

# **Community health workers' understanding of their role in rendering Maternal, Child and Women's Health Services**

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*Master of Nursing Science* degree in *Community Nursing  
Science* at the North-West University

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## DECLARATION

I, Thembeke Gladys Zenzile **Student number:** 12896640

Declare that a study titled “**Community Health Workers’ understanding of their role in rendering Maternal, Child and Women’s Health Services**” is my own work and that all the sources that I have quoted have been acknowledged by means of complete references.

The study has been approved by the Ethics committee of the Institutional Office of the North-West Province, as well as Dr Kenneth Kaunda District management.

The study complies with the research ethical standards of the North-West University

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**TG ZENZILE**  
**November 2017**

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## ABSTRACT

**Background:** Community Health Workers (CHWs) play a meaningful role in rendering of Maternal, Child and Women's Health (MCWH) in South Africa. CHWs attended training to equip them with the necessary knowledge to render MCWH services at household level.

**Objective:** To explore, interpret and describe the CHWs understanding of their role in rendering MCWH services in their electoral wards.

**Research Methods:** CHWs within Ward Based Outreach Teams (WBOTs) were recruited from four sub-districts (Matlosana, Tlokwe, Maquassi Hills and Ventersdorp) of Dr Kenneth Kaunda District. A total of 8 (eight) focus group interviews were conducted, with two conducted in each sub-district. Data was analysed, themes and sub-themes were extracted.

**Results:** Five themes and fifteen sub-themes emerged from data analysis.

Findings revealed that CHWs understand their role in relation to provision of MCWH services. Meeting the client's family, coupled with the support of the Outreach Team Leader (OTL) were found to be major factors perceived by CHWs to can enhance provision of MCWH services by CHWs.

Cultural beliefs, HIV & AIDS, stigmatization and inaccessible residential areas were identified as the main barriers to provision of MCWH services by CHWs. The study revealed that most of the CHWs were not coping with the challenges they face as they execute their duties; it further revealed that CHWs discuss their challenges amongst themselves and with their OTLs in order to cope.

Participants suggested that Professional Nurses can prepare Ante Natal Care clients and mothers to expect a visit from a CHW at home. Participants also suggested that CHWs should be sent for refresher courses or more training, if possible at a Further Education Training (FET) college: a course which is accredited by SETA. Some of the suggestions were however unrealistic e.g. introduction to ANC clients when they visit the clinic and not moving about with bicycles when visiting households.

## **ABBREVIATIONS / ACRONYMS**

AIDS:	Acquired Immune Deficiency Syndrome
ANC:	Ante Natal Care
ART:	Anti-Retroviral Therapy
CARMMA:	Campaign on Accelerated Reduction of Maternal and child Mortality in Africa
CHW:	Community Health Workers
DHIS:	District Health Information System
DHP:	District Health Plan
DoH:	Department of Health
Dr KK District:	Dr Kenneth Kaunda District
GOBI-FFF:	G (Growth monitoring), O (Oral rehydration), B (Breastfeeding), I (Immunization), F (Female education), F (Family Planning), F (Food supplements)
HREC:	Health Research Ethics Committee
HIV:	Human Immunodeficiency Virus
iCCM:	Integrated Community Case Management
IMCI:	Integrated Management of Childhood Illnesses
MEC:	Member of the Executive Committee
MCWH:	Maternal, Child and Women's Health
MMR:	Maternal Mortality Ratio
NDoH:	National Department of Health
NGO:	Non-governmental Organisation
NWU:	North-West University
OTL:	Outreach Team Leader
PDoH:	Provincial Department of Health
PHC:	Primary Health Care
PICT:	Provider initiated counselling and testing

PMTCT: Prevention of Mother to Child Transmission  
PN: Professional Nurse  
SDGs: Sustainable Development Goals  
UNICEF: United Nations International Children's Fund  
WBOT: Ward Based Outreach Team  
WHO: World Health Organization

