to execute a PHC talk on nutrition, participants shared the views that communities have limited information on nutrition and how to preserve nutrients when cooking. During the discussion they indicated that CHWs should continue to give health talks on nutrition during home visits as well as at the clinics until the people are informed.

The following were statements and remarks made:

- *"...PHC talks on nutrition should be enhanced with posters and food models so that people can be able to see what is being talked about or else, it'll be useless..."* [FD2]
- *"We and the nurses at the clinics and homes should form a joint venture to train communities on nutrition and its importance in the body"* [TM1]
- *"I think that the problem that people are not interested in nutrition is because they are poor and cannot purchase the needed food... like they say, it does not matter as long as we can fill our stomachs"* [Motheo]
- *"Nutrition is not buying expensive food; people do not know this therefore..."* [TM2]
- *"...people should be encouraged to erect food gardens to obtain fresh vegetables as a means of good nutrition"* [TM1]
- *"...we should not stop the health talks until everyone is okay..."* [Xhariep]
- *"Communities need to be told that the body need good nutrition to improve its immune system and fight infection"* [TM3]
- *"Importance of food refrigeration to preserve freshness and be very careful with checking and observing expiry dates on tinned foods"* [FD1].

The researcher observed verbal and non-verbal cues from participants when emphasising the importance of informing communities about nutrition. For example, nodding of heads and sounds indicating their approval. Furthermore, it appeared as if prior to 1994 information on nutrition was not a priority for the communities due to illiteracy and poverty. But thereafter, the 2015 NDoH Millennium Developmental Goals identified nutrition and adequate food supply as important PHC elements. Therefore, it is important for communities to be well-informed about the importance of good nutrition.

4.3.2.2 Theme 2: Food groups

Similar to what was discussed in theme one (1) above, participants' views were that community members lacked information on the groups of food. For example, one participant from Fezile Dabi district voiced out: *"...our people have no idea that food is classified into food groups"* [FD1]. In addition, the following statements were made by the other participants:

- *"...our papa and morogo (porridge & spinach) covers all..."* [TM3]
- *"The community have no idea that porridge and potatoes fall into one food group namely, starch and that both their end product is sugar..."* [TM2]
- *"Our people say food groups are affordable to the rich only"* [Motheo]
- *"...soya beans are one group that is not nice and cause one to have lot of gas...and discomfort"* [TM1]
- *"Iyo!, groups of food are found in vitamins that are purchased from the chemists and are very expensive we cannot afford them"* [FD2]
- *"We once heard that proteins are found in meat...but poverty and unemployment forces us to eat meat once a month after receiving a grant"* [Xhariep].

In addition to the statements made above, one FGI session at Thabo Mofutsanyane district shared their views that during execution of health talks at

the clinics, difficulty is encountered in obtaining feedback on the questions pertaining to food groups.

For example, the following answers were given by the participants to the following questions asked:

- *What are food groups? Answer: "...not sure"*
- *How many food groups do we have? Answer: "... two?, three or four..."*
- *What are vitamins? Answer: "pills"*
- *Name one example of food belonging to the carbohydrates group? Answer: "sugar"*
- *Where do we get fats and oils? Answer: "meat and cooking oil" .*

According to the responses above, at least the last answer was correct compared to the rest. Therefore, the researcher's opinion is that health care workers should emphasise the importance of food groups so that people can buy food knowing its content. In addition, the necessity of eating variety of foods should also be explained to communities. For example, we need to eat vitamins to boost the body's immune system, proteins to build and rejuvenate our body cells, carbohydrates to supply us with energy and fats to keep us warm and cover the delicate organs of our bodies. Furthermore, the researcher realised that there was a lack of illustrations in the CHWs' manual on food groups and this might have been the reason why participants could not share proper information on food groups. However, some of the comments made indicated that CHWs are able to conduct health talks on the food groups.

4.3.2.3 Theme 3: Functions of food in the body

With the responses to theme three (3), participants expressed that executing PHC talk on functions of food in the body was interesting. For example, one participant said: *"people understand the topic very well and they shared their experiences..."* [Motheo]

In addition, the following phrases were highlighted:

- *"...starch and carbohydrates supply the body with energy"* [FD1]
- *"Vitamins and minerals serve as protective foods"* [FD2]
- *"...we eat fats and oils to give our bodies warmth and to cover delicate organs"* [TM2]
- *"...no food should be eaten in excess as it can become a danger to the body, for example too much fat"* [Xhariep]
- *"Proteins are essential for building the body cells"* [TM1]
- *"...we also regard water as food and it cleanses our body and supply oxygen and hydrogen to burn all the food that we eat..."* [TM3].

Following above phrases, there was however a different view from Thabo Mofutsanyane and Fezile Dabi districts participants. They stated that there was still lack of information on the functions of food in the body because of the replies on questions pertaining to the functions of food in the body. To support their statement, they obtained the following answers for the questions asked:

- *"Food makes people fat and relieves hunger"*[TM2]
- *"Okay, food makes us healthy but, we don't know how"*[TM1]
- *"We have got no idea that proteins are the body building blocks"*[FD1]
- *"Food makes us not to suffer from hunger"*[TM3]
- *"I never knew that vegetables have minerals, which are news to me"* [TM1].

According to the responses above, the researchers' opinion is that the participants' manual on nutrition be revised. For example, the manual should use more illustrations and clear objectives on the functions of food. In addition, during the discussion it appeared that participants struggled to recall the functions of food because they took a while to respond to the question. Also, the researcher thinks that the gap between 2004 when the participants received information and 2012 when the study was conducted is very huge and

it might have affected their memories to respond timeously to the question. However, CHWs and other health workers who have basic information on food should take the responsibility to educate the community on food as it has been mentioned as one of the important elements in PHC re-engineering.

4.3.3 Focus area 3: Engagement in basic health promotion with specific reference to the prevention and management of accidents and disasters

In this focus area, responses from the participants are also based on the experiences, opinions and attitudes with regard to their ability to promote basic health with specific reference to prevention and management of accidents and disasters. Out of the responses, four (4) themes were identified namely; burns, fractures, drowning and paraffin poisoning.

4.3.3.1 Theme 1: Burns

In this theme, the participants revealed the information acquired in the prevention and management of burns during the GETC in AHC qualification training.

To support the statement the following quotations were made:

- *"Communities should not leave open fires unattended"* [Motheo]
- *"Burns blisters should not be pricked to avoid water loss from the burnt patient"* [TM1]
- *"Gas stoves should be completely switched off before going to sleep"* [TM3]
- *"Burnt patients should immediately be taken to the doctor or clinic for help"* [Xhariep]
- *"No soil or raw eggs should be poured on burns"* [FD2]
- *"Mbaola (fire tin) not to be left unattended and should be taken out every night just before going to sleep"* [TM2]

- *"Enough spaces should be maintained between the shacks to avoid close by fire disasters"* [FD1]
- *"Use high levelled places for cooking unreachable to children"* [Motheo]
- *"Mothers should pour cold water first in the bath, followed by hot water"* [FD2]
- *"Families should avoid long, freely hanging table cloths as they predispose toddlers to tea burns"* [TM2]
- *"Be aware of the location of fire extinguishers to use when fires occur"* [TM1]
- *"Never use water to extinguish fires caused by gas or oils, water will worsen the situation"* [TM3]
- *"If a burn occur, it should be covered with a clean wet cloth to reduce pain and the patient should be taken to the clinic for help"* [Motheo]

In addition to the responses made, the researcher observed that the introduction of health awareness on prevention and management of home accidents through the PHC outreach programme in the districts improved precautionary measures on home accidents and fires that could result in burns. Hence, in the district information system report of 2010/11 there was an indication of a decrease in the incidence of burns and home accidents in the FSP. Therefore the researcher recommends that outreach programmes on health issues should be sustained in the districts.