# TABLE OF CONTENTS

<b>DECLARATION</b>	.....	<b>ii</b>
<b>ACKNOWLEDGMENTS</b>	.....	<b>iii</b>
<b>ABSTRACT</b>	.....	<b>iv</b>
<b>ABBREVIATIONS / ACRONYMS</b>	.....	<b>v</b>
<b>LIST OF TABLES</b>	.....	<b>xiii</b>
<b>LIST OF FIGURES</b>	.....	<b>xiv</b>
<b>CHAPTER 1</b>	<b>OVERVIEW OF THE STUDY</b> .....	<b>15</b>
1.1	INTRODUCTION.....	1
1.2	BACKGROUND.....	1
<b>2.</b>	<b>THEORETICAL DEPARTURE POINT OF STUDY</b> .....	<b>4</b>
<b>3.</b>	<b>PROBLEM STATEMENT</b> .....	<b>7</b>
3.1	Research question.....	7
3.2	Overarching aim .....	8
3.3	Research objective .....	8
<b>4.</b>	<b>CENTRAL THEORETICAL ARGUMENT</b> .....	<b>8</b>
4.1	Definition of key concepts.....	9
4.1.1	Community Health Workers (CHW): .....	9
4.1.2	Maternal .....	10
4.1.3	Child.....	10
4.1.4	Woman.....	10
4.1.5	Health.....	10

4.1.6	Ward Based Outreach Team (WBOT):.....	10
1.5	RESEARCH DESIGN .....	11
1.6.	RESEARCH METHODS .....	11
1.6.1	Population and Sampling .....	11
1.6.1.1	Population.....	11
1.6.1.2	Sampling.....	12
1.6.2	Recruitment of participants.....	13
1.7.	DATA COLLECTION.....	14
1.7.1	Methods of data collection.....	14
1.7.2	Setting.....	15
1.7.3	Data collection interviews.....	15
1.7.4	Data management.....	16
1.8	DATA ANALYSIS .....	17
1.9	MEASURES TO ENHANCE CREDIBILITY .....	18
1.9.1	Quality considerations.....	18
1.9.2	Evaluation criteria.....	19
1.9.2.1	Epistemological integrity.....	19
1.9.2.2	Representative credibility .....	19
1.9.2.3	Interpretive authority .....	19
1.9.3	Beyond evaluation.....	20
1.9.3.1	Moral defensibility .....	20
1.9.3.2	Disciplinary relevance .....	20

1.9.3.3	Probable truth.....	20
1.10.	ETHICAL CONSIDERATIONS .....	21
1.10.1	Ethical norms and standards of the study .....	21
1.10.1.1	Relevance and value of research .....	21
1.10.1.2	Scientific Integrity .....	21
1.10.1.3	Role player engagement.....	22
1.10.1.4	Favourable risk benefit ratio .....	22
1.10.1.5	Fair selection of participants .....	23
1.10.1.6	Informed consent.....	23
1.10.1.7	Respect, privacy, anonymity and confidentiality.....	24
1.10.1.8	Researcher competence and expertise .....	24
1.11.	OUTLINE OF STUDY .....	24
1.12	SUMMARY .....	25
<b>CHAPTER 2</b>	<b>RESEARCH METHODOLOGY .....</b>	<b>26</b>
2.1	INTRODUCTION.....	27
2.2	THE ROLE OF THE RESEARCHER .....	27
2.3	RESEARCH STUDY ASSUMPTIONS.....	28
2.3.1	Meta-paradigmatic assumptions .....	28
2.3.2	Theoretical assumptions.....	29
2.3.3	Methodological assumptions .....	30
2.4	RESEARCH DESIGN.....	31
2.4.1	Explorative Interpretive Descriptive design .....	31

2.4.2	Context of research area (Dr Kenneth Kaunda district) .....	32
2.5	RESEARCH METHODS .....	34
2.5.1	Population.....	34
2.5.1.1	Inclusion Criteria .....	35
2.5.1.2	The exclusion criteria .....	35
2.5.2	Sampling.....	35
2.5.2.1	Recruitment of participants and ethical issues related to sampling.....	36
2.5.2.2	Sampling size.....	36
2.5.2.3	Establishing contact with participants .....	37
2.5.3	Data collection .....	37
2.5.3.1	Data collection process .....	37
2.5.3.2	Data collection approach and method .....	38
2.5.3.4	Ethical considerations related to data collection .....	44
2.5.4	Data analysis process .....	44
2.5.5	Data Management.....	45
2.6	ETHICAL CONSIDERATIONS.....	45
2.6	CONCLUSION.....	46
<b>CHAPTER 3</b>	<b>RESEARCH RESULTS SUPPORTED BY/COMPARED WITH LITERATURE CONTROL.....</b>	<b>47</b>
3.1	INTRODUCTION.....	48
3.2	CREDIBILITY .....	48
3.3	DATA ANALYSIS.....	48