4.3.3.2 Theme 2: Fractures

According to theme two (2) discussions, the participants shared their experiences, opinions and attitudes regarding their ability to engage in the prevention and management of fractures.

For example, the participants voiced their opinions as follows:

- *"...children should be supervised when playing on the swings and trees"* [FD2]
- *"Community should avoid illegal power connection with cables running loose on the ground where people may trip and fall... fractures"* [Xhariep]
- *"All uncovered Municipality work holes should be encircled with hazard tapes to caution people"* [TM3]
- *"Risky games like climbing and jumping off the trees by children should be discouraged"* [FD2]
- *"Families should remove tempting objects like ladders and empty drums lying around the yards for children to climb on"* [Motheo]

The researcher observed that at first the participants' responses were more on giving advice to the community on the prevention of fractures than the management. Hence, the facilitator had to prompt them to discuss their experiences with the management of fractures and the following quotations were made:

- *"Summon an ambulance immediately when a fracture is suspected"* [TM1]
- *"People should avoid crowding an emergency scene area for paramedics to work"* [FD2]
- *"If there are suspicions that a limb is fractured, avoid fiddling with the limb instead, splint and immobilise then summon help from first aiders or paramedics"* [Xhariep]
- *"If the fractured person is conscious, calm her down by assuring that help is on the way and keep her warm until paramedics arrive"* [Motheo]

According to above quotations, the management of fractures was regarded as an emergency. As a result, Emergency Management Service (EMS) and health care workers trained in basic life support were identified as the appropriate people to be summoned during these accidents. As far as the knowledge

acquired by the participants on the prevention and management of fractures, the researcher was satisfied as the critical measures for stabilising a fracture were observed; for example, immobilisation of a fractured limb with splints whilst transporting or waiting for paramedic assistance.

4.3.3.3 Theme 3: Drowning

According to theme three (3) discussions, the focus was more on informing the community about the prevention and management of drowning.

To support the participants' views, here follows the quotations that were made:

- *"Municipality should camp and secure all dug open water furrows on the streets"* [Motheo]
- *"Mothers should not leave water baths unattended with children around"* [TM1]
- *"Children should be supervised all the time when swimming"* [TM2]
- *"...should appoint security to guard public swimming pools"* [TM3]
- *"Children should be restricted to play next to the river banks"* [Xhariep]
- *"... muddy dams and rivers should be identified as dangerous spots"* [FD1]
- *"...people should be prohibited to erect shacks next to the river banks..."* [FD2]
- *"Parents should empty water baths immediately after use"* [TM3]
- *"All pit privies, should be locked at all the times to prevent access by small ones"* [Motheo]
- *"...summon EMS or divers immediately when a person has drowned"* [Xhariep]
- *"Municipality should abolish pit toilets they are a hazard to the little ones"* [FD2]

According to the quotations above, the researcher observed that a recommendation was made to the local municipalities to provide safety

measures at public swimming pools. In addition, during the summer seasons there have been reports in the newspapers on drowning caused by uncovered water furrows and holes in the village streets. Equally important, the local government should erect proper toilet facilities in the villages to decrease drowning risks predisposed by the pit privies. Nevertheless, it is still the community's responsibility to take precaution not to predispose themselves to drowning as one participant said: *"...if you do not know how to swim, do not jump into the river because you'll drown"*. This also emphasised that unsupervised swimming is dangerous, particularly if you do not know how to swim. Therefore, it is every parent's responsibility to always supervise children when swimming in public pools as well as at home. As for the shacks that are erected alongside the river banks, the researcher's opinion and recommendation is that government should prevent people to erect shacks on unauthorised grounds because during the storms property and lives are lost.

4.3.3.4 Theme 4: Paraffin poisoning

The discussions on this theme were also based on informing the community on how to prevent and manage paraffin poisoning with a special emphasis on paraffin containers.

The views shared were the following:

- *"...only South African Bureau of Standard (SABS) approved paraffin containers be used because they have child proofs"*[Motheo]
- *"...the rule is, keep and lock away all poisons from children"*[FD1]
- *"Never use cool drink bottles to pour paraffin"*[FD2]
- *"...obtain child proof bottle lids from the petrol garages"*[Xhariep]
- *"When a child has drunk paraffin, summon EMS immediately"*[TM2]
- *"Do not give anything by mouth after a child has swallowed paraffin"* [TM3]. To emphasise these views one participant from Motheo district explained the reason why not to give anything by mouth after drinking

paraffin and said: *"Liquids like water and milk are heavier than paraffin, if you give a child one of those, paraffin will rise on top and increase the possibility of paraffin entering the lungs which can result into pneumonia"*.

The other participants' views to add on were:

- *"Never let the child to vomit as this can also complicate to pneumonia"* [TM1]
- *"...keep all external poisonous chemicals locked and separate from consumables"* [Motheo]

According to the discussions, it appeared that paraffin poisoning was a major challenge in most communities. It also appeared that it was due to negligence and wrong placement and use of paraffin containers by the community. But, the discussions also highlighted the measures in place to prevent such accidents. Therefore, the researcher realised that the information acquired by the participants during their GETC in AHC training on prevention and management of paraffin poisoning helped the communities reduce paraffin poisoning incidences.

4.3.4 Focus Area 4: Referral of clients to formal health services and health-related systems

The interviews discussion on the ability of CHWs to refer clients to formal and health-related services identified three (3) themes namely clinics, Community Health Centres (CHC) and Social and Welfare Departments (SWD).

4.3.4.1 Theme 1: Clinics

Referral of clients to and from the clinics was reported as improved because of the introduction of PHC roving teams by FSDoH. These teams operate at every local municipality area where families are visited and treatment plans are

formulated. Also, the teams do follow-up on patients who are on long term chronic medication and refer them for further management at the clinics. However, it appeared from the participants' discussions that irrespective of more nurses allocated at the clinics, there are still long queues that affect referral of patients to the clinics.

The following quotations and statements were made to support their view:

- *"...long queues and working slow by the nurses discourage patients to attend clinics"*[FD1]
- *"It is not nice as some of the nurses do not treat the patients correctly, they shout at them in front of other patients"*[Motheo]
- *"...nurses work slowly, take long tea and lunch breaks, whilst patients are waiting"*[FD2]
- *"...there is a shortage of speciality nurses at the clinics to attend the patients"*[TM1]
- *"There is no cooperation between CHWs and nurses during referral because nurses query the notes written by CHWs"*[Xhariep]

According to the statements above, participants observed the manner in which the nurses handled the patients at the clinics and not what their experiences were when referring the patients to the clinic. Therefore, the facilitator prompted them to focus on their experiences when referring patients to clinics. Then the responses were as follows:

- *"Team-work is important between CHWs and nurses at the clinics"* [Motheo]
- *"... and clinic nurses should understand that CHWs are trained to observe and refer patients who need further consultation"*[TM3]
- *"FSDoH should improve staff establishment at the clinics to reduce stress and burn-out on personnel... affect referral of patients"*[Xhariep]

- *"Clinic staff together with the CHWs should attend customer care in-service training to improve their service skills"*[TM1]
- *"Ambulances should respond timeously to take the patients to the clinic"* [TM2]
- *"...more mobile clinics to be allocated to the farm community to address their health needs on time"*[TM3]
- *"...nurses should rotate during tea and lunch breaks so that the patients are not left unattended"*[Motheo]

According to the discussions, participants shared few experiences when referring patients to the clinics. The responses also indicated that there are still staff shortages at the clinics and that these affect quality service delivery. The researcher's opinion is that CHWs should have applied their minds to the challenges encountered when referring patients to the clinic and provide recommendation in this regard. According to the researcher's experience, the introduction of the PHC roving teams in the rural areas has decreased long queues at the clinics. Therefore, it is important for CHWs to refer patients to the clinics for further management and treatment.

4.3.4.2 Theme 2: Community Health Centres (CHC)

In the case of theme two of this focus area, the participants' ability to refer patients to community health centres was viewed almost the same as in theme one. For example, the participants expressed shortage of staff and attitude as predisposing factors for poor referral to the health facilities. To support their observations they said the following:

- *"CHC staff is experiencing burn-out due to overwork, therefore, they are on a go slow"*[FD1]
- *"Ambulances take a long time before fetching the patients due to shortage of staff at EMS"*[TM2]

- *"...and patients die on the way to hospitals due to transport delay and absence of doctors at the hospitals particularly after hours"*[Motheo]
- *"Some doctors and nurses try their level best to help and treat the patients at the CHCs but absence of resources spoil all the efforts"*[FD2]
- *"...towns are too scattered and it takes a long time before a patient can get help"*[TM]

From the above responses, it was indicated that working relations between CHWs and other health care professionals have improved referral of patients to the CHCs. In addition, the following quotes were shared:

- *"...availability of CHWs has made referral system easy from the clinics to the CHC"*[Motheo]
- *"Skilled personnel are allocated at the CHCs to provide health care e.g. doctors, speciality nurses, pharmacists and allied health professionals"* [FD2]
- *"Patients are treated with respect and dignity"*[Xhariep]
- *"Referrals should depend on the capacity handled by a CHC"*[FD1]
- *"...we should continue sorting cases according to their urgency"*[Motheo]
- *"The elderly are attended quickly so that they return home on time"*[TM1]

According to the responses, an overall view by participants on referral of patients to the CHCs is that it is handled well. In addition, the views were based on mutual understanding of the roles of each health worker at the CHCs that it adds to the improvement of service delivery during referral of patients. Furthermore, provision of human capacity and material resources to the CHCs can enhance quality service. Therefore, the researcher recommends that FSDoH should revisit 2012-15 Strategic Plan on revitalisation of the health facilities to assess the status of the infrastructures and human capacity.

4.3.4.3 **Theme 3: Social and Welfare Department**

The discussion on the CHWs' ability to refer patients to the health related services with reference to the Social and Welfare Department was based on communication and personnel attitudes. Participants from the various FGIs expressed the following:

- *"...social workers refuse referral letters from nurses and CHWs"*[Motheo]
- *"...some personnel at the SWD demand bribery before helping the community and this is wrong..."*[TM1]
- *"Few social workers are employed by the FSDoH that is why we struggle to assist our patients"*[TM2]
- *"Limited families are assisted by the SWD after referral"*[Xhariep]
- *"When we refer patients to SWD to be assisted with the identity documents, their help is prolonged"*[FD2]
- *"...process to obtain grants for orphans and vulnerable children takes a long time, mean-while there is poverty"*[FD1]
- *"Discrimination of clients' statuses makes them to refuse referral to the SWD"*[TM3]

Notably, some of the participants from Motheo, Thabo Mofutsanyane and Xhariep districts expressed that it is not all the personnel working at SWD who have negative attitudes when assisting the patients. For example, they said the following:

- *"I met one dedicated official who explained everything to my patient and gave her a follow-up date to check on her grant application, we were so... with the patient and..."*[TM2]
- *"...at our town, operation "hlasela" has assisted a lot in helping the needy"* [Xhariep]
- *"...municipality has made pay-points accessible and easy for needy clients"* [Motheo]

- *"SWD has improved the life of poverty stricken families by providing the food parcels at the rural schools"*[TM1]
- *"Long procedures and queues to obtain grants have improved at our SWD office since the introduction of electronic cards..."*[TM3]
- *"Social workers work nicely with us when we bring patients referred by the clinic nurses"*[FD2]
- *"Involvement of the social workers in the roving teams have brought SWD service closer to the community and CHWs who do home visits report their patients and are assisted timeously"*[TM2]

Furthermore, an expression from Thabo Mofutsanyane district participants was that SWD experience challenges with patients who come from Lesotho and do not possess the South African identity document and said: *"...these patients demand grants and say they do have children and relatives in Free State so, why are they denied grants?"*. The researcher also noticed this as a huge challenge because most of the Free State clinics that are located next to the borders of Lesotho, Mpumalanga and KZN are attended by patients from these provinces. As a result, personnel at those clinics are over-worked and their pharmaceutical stocks are depleted before their next ordering date. Therefore, the researcher recommends that government should put measures in place to control and assist with the situation. Also, the FSDoH should have a memorandum of understanding to supply medicines to these neighbouring provinces.

4.4 CONCLUSION

Chapter 4 outlined the findings and discussions based on data analysis. Subsequently, the focus areas were used to obtain the responses from the seven (7) FGI sessions in the different districts. The approach enabled the researcher to gain a clear picture of the findings, in particular the abilities of CHWs to reflect and discuss their experiences, opinions and attitudes towards the focus areas (*vide 4.1*). Within these discussions, an overview of the impact

of GETC in AHC qualification was investigated by using assessment criteria of the GETC in AHC qualification (Appendix A) as a rationale to formulate the FGI questions (Appendix F).

In the next chapter, Chapter 5, entitled **Summary, Recommendations, Limitations and Conclusion of the Study**, will be based on the summarised responses and recommendations from the researcher and the FGI sessions. Thereafter, the limitations of the study will be considered based on the attainment of the study objectives (*vide 1.5*).

CHAPTER 5

SUMMARY, RECOMMENDATIONS, LIMITATIONS AND CONCLUSION

5.1 INTRODUCTION

The focus in this last chapter will be on the summary of the study based on the findings and discussion in the previous chapter. The summary will be followed by recommendations. These recommendations will be directed to the South African Qualification Authority (SAQA) and Health and Welfare Sector Education and Training (HWSETA) as the GETC in AHC qualification authorising bodies as well as the Free State Provincial Government (FSPG) and the Free State Department of Health (FSDoH). In addition, there will be recommendations for further study on CHWs training. Following the recommendations, there will be limitations of the study and conclusion.

5.2 SUMMARY

The summary of the study is based on the findings and discussion of the data collected during the FGI. The focus in the summary is whether the CHWs were able to (i) identify and assess community health needs; (ii) execute primary health care talk; (iii) engage in basic health promotion by means of preventing and managing accidents and disasters and (iv) refer clients to the formal health services and other health related systems. These findings were based on the personal experiences, opinions and attitudes regarding the role of CHWs.

5.2.1 Ability to identify and assess community health needs

According to the responses of the participants it seems as if CHWs are able to identify and assess the basic community health needs since in the FGI they were able to identify that some of the communities are still staying in small and overcrowded shacks. The participants were also able to recognise that these

shacks are unhygienic and can lead to droplet infections like Tuberculosis. Also, the participants were able to identify that orphans and vulnerable children are malnourished because they eat unbalanced food and some lack skills to prepare food properly. These CHWs were even able to make suggestions to address these problems. The other important aspect indicating that the CHWs are able to identify and assess community health needs is that they stated that there are still communities drinking polluted water. Furthermore, the CHWs were even able to assess that people lack information on how to disinfect water. Another evidence that CHWs were able to identify and assess community health needs is based on the response to health care. In their response they stated that some communities do not take care of their surroundings and this could lead to water-borne diseases. One of the CHWs also identified that lack of mobile clinics in rural communities contribute to poor health. Lastly, the CHWs were also able to identify unemployment and poverty as causes of poor level of education. In fact, one of the CHWs identified a need for continued skills development, entrepreneurship and learnerships.