3.3.1	Integration of data sources .....	49
3.3.2	Coding.....	49
3.4	DISCUSSION OF THEMES AND SUB-THEMES EMERGED IN THIS STUDY .....	51
<b>SUMMARY</b>	.....	<b>62</b>
<b>CHAPTER 4</b>	<b>CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS .....</b>	<b>63</b>
4.1	INTRODUCTION.....	64
4.2	SUMMARY OF PROCEDURES .....	64
4.2.1	Conclusions on the Objectives.....	65
4.2.1.1	Participants' understanding of their role in providing services to mothers and children.....	66
4.2.1.2	Factors perceived to be making it easy for CHWs to provide MCWH services? .....	66
4.2.1.3	Perceived barriers to rendering MCWH services .....	66
4.2.1.4	Perceived suggestions to better the MCWH services .....	67
4.2.1.5	Coping mechanisms applied by CHWs.....	67
4.3	LIMITATIONS OF THE STUDY .....	68
4.3.1	Limitations of the method used.....	68
4.4	RECOMMENDATIONS .....	68
4.5	SUGGESTIONS FOR RESEARCH, EDUCATION AND PRACTICE .....	70
<b>5.</b>	<b>SUMMARY.....</b>	<b>71</b>
<b>REFERENCE LIST</b>	.....	<b>72</b>

<b>ADDENDUMS A, B, C, D, E and F.....</b>	<b>80</b>
<b>ADDENDUM A: Cover letter and Informed consent.....</b>	<b>81</b>
<b>ADDENDUM B: Ethics Approval North-West University .....</b>	<b>87</b>
<b>ADDENDUM C: Ethics Approval North West Province DoH .....</b>	<b>88</b>
<b>ADDENDUM D: Example of research permission request .....</b>	<b>89</b>
<b>ADDENDUM E : Permission granted to conduct research by Dr KK District.....</b>	<b>91</b>
<b>ADDENDUM F: Example of focus group transcription.....</b>	<b>92</b>

**LIST OF TABLES**

**Table 2.1            Breakdown of focus groups and participants per sub-district..... 37**

**Table 3.1            Objective of this research ..... 49**

**Table 3.2:            Themes and sub-themes identified with focus group  
interviews of CHWS regarding understanding of their role in  
rendering maternal, child and women’s health ..... 51**

## LIST OF FIGURES

Figure 1.1:	Re-engineering framework based on the District Health Model (NDoH 2010:17) .....	9
Figure 2.1:	Ward Based Outreach Team, OTL, CHW's and households linked with PHC facility.....	30
Figure 2.2	Graphical presentation of population distribution among the Sub-Districts for Dr Kenneth Kaunda District NDoH (DHP 2015/16:19).....	33
Figure 2.3	Sub-districts of Dr Kenneth Kaunda district .....	34
Figure 4.1:	Ward-based community health worker outreach teams: The success of the Sedibeng Health Posts (Policy Brief 2014:1) .....	65

**CHAPTER 1**  
**OVERVIEW OF THE STUDY**

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## 1.1 INTRODUCTION

In this chapter the background assists the reader to formulate a research gap based on the scientific literature review. The background leads to formulation of a research question, as well as the aim and objective for the study. The researcher's assumptions are declared in this chapter followed by the research methodology and ethical guidelines which are essential to protect the participant, the researcher, the North-West University and the Provincial Department of Health (PDoH). Ethical principles assist the researcher to conduct research that is scientifically correct and with integrity. The chapter is finalised with an outlay of the dissertation and a summary.

## 1.2 BACKGROUND

Globally 287 000 mothers die from complications of pregnancy and childbirth, with Sub-Saharan Africa and Asia accounting for 85% of such deaths (Arba *et al.*, 2016:2). In addition, each year an estimated 4 million births occur in the United States; anywhere between 15% and 25% of these pregnancies result in ante-partum hospitalisation for complications (Clark, 2008:428). Contributing to the high maternal and neonatal deaths is non-compliance to antenatal primary health care facility visits. In Ethiopia only 20.6% of pregnant women visited the antenatal primary health care facility at least four times during their pregnancy, as prescribed by the World Health Organisation (WHO); the results thereof revealing a low level of knowledge regarding danger signs during pregnancy (Arba *et al.*, 2016:4). To address maternal mortality rates, Antenatal Primary health care facility (ANC) visits during early gestation (before 20 weeks) are important for HIV positive mothers as it provide opportunities to initiate Prevention of Mother to Child Transmission (PMTCT) services and it assist in identifying those pregnant women who are likely to haemorrhage before or after delivery. The health status regarding Maternal, Child and Women's Health (MCWH) services in SA show the following trends: the rates of antenatal care coverage for visits before 20 weeks have been far from optimal with rates consistently below 45% reported since 2002; antenatal clients introduced to anti-retroviral therapy (ART) was 89.3% against a target of 100% (District Health Barometer, 2012-2013:87 and 167). The coverage rate of the Dr Kenneth Kaunda District performance on antenatal care visits before 20 weeks coverage was ranked ninth from the bottom, out of 52 Districts in South Africa, and the diarrhoea case fatality rate was 7.0% against South Africa's overall performance average of 4.3% (Health Systems Trust (HST), 2013:89).

Consequently, the WHO assisted countries to set indicators in order to reduce the maternal mortality rate with three quarters between the period of 1990 and 2015 (WHO, 2015:41). The

maternal mortality rate is the sum of women that die between conception and 6 weeks (42 days) postpartum per 100 000 deliveries (Perinatal Education Programme, 2008:23). Globally the maternal mortality rate decreased from 269/100 000 live births in 2009 to 136/100 000 live births in 2013 (WHO, 2014:1). South Africa also experienced a decrease in maternal mortality rate to 141/100 000 live births in 2013 (Statistics South Africa, 2015a: xxv). Causes of women mortality included unsafe abortions, failure of women to present themselves on time at health care facilities and failure to get tested for HIV during pregnancy (Hattingh *et al.*, 2012:130). The maternal mortality rate in South Africa has remained unacceptably high even though on a decline, with Dr Kenneth Kaunda District (the focus district of this research) constantly being above the target ratio of 200 per 100 000 live births according to the District Health Information System (DHIS). The Maternal Mortality Ratio (MMR) was 272.6/100 000 live births (2<sup>nd</sup> quarter 2013/14), 325.4/100 000 live births (3<sup>rd</sup> quarter 2013/14) with an annual rate of 232.5/100000 live births. The United Nations Assembly through Sustainable Development Goals (SDG) set a target for maternal mortality rate of less than 70 per 100 000 live births by 2030 (NDoH, 2015a:9).

The global mortality rate among neonates only decreased by 36%, from 33 deaths/1000 live births in 1990 to 21 deaths/1000 live births in 2012. These neonatal deaths were related to an overwhelming 2.6 million deaths globally during the third trimester of pregnancy or stillbirths during the intra-partum period (WHO, 2013:2). As in other countries and South Africa, deaths during the new born or neonatal period (the first 28 days of life) contribute to elevated children under-five mortality. For the period of 2009 to 2013 the neonatal mortality rate decreased from 13 deaths per 1000 live births to 11 deaths per 1000 live births in South Africa. Foetus and newborn affected by maternal factors and by complications of pregnancy, labour and delivery ranked third over the three-year period and accounted for 9,8% of early neonatal deaths in 2013, 11,0% in 2014 and 10,4% in 2015. Infections specific to the perinatal period was the fourth leading cause of early neonatal deaths, accounting for 7,1% of early neonatal deaths in 2013, 7,7% in 2014 and 7,6% in 2015 (Statistics South Africa, 2015:23).