5.2.2 Ability to execute primary health care talk

Responses by the CHWs seem to indicate that they were able to identify problems and that they were able to identify that some communities have limited information on proper food preservation and preparation. As a result, they realised the importance of forming a joint venture with the PHC nurses to educate communities more on the importance of good nutrition. Furthermore, evidence to indicate that CHWs are able to execute a PHC talk is that one of them shared her knowledge that good nutrition does not mean eating expensive food but to have the skill to prepare the food properly. However, it was evident that there was lack of information on food-groups. Even so, CHWs took a long time to respond to the question on food groups and the functions of food. Equally important, it appeared that the prescribed manual for CHW training on nutrition did not use colourful and clear illustrations on food groups and the functions of food. It could also be because of the long period of time

between the completion of the qualification (in 2006) and this research (in 2012).

5.2.3 Ability to engage in basic health promotion with specific reference to the prevention and management of accidents and disasters

According to the responses from the participants it seems as if the CHWs are able to prevent and manage home accidents and disasters. For instance, they mentioned that communities should be educated on not to leave open fires unattended in order to prevent fires and burns. In the case of prevention and management of fractures, CHWs shared the knowledge obtained from the GETC in AHC programme on immobilisation and splinting of fractured limbs. Quite as evident regarding the CHWs' ability to prevent drowning, they mentioned that parents should always supervise children during swimming and bathing. Also, they suggested the abolition of pit privies as they pose a hazard and possibility of drowning of children. The other important aspect indicating that CHWs are able to prevent and manage accidents especially with paraffin poisoning is that they stated that communities should only use SABS approved paraffin containers as they have child proof lids. Lastly, CHWs mentioned that when an accident and disaster occur, communities should summon appropriate experts such as EMS to deal with the situation.

5.2.4 Ability to refer clients to formal health services and health-related systems

Once again it seems as if CHWs are able to refer clients to formal health services. However, the CHWs stated that there is no mutual understanding and team work between CHWs and PHC nurses at the clinics. As a result, there are long queues at the clinics affecting quality patient referral and care. Again, the participants stated that small spaces at the clinics result in overcrowding that predisposes nurses and other patients to droplet infections like TB. In the case

of referring clients to the CHC, the participants stated that lack of resources like transport; personnel and medicines affect the referral system. What is more, some of the participants even suggested that referrals to the health facilities should be based on the capacity that a facility can handle. Furthermore, the participants were able to share their experiences with referring clients to the health related systems. For example, they mentioned a long process that is followed when applying for social grants for the orphans and vulnerable children as a problem. The other important aspect mentioned about the referral system to the SWD is that there are challenges with the handling of grants application by people from Lesotho who are residing in the FSP.

5.3 RECOMMENDATIONS

The recommendations in this study will be directed to the South African Qualification Authority (SAQA) and the Health and Welfare Sector Education and Training (HWSETA) as the GETC in AHC qualification authorising bodies, the Free State Department of Health (FSDoH) and the Free State Provincial Government (FSPG). In addition, there will be recommendations for further study on CHW training.

5.3.1 Recommendations to SAQA and HWSETA

The recommendations to SAQA and HWSETA refer specifically to the execution of a PHC talk on nutrition. It seemed as if the participants were struggling to identify and select different food groups in accordance with the specified nutritional requirements. This might have been due to the manner in which the content and the learning objectives on nutrition are structured in the GETC in AHC manuals. Hence the following recommendations:

- The GETC in AHC manual should have more, clear and colourful illustrations especially on food groups and its functions for the learners' better understanding.

- The content in the manual should be arranged according to the formulated objectives for the learners' comprehension.

5.3.2 Recommendations to the FSDoH

The recommendations to FSDoH are especially based on PHC talks focussing on nutrition and water. As mentioned previously with nutrition, it appeared as if CHWs had less confidence in executing health talks on nutrition. Also, they had different views on the methods used to purify water. Furthermore, CHWs stated that the lack of resources at the clinics and CHCs contributed to poor health service delivery. For example, lack of working space, staff shortages and inadequate allocation of mobile clinics and ambulances to the rural areas. Hence, the following recommendations.

- Locally allocated PHC teams should hasten the execution of health talks on nutrition.
- Community Health Workers should have regular training on correct methods of water purification.
- Increasing the number of mobile clinics to the rural areas.
- Allocation of enough ambulances to the deep rural communities.
- Re-vitalisation of the infrastructure of the health facilities to accommodate referred clients.
- Upgrading of staff-establishment to capacitate the clinics and CHCs.

5.3.3 Recommendations to the FSPG

Recommendations to FSPG specifically refer to challenges with housing, water, sewerage system as well as an influx of the refugees into the FSP as discussed previously (*vide* Chapter 4 paragraphs 4.3.1.1, 4.3.1.3 & 4.3.4.3). These issues appeared during the discussions on identification and assessment of the basic community health needs.

Hence the following recommendations:

- Prioritising the building of houses for needy communities.
- Upgrading sewerage system by replacing worn-out pipes.
- Replacing the bucket and pit privies with running water toilets.
- Regulating the influx of the refugees from Lesotho and the neighbouring provinces into the FSP.

5.3.4 Recommendation for further study on CHW training

The recommendations for further study according to the researcher are based on limited literature obtained on CHW training programmes world-wide. Since this study was conducted on only four objectives of the GETC in AHC, the researcher suggests that further research be done on the other remaining objectives of the qualification for amendments if necessary. Also, the other provinces should conduct further research on the ability of CHWs' performance after obtaining the GETC in AHC qualification as this study only concentrated on FSP.

Hence the following recommendations:

- Comparative study to determine the differences and similarities available with the CHW training programmes internationally, in the Southern African Democratic Countries (SADC) and in SA.
- Research on the alignment of the GETC in AHC qualification objectives and the exit level outcomes.
- Research on the skills of CHWs who obtained the GETC in AHC qualification in other provinces.

5.4 LIMITATIONS OF THE STUDY

The limitations of the study are based on the literature review, FGI facilitation, FGI sessions' allocated time and the gap between the CHW obtaining the GETC in AHC qualification and the study.

5.4.1 Literature

With reference to Chapter 2, the researcher experienced a limitation with obtaining enough literature on training CHWs because most of the literature concentrated on the definitions and roles of CHWs rather than the CHW training programme. Therefore, it seemed as if the literature is limited to adequately address the research problem.

5.4.2 FGI facilitation

Unfortunately, because of a family tragedy the experienced facilitator could not facilitate all the sessions. However, the researcher appointed a District Training Coordinator (DTC) to continue with the other sessions. Fortunately, this coordinator was present during the other sessions that were facilitated by the experienced facilitator. In order to maintain consistency and quality, the researcher further guided the coordinator on how to facilitate the sessions. Therefore, there might have been a difference in the responses obtained during the sessions. It is important to note that it was a challenge to discontinue the sessions until the experienced facilitator came back because of financial and logistical constraints.

5.4.3 Time allocation

It seems as if the time allocated for the FGI was limited and might have restricted the flow of discussions and therefore a point of saturation.

5.4.4 The gap between the award of the GETC in AHC qualification and the study

The researcher is of the view that the gap that existed between the time when CHWs obtained the qualification and the time when the study was conducted seemed to have influenced the type of responses obtained during the FGIs. This might have been due to memory loss to some of the information given.