Globally more than 10 million and in South Africa more than 106 000 children under five years of age die each year from largely preventable causes (Kibel *et al.*, 2012:288). In 1978, the Alma Ata Conference on Health for All, the World Health Organization (WHO), and United Nations International Children's Fund (UNICEF) acknowledged that high and unacceptable rates of child mortality and morbidity needed to be reduced, the focus should be on community health, and not just individualised care (Kibel *et al.*, 2012:288). To address high mortality in children, the GOBI-FFF strategy was developed by the WHO, and the implementation of growth

monitoring, oral rehydration, breastfeeding, immunization, female education, family spacing, and food supplementation (GOBI-FFF) strategy by WBOTs at community level can be instrumental in improving child survival (Hattingh *et al.*, 2012:126; Dennill & Randall-Mkosi 2012:16-19). Furthermore the mortality rate for preventable deaths of newborns and children under 5 years of age should be 20 per 1000 live births which was not reached due to conditions such as diarrhoea, pneumonia, malaria, injuries, HIV/AIDS, pertussis, meningitis, measles and congenital abnormalities (Hattingh., *et al.* 2012:125). According to Statistic SA child mortality accounted for 7.7% of deaths in 2013 (Statistic SA, 2013:18).

In order to address unacceptably high maternal and child mortality rates, the National Department of Health (NDoH) aims to strengthen the effectiveness of the health system through a Negotiated Service Delivery Agreement to improve health outcomes (NDoH, 2010:25). Additionally, the Sustainable Development Goals (SDGs) aim to ensure universal access to sexual and reproductive health services, reducing global maternal mortality to 70 per 100 000 live births and to end preventable deaths of new-borns and children under 5 years of age by 2030 (NDoH, 2015a:9). In order to learn lessons from other countries, the Minister of Health together with Members of the Executive Committee (MECs) for Health visited Brazil in 2010 and returned with a vision for re-engineering of Primary Health Care (PHC) services. Brazil was able to improve health outcomes by, among other things, expanding the role of community agents working in teams with health professionals, in designated catchment areas. Upon returning home, the Minister established a small team to elaborate on a South African model to strengthen Primary Health Care (PHC) (Sampaio, 2010:365).

The basic concept presented was adopted with the intention that we build a South African model based on electoral ward systems as had been piloted in KwaZulu-Natal. Since this meeting in November 2010, a number of innovations have been added to the basic model. In discussion with the Minister of Health and after a debate in the National Health Council, a three stream approach to PHC re-engineering was adopted by the DoH. The model contains three streams:

- a Ward-based PHC outreach team for each electoral ward;
- strengthening school health services; and
- District-based primary health care facility specialist teams with an initial focus on improving maternal and child health.

To cater for 84% of the population in South Africa, the following cadre of health workers are required: a total of 5482 Ward Based Outreach Teams (WBOTs) and at least 52 District Primary health care facility Specialist Teams (NWDoH, 2011:2). There are 29 000 schools in South Africa; it is thus not possible to place a school health nurse at every school. In relation to school health services focus is given to quintiles 1 and 2 (poorest) schools and priority is given to a selected range of services (NWDoH, 2011:6).

## **2. THEORETICAL DEPARTURE POINT OF STUDY**

The role of Community Health Workers (CHW) in many countries was believed to have contributed to better health outcomes. The CHWs home visit itself may serve as a reminder or a “nudge” to women who were already planning to attend antenatal care (ANC) at the time of the CHWs visit. The potential of the CHW to successfully “nudge” people has recently been demonstrated by a study that investigated the use of CHWs for improving adherence to medications by patients with chronic diseases (Lema *et al.*, 2014:196). According to the DoH audit results, South Africa has an estimated 72 000 CHWs in outreach teams at an estimated cost of R2.4 billion, yet good health outcomes are not achieved (NWDoH, 2011:3). It is suggested that this is the result of multiple factors related to CHWs. These include inadequate training, inadequate support and supervision, random distribution with poor coverage, no link between the community based services and services offered by PHC facilities, health programs funded through Non-governmental Organizations (NGO) with inadequate accountability, and limited or no targets for either coverage or quality to be reached (Lehmann & Sanders, 2007:19-20).

- The WBOTs were designed to correct the above-mentioned limitations and the way community based health services are currently provided in the country. The WBOTs can contribute positively to the following recommendations of the Confidential Enquiry into Maternal Deaths in South Africa 2011-2013 (NDoH, 2013:23). All pregnant women should be offered information on screening for all diseases that may affect both the woman and the foetus e.g. malnutrition. Contraceptives should be promoted at antenatal and postnatal care services in order to strengthen fertility counselling and family planning services (Hattingh *et al.*, 2012:131). Furthermore, WBOTs can assist to:
- strengthen and promote access to comprehensive sexual reproductive health services with specific focus on family planning services;
- advocate and promote health for early antenatal care and attendance;

- improve child survival by promoting
- and supporting exclusive breastfeeding for at least the first 6 months of life;
- improve immunisation and vitamin A coverage;
- Intensify case management of sick children through improved implementation of key family practices such as diarrhoea management at home (Dennill & Randall-Mkosi 2012:16-19).

Infant and child mortality rates have increased in South Africa and a few other countries in the region, largely due to the massive impact that the HIV epidemic has had on all aspects of health, including children being infected and mothers being unwell and unable to care for their offspring. This resulted in overstretched health systems being unable to deliver several additional and complex programmes (Kibel *et al.*, 2012:292). To decrease child mortality rates, CHWs are needed to support mothers who provide exclusive breastfeeding to ensure that mixed feeding does not happen. Breastfeeding exclusively is likely to reduce mother to child transmission of HIV (Hattingh *et al.*, 2012:125).

Given the key role that the CHW would play, they were taken over and directly managed by the DoH, as opposed to Non-Governmental Organisations which often have their own agenda e.g. HIV/AIDS counsels or social work CHWs. The NDoH emphasised that each team should be linked to a Primary Health Care (PHC) facility with a professional nurse, who is a team leader of the WBOT. The outreach team leader (OTL) is responsible for ensuring that the team's work is targeted and linked to service delivery targets and that CHWs are adequately supported and supervised. The roles of CHWs, as part of the WBOTs, will include:

- Conduct community, household and individual health assessments and identify health needs and risks (actual and potential) and facilitate the family or an individual to seek the appropriate health service;
- Promote the health of the households and the individuals within these households;
- Refer persons for further assessment and testing after performing simple basic screening e.g. the CHWs will use a list of pre-determined questions to screen a client for pulmonary tuberculosis, mentally illness and early pregnancy and then refer the client to the primary health care facility if there is a "yes" response to any of the questions; or to measure upper arm circumference to identify malnutrition in pregnant women and children as early as possible;

- Provide limited, simple health interventions in a household (e.g. basic first aid, oral rehydration and any other basic intervention that they are trained to provide);
- Provide psycho-social support and manage interventions such as treatment defaulter tracing and adherence support (NDoH, 2011:5).

In addition to the above roles, the CHW underwent training that empowered them on MCWH and are now providing the following services to the community: the CHW advise on good nutrition, healthy lifestyles for women before, during and after pregnancy; they monitor the pregnant woman's health throughout; and they follow-up on women post-delivery and encourage the woman to attend a primary health care facility for postnatal assessment within 3 days after delivery. These actions aim to identify complications early and to refer them to the appropriate PHC, thus aiming to reduce maternal and child mortality. Consequently the health of the mother and any women at childbearing age health can be furthered increase by access to contraception which is also an aspect associated with lower maternal mortality rates. Contraception is one of the most powerful public health tools for any country. Providing women and engaging men/partners with access to safe and effective contraception is a critical element of women's health which can result in better economic and social opportunities. Birth spacing also improves the opportunities for children to thrive physically and emotionally (NDoH, 2012:4-6; HST, 2012-13:34; NDoH, 2012:2).

Ideally each ward within the country should be covered by a PHC outreach team. There are 4 277 electoral wards in South Africa, including 98 wards in Dr Kenneth Kaunda District, which is the focus of this research. The population sizes of wards differ, as well as the geographical area and density of each ward. Urban wards have a larger population and are reasonably accessible whilst rural wards are sparsely populated and often with poor roads and poor infrastructure. That means that ward populations may range from less than 1000 inhabitants in some wards to more than 20 000 inhabitants in others (NDoH, 2011:4). In Dr Kenneth Kaunda District the outreach teams currently consist of a professional nurse and 6-8 CHWs per ward. Environmental officers have a vital role to ensure improvement in the environment in which women and children stay; however, due to unavailability of environmental health officers they cannot be included in the outreach teams. At this point only 79 of the 98 electoral wards are covered by WBOTs in Dr Kenneth Kaunda District.