5.5 CONCLUDING REMARKS

The study was undertaken after the FSDoH was commissioned by the FSGDS to conduct a research project to determine the role played by the GETC in AHC qualification in the improvement of community health care services and therefore the need for further CHW training. Subsequently, an investigation was done to explore by means of focus group interviews the personal experiences, opinions and attitudes regarding the role of CHWs to: (i) assess and identify community health needs, (ii) execute primary health care talk, (iii) engage in basic health promotion with a specific reference to preventing and managing accidents and disasters and (iv) referring clients to the formal health services and other health-related systems. All these four focus areas were used to find out the role and the value of the GETC in AHC qualification in improving community health care services in the FSP.

The findings indicated that participants were able to engage and respond to the FGI questions by applying their previous knowledge and experience. However, it seemed as if a gap that existed as mentioned previously in (*vide* paragraph 5.4.4), influenced the way the participants responded. Nevertheless, the participants' discussions on the four (4) focus areas assisted the researcher to come up with the recommendations to SAQA, HWSETA, FSDoH and FSPG respectively. The researcher is of the opinion that if SAQA, HWSETA, FSDoH and FSPG consider the implementation of the recommendations in this study, there can be an improvement in the CHW training programme and the delivery of the health services in the FSP.

APPENDIX A

SAQA GENERAL EDUCATION AND TRAINING CERTIFICATE IN ANCILLARY HEALTH CARE

SAQA GENERAL EDUCATION AND TRAINING CERTIFICATE IN ANCILLARY HEALTH CARE



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**SOUTH AFRICAN QUALIFICATIONS AUTHORITY
REGISTERED QUALIFICATION:**

General Education and Training Certificate: Ancillary Health Care

SAQA QUAL ID	QUALIFICATION TITLE		
49606	General Education and Training Certificate: Ancillary Health Care		
SGB NAME	NSB	REGISTERING PROVIDER	
SGB Ancillary Health Care	NSB 09-Health Sciences and Social Services		
Quality Assuring ETQA			
-			
QUALIFICATION TYPE	FIELD	SUBFIELD	
National Certificate	Health Sciences and Social Services	Promotive Health and Developmental Services	
ABET BAND	MINIMUM CREDITS	NQF LEVEL	QUAL CLASS
ABET Level 4	134	Level 1	Regular-Unit Stds Based
REGISTRATION STATUS	SAQA DECISION NUMBER	REGISTRATION START DATE	REGISTRATION END DATE
Registered	SAQA 0264/06	2006-02-09	2009-02-09

PURPOSE AND RATIONALE OF THE QUALIFICATION

Purpose:

Learners who complete this qualification will possess the competence required to perform community health functions under the supervision of a professional health worker. They will have the fundamental skills required for employment by a range of health, social and other sector employers. They will be in possession of a recognised qualification that will provide a platform for further education and training in a career

pathway towards becoming professional health workers.

Qualified learners in this field will provide a service that will assist communities to better manage their own health and wellness. They will have the skills to provide support services within a multidisciplinary health care team.

Recipients of this qualification will be able to:

- Communicate in a variety of ways.
- Use mathematics in real life situations.
- Collect and provide information to support community health.
- Provide community based care.
- Develop personal and community skills.

Practitioners will generally carry out their roles within the context of:

- The client`s home.
- A community care centre.
- The broader community.

Rationale:

The South African Government is committed to combining the national human resource development strategy with the rapid upgrading of service delivery to all of the nation`s communities.

Integral parts of this strategy are initiatives to strengthen the ability of communities to empower themselves to participate in the political, economic, social and development spheres of South African life. Two key components in this empowerment process are the ability of communities to integrate with, and access, state services, and their ability to further the health and wellness of community members.

There is no doubt from the international experience of community health workers (CHW) that they play a role in improving the basic health status of communities. In South Africa, the important supportive role of CHWs in the provision of health care services has been extensively documented. This contribution is further exemplified in those parts of the country where there is a shortage of professional health workers to provide the necessary health care services, based on identified needs.

The focus in this learning field is therefore on primary health care within the framework of community development, with health promotion as a vital aspect. The Ancillary Health Worker (AHW) is required to play a pre-emptive role in the assessment and identification of health needs as well as to intervene in primary health care activities. This takes place in collaboration with, and referral to, the formal health services and other health related systems. Home-based care is also a key function of the AHW. Preventive measures for the management of disasters and accidents also form an important aspect of their activities. In all these activities the AHW observes the ethical codes of practice, norms, values and rights of the community.

This qualification forms the introduction to ancillary health work and will provide the learner with essential skills that will be needed to progress to the national certificates in ancillary health care at Levels 2, 3 and 4.

LEARNING ASSUMED TO BE IN PLACE AND RECOGNITION OF PRIOR LEARNING

This qualification is the starting point of a progressive route in ancillary health care and learners starting to learn towards this qualification are assumed to have the following competencies:

- Communication at ABET level 3.
- Mathematical Literacy at ABET level 2.
- Ability to undertake independent learning.

Recognition of prior learning:

This qualification can be achieved wholly or in part through recognition of prior learning in terms of the defined exit level outcomes and/or individual unit standards.

Evidence can be presented in various ways, including international and/or previous local qualifications, products, reports, testimonials mentioning functions performed, work records, portfolios, videos of practice and performance records.

All such evidence will be judged in accordance with the general principles of assessment described above and the requirements for integrated assessment.

RECOGNISE PREVIOUS LEARNING?

Y

QUALIFICATION RULES

Fundamental:

- Communication:
 - > Candidates are required to achieve all 23 credits for Communication.
- Mathematical Literacy:
 - > Candidates are required to demonstrate achievement of the 16 credits for Mathematical Literacy within the context of healthcare provision.
- Learning strategies:
 - > Candidates are required to achieve all 5 credits for developing learning strategies from the available credits.

Core:

- Candidates must achieve all 80 Core credits listed.

Elective:

- Candidates must achieve at least 15 credits of their choice from any of the available Elective credits listed. In order to achieve an Exit Level Outcome, candidates must achieve all of the credits for that Exit Level Outcome.

EXIT LEVEL OUTCOMES

1. Communicate in a variety of ways.
2. Use mathematics in real life situations.
3. Collect and provide information to support community health.
4. Provide community based care.
5. Develop personal and community skills.

Possible Credits for Exit Level Outcomes:

- Fundamental:

- > Exit Level Outcome 1: 18 Credits.
- > Exit Level Outcome 2: 16 Credits.
- > Exit Level Outcome 5: 5 Credits.
- > Total: 39 Credits.
- > Required: 39 Credits.

- Core:

- > Exit Level Outcome 3: 44 Credits.
- > Exit Level Outcome 4: 36 Credits.
- > Total: 80 Credits.
- > Required: 80 Credits.

- Elective:

- > Exit Level Outcome 3: 27 Credits.
- > Exit Level Outcome 4: 32 Credits.
- > Exit Level Outcome 5: 12 Credits.
- > Total: 71 Credits.
- > Required: 15 Credits.

Critical cross-field outcomes:

This qualification addresses the following critical cross-field outcomes, as detailed in the unit standards:

- Identifying and solving problems in which responses indicate that responsible decisions using critical and creative thinking have been made:
 - > Exit Level Outcome 2.
 - > Exit Level Outcome 3.
 - > Exit Level Outcome 4.
 - > Exit Level Outcome 5.
- Working effectively with others as a member of a team, group, organisation or community:
 - > Exit Level Outcome 3.
 - > Exit Level Outcome 4.

- > Exit Level Outcome 5.
 - Organising and managing oneself and one`s activities responsibly and effectively:
 - > Exit Level Outcome 3.
 - > Exit Level Outcome 4.
 - > Exit Level Outcome 5.
 - Collecting, analysing, organising and critically evaluating information:
 - > Exit Level Outcome 3.
 - > Exit Level Outcome 4.
 - > Exit Level Outcome 5.
 - Communicating effectively using visual, mathematical and/or language skills in the modes of oral/written persuasion:
 - > Exit Level Outcome 1.
 - > Exit Level Outcome 2.
 - > Exit Level Outcome 3.
 - > Exit Level Outcome 4.
 - > Exit Level Outcome 5.
 - Using science and technology effectively and critically, showing responsibility towards the environment and health of others:
 - > Exit Level Outcome 3.
 - > Exit Level Outcome 4.
 - > Exit Level Outcome 5.
 - Demonstrating and understanding of the world as a set of related systems by recognising that problem-solving contexts do not exist in isolation:
 - > Exit Level Outcome 3.
 - > Exit Level Outcome 4.
 - > Exit Level Outcome 5.

Learning programmes directed towards this qualification will also contribute to the full personal development of each learner and the social and economic development of society at large, by making individuals aware of the importance of:

- Reflecting on and exploring a variety of strategies to learn more effectively.
- Participating as responsible citizens in the life of local, national and global communities.
- Being culturally and aesthetically sensitive across a range of social contexts.
- Exploring education and career opportunities; and developing entrepreneurial opportunities.

ASSOCIATED ASSESSMENT CRITERIA

1:

- *Oral communication is maintained and adapted as required to promote effective interaction in a community context.*
- *Information is accessed from standing instructions, visual information and a range of other workplace texts and responses where required are appropriate to the context.*
- *Written communication is clear and unambiguous and at an appropriate level for designated target audiences.*

2:

- *Mathematical functions are used correctly to solve routine workplace problems and tasks.*
- *Mathematical signs and symbols are correctly identified in terms of their functions and use.*

3:

- *Information is collected that accords with community needs.*
- *The information collected is used in promoting the health of the community.*
- *Community health is understood and implemented.*
- *Information about community illnesses is disseminated accurately and appropriately and leads to minimisation of the illnesses.*

4:

- *Care is provided in a safe manner in a secure environment.*
- *Procedures are performed which enhance and prolong the life of the client.*
- *The client and family are assisted in accessing relevant services.*
- *Specific care is provided to children and the frail in accordance with their specific needs.*

5:

- *Different learning strategies are implemented according to the needs of the learners.*
- *Personal finances are managed in accordance with accepted budgeting principles.*
- *The roles and responsibilities of a community committee are identified and adhered to.*

Assessment Criteria:

To be awarded the qualification, candidates must achieve the required number of credits as specified in the rules of combination, as well as the criteria specified for integrated assessment.

Integrated Assessment:

Assessment is not a single event but rather a structured process of gathering evidence and making judgements of the learners' performance in relation to the qualification. A range of formative and summative methods can be used in assessing learners. This may include:

- *Written and oral tests/examinations.*
- *Case studies and assignments.*
- *Role play and simulation sessions.*
- *Written reports/work plans.*
- *Peer group review.*
- *Feedback from clients.*

Assessment should be carried out at regular intervals as well as at the end of the periods of study and should be offered in an integrated way. It is envisaged that learners will work at more than one unit standard at a time.

Assessment will take place according to the detailed specifications indicated in the unit

standards associated with each exit level outcome.

Over and above the achievement of the specified unit standards, evidence of integration will be required as per the following broad criteria, all within the context of workplace activities.

Assessors should note that the evidence of integration could well be presented by candidates when being assessed against the unit standards. Thus, there should not necessarily be separate assessments for each unit standard and then further assessment for integration. Well-designed assessments should make it possible to gain evidence against each unit standard while at the same time gaining evidence of integration.

Candidates must demonstrate the ability to engage in the operations selected in an integrative way, dealing with divergent and "random" demands related to these work operations, effectively. Evidence is required that the candidate is able to achieve the purpose of the qualification as a whole at the time of the award of the qualification. Integration of skills will be demonstrated through the achievement of the core operational standards.

Assessment Principles:

Assessment should be in accordance with the following general and specific principles:

- The initial assessment activities should focus on gathering evidence, in terms of the main outcomes expressed in the titles of the unit standards, to ensure assessment is integrated rather than fragmented. Where assessment at title level is unmanageable, then the assessment can focus on each specific outcome, or groups of specific outcomes. Take special note of the need for integrated assessment.*
- Evidence must be gathered across the entire range specified in each unit standard, as applicable. Assessment activities should be as close to the real situation as possible, and where simulations or role-plays are used, there should be supporting evidence to prove that the candidate is able to prove competence in the real situation.*
- All assessments should be conducted in accordance with the following universally accepted principles of assessment:
 - > Use appropriate, fair and manageable methods that are integrated into real work-related or learning situations.*
 - > Judge evidence on the basis of its validity, currency, authenticity and sufficiency.*
 - > Ensure assessment processes are systematic, open and consistent.**

INTERNATIONAL COMPARABILITY

Ancillary Health Care training for people at lower NQF levels is done in many developing countries, particularly in sub-Saharan Africa and in parts of South America.

Ancillary Health Care is offered in First World countries, as part of their sophisticated integrated health care systems, by officials who are, in the main, graduates in nursing, social work and community development.

An analysis of training offered by the World Health Organisation (WHO) in primary

health care in sub-Saharan Africa consists mostly of short courses which encompass the same knowledge and competencies as contained in this qualification. These courses are tailored to meet specific community needs at specific times. None however, combines all into one extended programme leading to a complete qualification.

The WHO courses cover aspects such as locally endemic infectious diseases (malaria, measles, Dengue/Congo fever, gastro enteritis/cholera) malnutrition and HIV/AIDS and its resulting social implications.

As can be seen from this comparison, the qualification contains all the elements contained in the short courses offered in developing countries. This is the first attempt to produce a qualification that includes all such aspects and is tailored from the unique situation in which South Africa finds itself, with its urgent need for Primary Health Care provision across vast and wide-spread rural areas, to large numbers of people, using limited resources and personnel.

This qualification is unique to South Africa since no other country has yet generated a full and formal qualification in Ancillary Health Care at NQF Level 1: ABET Level 4. This qualification is appropriate for the unique health service requirements in this country and is applicable throughout sub-Saharan Africa, where short courses in community and primary health care are offered, inter alia, by organizations such as the World Health Organisation.

ARTICULATION OPTIONS

This qualification has been designed and structured so that qualifying learners can move from one context to another. It is the starting point in ancillary health work and acts as a springboard from which learners may progress to the National Certificate in Home Based Care: NQF Level 2 and other qualifications at level 3 or 4 in related health, development and social care fields.

MODERATION OPTIONS

Providers offering learning towards achievement of any of the unit standards that make up this qualification must be accredited through the relevant ETQA or with an ETQA that has a Memorandum of Understanding in place with the relevant ETQA.

Internal moderation of assessment must take place at the point of assessment, with external moderation or verification being provided by the relevant ETQA or with an ETQA that has a Memorandum of Understanding in place with the relevant ETQA.

CRITERIA FOR THE REGISTRATION OF ASSESSORS

Assessors registered with the relevant ETQA or with an ETQA that has a Memorandum of Understanding in place with the relevant ETQA, must carry out the assessment of candidates for any of the unit standards that make up this qualification. The following criteria are specified for assessors of this qualification:

- Be in possession of a relevant qualification at NQF level 5 or higher.
- Be experienced in the fields of primary health care and community development.
- Be registered as an assessor with the relevant ETQA.

NOTES

This qualification replaces qualification 23193, "GETC in Ancillary Health Care", Level 1, 120 Credits.

Structure of the qualification:

The qualification has the following general structure:

The rationale and purpose provides, among other things, a broad description of what holders of the qualification can do.