Not much research has been conducted on the role of CHWs in WBOTs in relation to MCWH in South Africa, as identified through a literature search. This may be because some studies concentrated more on Community Home-Based care and others focused on other areas of

WBOTs' responsibilities e.g. Tuberculosis (Moetlo *et al.*, 2011:140). A quantitative performance evaluation study on 'Community Health Workers to Improve Antenatal Care and PMTCT Uptake' was conducted in Dar es Salaam, Tanzania by Lema *et al.* (2014:196). The study by Nanyonjo *et al.* (2015:1-11), revealed that CHWs were involved with success in integrated Community Case Management (iCCM), where CHWs treated diarrhoea, pneumonia and malaria in Uganda. Due to minimal research on the role of CHWs in the WBOTs to improve MCWH services, research needed to be done in order to determine whether CHWs understand their role and its impact on MCWH performance in the Dr Kenneth Kaunda District. This research therefore focused on the CHWs' understanding of their role in improving MCWH services in the Dr Kenneth Kaunda District.

### **3. PROBLEM STATEMENT**

No literature could be found regarding CHWs' understanding of their role in relation to MCWH services and therefore this is an area that needs to be explored. The function of the WBOTs is to take MCWH services, including health education to the community (NDoH, 2011:4). The Dr Kenneth Kaunda District performance regarding MCWH services was ranked very low in the District Health Barometer (2012-2013:33). The antenatal care coverage rate for first visits before 20 weeks was below the set target of 45%, the contraception coverage rate was 26.9% against a set target of 37% and antenatal clients initiated on anti-retroviral therapy (ART) was 89.3% against a target of 100% (District Health Barometer, 2012-2013: 87 and 167). Statistics SA (2013) identified that the diseases contribute to mortality of children under five (5) years of age, are mostly avoidable when the Integrated Management of Childhood Illnesses (IMCI) guidelines are properly implemented and CHWs should be very active in the community conducting case findings, which currently is not the case (Hattingh *et al.*, 2012:125). The number of children under five years who die account for 7.7% of total deaths in South Africa (Statistics SA, 2013:18). These statistics reflected that the CHWs in WBOTs does not perform satisfactorily in the community. Based on the background and the problem statement the following research question was formulated:

#### **3.1 Research question**

What is the CHWs understanding of their role in rendering MCWH services in their electoral wards?