The qualification is further defined by means of a number of Exit Level Outcomes. These Exit Level Outcomes provide a means for candidates to exit the qualification with recognition for clusters of competencies, even if they do not achieve the whole qualification. The Exit Level Outcomes also provide a means to organise the unit standards into coherent clusters, thus facilitating integrated assessment.

Each Exit Level Outcome is further defined by means of the associated unit standards. Some of these unit standards may be indicated as Core (compulsory), while others may be identified as Electives, with rules of combination provided.

Assessment criteria are provided for each Exit Level Outcome where required, mainly to address the need for evidence of integration of competencies.

Each unit standard contains details of specific outcomes, range statements and assessment criteria, thus making it possible for assessors to judge competence in terms of each unit standard, while at the same time providing possible evidence of integration of competencies.

UNIT STANDARDS:

	ID	UNIT STANDARD TITLE	LEVEL	CREDITS
Core	116999	Apply accurate information about HIV & AIDS to everyday life	Level 1	2
Core	9827	Assess the client`s situation and assist and support both client and family to manage home based health care	Level 1	12
Core	119564	Assist the community to access services in accordance with their health related human rights	Level 1	5
Core	110044	Collect information to support a community needs assessment	Level 1	12
Core	14656	Demonstrate an understanding of sexuality and sexually transmitted infections including HIV/AIDS	Level 1	5
Core	119559	Demonstrate knowledge of the provision and implementation of primary health care	Level 1	10
Core	119563	Engage in basic health promotion	Level 1	8
Core	113966	Identify security, safety and environmental risks in the local environment	Level 1	6

Core	119567	Perform basic life support and first aid procedures	Level 1	5
Core	117017	Provide information about Tuberculosis and directly observed treatment (DOTS)	Level 1	3
Core	116991	Assist in establishing a disability friendly environment	Level 2	8
Core	119560	Promote an awareness of Sexually Transmitted Infections (STIs) in the community	Level 2	4
Fundamental	7464	Analyse cultural products and processes as representations of shape, space and time	Level 1	2
Fundamental	7451	Collect, analyse, use and communicate numerical data	Level 1	2
Fundamental	7449	Critically analyse how mathematics is used in social, political and economic relations	Level 1	2
Fundamental	14084	Demonstrate an understanding of and use the numbering system	Level 1	1
Fundamental	7463	Describe and represent objects and the environment in terms of shape, space, time and motion	Level 1	2
Fundamental	12462	Engage in a range of speaking and listening interactions for a variety of purposes	Level 1	6
Fundamental	12471	Explore and use a variety of strategies to learn (revised)	Level 1	5
Fundamental	12469	Read and respond to a range of text types	Level 1	6
Fundamental	7461	Use maps to access and communicate information concerning routes, location and direction	Level 1	1
Fundamental	7447	Working with numbers in various contexts	Level 1	6
Fundamental	12470	Write for a variety of different purposes	Level 1	6
Elective	119565	Assist with Palliative Care	Level 1	6
Elective	14659	Demonstrate an understanding of factors that contribute towards healthy living	Level 1	4
Elective	119566	Explain preventive measures to reduce the potential impact of disasters	Level 1	5
Elective	15092	Plan and manage personal finances	Level 1	5
Elective	117029	Provide care to a frail person	Level 1	12
Elective	119561	Support clients who are receiving Anti Retroviral Treatment (ART)	Level 1	6
Elective	114950	Apply ways of leading in different situations	Level 2	3
Elective	117007	Assist in the establishment of good nutrition	Level 2	12
Elective	14042	Demonstrate knowledge of environmental health and community hygiene practices	Level 2	6
Elective	12352	Demonstrate knowledge of the roles and	Level 2	4

		responsibilities of a community committee		
Elective	119562	Give guidance on the integrated management of childhood illnesses and childhood home accidents	Level 2	8

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APPENDIX B

PERMISSION TO CONDUCT RESEARCH

PERMISSION TO CONDUCT RESEARCH



health

Department of Health
FREE STATE PROVINCE

DATE:	28/02/2011	FILE NO:	
TO:	HEAD-HEALTH Dr S Kabane	FROM:	Motsepe V V J Chief Training Officer Skill Development Unit 2 nd Floor A-East Bophelo House Tel: 051 408 1613 Cel: 0835608420

SUBJECT: Permission to conduct Research titled: Perceptions of Community Health Workers (CHWs) regarding the value and role played by the General Education and Training Certificate (GETC) in Ancillary Health Care (AHC) qualification in Free State Province (FSP).

1. PURPOSE:

To obtain permission from Head-Health to conduct a research project and use volunteers, community health workers (CHWs) and enrolled auxillary nurses who were part of a group of 44 CHWs who have completed the GETC in AHC qualification in Free State Province in 2005 as approval has already been granted by the Ethics Committee, Faculty of Health Sciences UFS on.....(Date) 2011.

2. BACKGROUND & MOTIVATION:

The official, Ms V.V.J. Motsepe is a registered student in Masters in Health Professions Education (MHPE) with the Faculty of Health Sciences at UFS. She has completed six modules which are a pre requisite to the M HPE script in 2009. According to Free State Growth and Development Strategy 2010/11, the need for FSDoH to continue training this cadre of volunteers/CHWs, depend on a research study to be conducted to find out the perceptions of CHWs regarding the qualification with a view to improve community health care service in FSP.

3. PERSONNELL IMPLICATION:

Participating volunteers, CHWs and ENAs form part of focus group interview sessions in Motheo, Xhariep, Fezile Dabi and Thabo Mofutsanyane districts respectively. They shall not be at their work stations during the sessions of about two hours each.

4. RECOMMENDATION:

It is recommended that Ms V.V.J Motsepe be permitted to conduct the research project and use personnel who were part of the 44 CHWs who have completed the GETC in AHC qualification in 2005 as participants from Motheo, Xhariep, Fezile Dabi and Thabo Mofutsanyane districts respectively.

Submitted By; V V J Motsepe CTO-HRD Date:	Supported / Not Supported: Ngele ZA Senior Manager-HRD Date:
Recommended / Not Recommended: Mabitle MCL General Manager- HRM Date:	Approved / Not Approved: Kabane S Head-Health Date:

Human Resource Development / Skill Development
P.O. Box 227, Bloemfontein, 9300
Bophelo House, Cnr Maitland and, Harvey Road, Bloemfontein.
2nd Floor A-East, Tel: (051) 408 1613 Fax: (051) 408 1967
E-mail Address: motsepev@fshealth.gov.za

PERMISSION GRANTED TO CONDUCT RESEARCH



health

Department of
Health
FREE STATE PROVINCE

27 May 2011

Ms VVJ Motsepe
Skill Development Unit
BLOEMFONTEIN
9300

Dear Me Motsepe

Subject: REQUEST FOR APPROVAL TO CONDUCT RESEARCH ON COMMUNITY HEALTH WORKERS REGARDING THE VALUE AND ROLE PLAYED BY THE GENERAL EDUCATION AND TRAINING CERTIFICATE IN ANCILLARY HEALTH CARE QUALIFICATION IN FREE STATE PROVINCE

The above mentioned correspondence bears reference.

Permission is hereby granted for the above – mentioned research on the following conditions:

- Approval from Ethics Committee needs to be obtained.
- Research results shared with the Department as well as all reports made available to the Free State Department of Health.
- Research does not impact negatively on service delivery.
- Confidentiality of information will be ensured and no names will be used.

Trust you find the above in order.

Kind Regards,

A handwritten signature in black ink, appearing to read 'S Kabane', written over a horizontal line.

Dr S Kabane
HEAD: HEALTH
Date: 12/05/2011

APPENDIX C

INFORMATION DOCUMENT

INFORMATION DOCUMENT



Study Title: Perceptions of Community Health Workers regarding the value and role played by the General Education and Training Certificate in Ancillary Health Care qualification in Free State Province in 2005.

Dear Participant,

I, Ms V. V. J. Motsepe, am doing a research on the perceptions of Community Health Workers who completed the General Education and Training Certificate in Ancillary Health Care qualification in Free State Province in 2005. Research is just a process to learn the answer to a question. In this study, I want to learn about the abilities that CHWs have gained towards the exit level outcomes of the qualification; with a view to improve community health care service in FSP.

I am inviting you to participate in this study, as one of the forty-three (43) CHWs who completed the GETC in AHC qualification in FSP in 2005. You are requested to participate in a focus group interview of about two hours duration, reflecting and discussing your perceptions on the exit level outcomes/objectives of the qualification.

Kindly note that an audio recorder will be used to capture data during the interviews. You are going to be given pertinent information on the study whilst involved in the research project and after the results are available.

Participation is voluntary; and refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled; you may discontinue participation at any time without penalty or loss of benefits to which you are otherwise entitled. As a participant, the researcher shall compensate you with traveling costs to and from the interview sessions amounting to R200.00.

Efforts will be made to keep personal information confidential. Absolute confidentiality cannot be guaranteed. Personal information may be disclosed if required by law. Organizations that may inspect and /or copy research records for quality assurance and data analysis include groups such as the Ethics Committee for Faculty of Health Sciences (*where applicable*).

If the results are published, this may lead to individual/cohort identification. Should you have any specific questions and/or need clarity about the study, my contact details are as follows:

Telephone number: 051 408 1613
Cellular phone: 0835608420
Postal Address: P.O. Box 227
Bloemfontein
9300

Ethics Committee Secretariat and Chair contact details for complaints/problems: Telephone: 051 405 2812.

Thank you for taking the time to read this information and I sincerely hope that you will be willing to contribute to this research project.

Yours faithfully,
Ms V.V.J. Motsepe, 2005105693

ECUFS nr 49/2011

APPENDIX D

CONSENT FORM TO PARTICIPATE IN A FOCUS GROUP INTERVIEW

CONSENT FORM TO PARTICIPATE IN A FOCUS GROUP INTERVIEW



health
Department of
Health
FREE STATE PROVINCE

Date: _____

Hereby I, the undersigned, consent to participate in a focus group interview, which is scheduled to take place on _____, time _____, venue _____

My full particulars are as follows:

Surname: _____
Full names: _____
Telephone number: _____
E-mail address: _____

Signature

You may contact Ms V.V.J. Motsepe at (051) 408 1613 any time if you have questions about the research or affected as a result of the research.

You may contact the Secretariat of the Ethics Committee of the Faculty of Health Sciences, UFS at telephone (051) 405 2812 if you have questions about your rights as a research participant.

Your participation in this research is voluntary, and you will not be penalized or lose benefits if you refuse to participate or decide to terminate participation.

V.V.J Motsepe
2005105693

ECUFS nr 49/2011

APPENDIX E

FOCUS GROUP INTERVIEW GUIDE

FOCUS GROUP INTERVIEW GUIDE



health

Department of
Health
FREE STATE PROVINCE

Appointed Facilitator-----

Independent observer-----

The **aim** of the study is to determine the perceptions of the CHWs regarding their experiences, opinions and attitudes as far as the value and role played by the GETC in the ACH qualification in improving community health care services in the FSP.

Welcome and Introductions

Thank the participants for agreeing to participate in the discussion group.

Allow each participant to introduce themselves to the group.

Reconfirm confidentiality and anonymity as well as the fact that the discussion will be audio recorded.

Remind the group that the purpose of the interviews will be based on the outcomes of the study.

Prompts: Think back, reflect on and discuss the role and value that the training certificate played and highlight your personal experiences, opinions and attitudes regarding your ability to:

- assess and identify community health needs;
- execute primary health care talk;
- engage in basic health promotion with specific reference to prevention and management of accidents and disasters;
- refer clients to the formal health services and other health related systems.

Conclusion:

Thank the participants for their responses.

Etovs number 49/2011

*V.V.J. Motsepe.
2005105693*

APPENDIX F

HPE FOCUS GROUP INTERVIEW QUESTIONS

HPE FOCUS GROUP INTERVIEW QUESTIONS

Perceptions of Community Health Workers regarding the value and role played by the General Education and Training Certificate in Ancillary health Care in the Free State Province

V.V.J. MOTSEPE

2005105693

ECUFS nr 49/2011

1.	Reflect and discuss your experiences regarding identifying and assessing basic community health needs.
1.1	What are your experiences re-ability to identify the following basic community health needs?
	<ul style="list-style-type: none"> • Shelter • Food • Water • Health Care and • Education
1.2	What are your experiences re-ability to assess the following basic community health needs?
	<ul style="list-style-type: none"> • Shelter • Food • Water • Health Care and • Education.
1.3	What are your opinions with identifying the following basic community health needs?
	<ul style="list-style-type: none"> • Shelter • Food • Water • Health Care and • Education.
1.4	What are your opinions with assessing the following basic community health needs?
	<ul style="list-style-type: none"> • Shelter • Food • Water • Health Care and • Education.
1.5	What are your attitudes towards identifying the following basic community health needs?
	<ul style="list-style-type: none"> • Shelter • Food • Water • Health Care and • Education.
1.6	What are your attitudes towards assessing the following basic community health needs?
	<ul style="list-style-type: none"> • Shelter • Food • Water • Health Care and • Education.

END OF QUESTION 1

2.	Reflect and discuss your experiences, opinions and attitudes regarding execution/delivery of Primary Health Care (PHC).
2.1	What are your experiences with the ability to execute/deliver of PHC talk/education on?:

	<ul style="list-style-type: none"> • Nutrition • Food groups and • Functions of food in the body
2.2	What are your opinions with the execution/delivery of PHC talk/education on?:
	<ul style="list-style-type: none"> • Nutrition • Food groups and • Functions of food in the body
2.3	What are your attitudes towards the ability to execute/deliver PHC talk/education on?:
	<ul style="list-style-type: none"> • Nutrition • Food groups and • Functions of food in the body

END OF QUESTION 2

3.	Reflect and discuss your experiences, opinions and attitudes towards health promotion regarding prevention and management of accidents/disasters in the community.
3.1	What are your experiences with the ability to prevent and manage the following accidents/disasters in the community?:
	<ul style="list-style-type: none"> • Burns • Fractures • Drowning and • Paraffin poisoning
3.2	What are your opinions with the prevention and management of the following accidents/disasters in the community?
	<ul style="list-style-type: none"> • Burns • Fractures • Drowning and • Paraffin poisoning
3.3	What are your attitudes towards the prevention and management of the following accidents/disasters in the community?
	<ul style="list-style-type: none"> • Burns • Fractures • Drowning and • Paraffin poisoning

END OF QUESTION 3

4.	Reflect and discuss your experiences, opinions and attitudes regarding referring clients to the formal health and health related services.
4.1	What are your experiences with the ability to refer clients to the following health services in the community?
	<ul style="list-style-type: none"> • Clinics, • Community Health Centres (CHC) and • Social and Welfare Department
4.2	What are your opinions with referring clients to the following health services in the community?
	<ul style="list-style-type: none"> • Clinics, • Community Health Centres (CHC) and • Social and Welfare Department
4.3	What are your attitudes towards referring clients to the following health services in the community?
	<ul style="list-style-type: none"> • Clinics, • Community Health Centres (CHC) and • Social and Welfare Department

END OF QUESTION 4