### **3.2 Overarching aim**

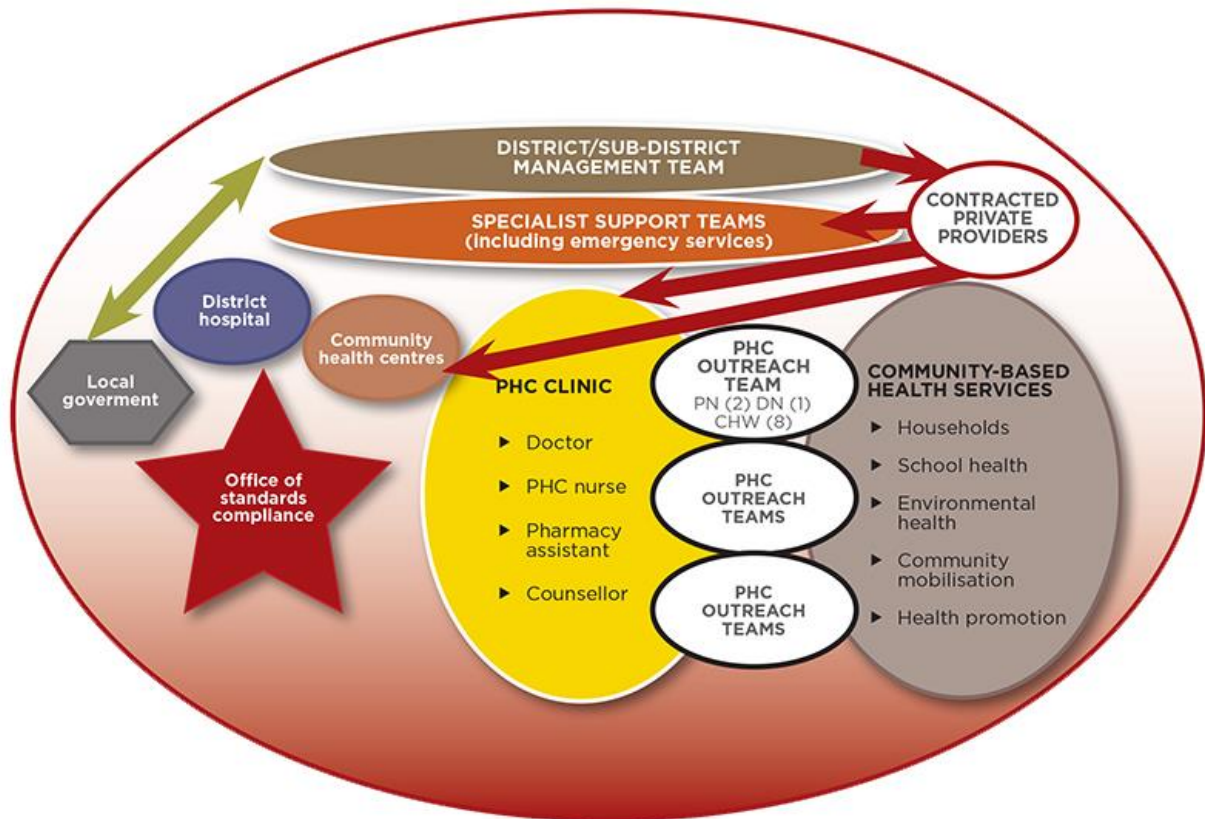
The aim of this research was to explore, interpret and describe the understanding of CHWs with regards to their role in rendering MCWH services within WBOTs, in order to derive recommendations which can be implemented in line with current guidelines to improve MCWH services.

### **3.3 Research objective**

To explore, interpret and describe the CHWs understanding of their role in rendering MCWH services in their electoral wards.

## **4. CENTRAL THEORETICAL ARGUMENT**

According to Burns and Grove (2009:126), the framework of the study plays a very important role during the guidance of developing a research study. The theoretical departure point for this study was based on the PHC model that was successfully implemented in Brazil and is outlined in the following paragraphs. The WBOTs are the focus of South Africa's community based health service that is linked with a PHC facility. Wards are smaller sections of a district and the ultimate aim is to allocate in each ward at least one outreach team. The number of teams per ward will be determined by the size of the population, the geographical area and other influencing factors such as the disease burden and epidemiology. Literature differs on the number of CHWs to be allocated in an electoral ward, but the ideal is between 6 and 8. The role of the CHW is to visit each household allocated to them and register each person in the household. The curriculum of training of a CHW focuses on community mobilisation, health promotion and disease prevention, functioning in a team and priority health issues such as HIV/AIDS, TB and maternal, child and women's health. Figure 1.1 provides an outlay with regard to WBOTs and when interpreting their role it provides information about the link between the WBOT and Community based health services.



**Figure 1.1: Re-engineering framework based on the District Health Model (NDoH 2011:17)**

The MCWH-related services of WBOTs can impact positively on the lives of the community and on MCWH indicators, and can thus lead to improved health outcomes and improved performance in Dr Kenneth Kaunda District if implemented correctly. Continuous applicable training to all team members is essential. The CHWs understanding of their role within the WBOT were essential to improve their performance in order to ensure improved MCWH indicators. With the feedback that was provided to CHWs at the end of this study, the researcher shared the findings and highlighted the recommendations formulated in line with current guidelines. These activities created an opportunity for the CHWs to be empowered to understand their role in rendering MCWH services and the importance thereof. In the next section a definition for each key concept will be provided.

## **4.1 Definition of key concepts**

### **4.1.1 Community Health Workers (CHW):**

A Community Health Worker (CHW) may be defined as ‘any health worker delivering health care services and who is trained in the context of the intervention, but has no formal

professional certificate, diploma or degree education' (HST, 2011:3). CHWs should be members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily be a part of its organisation, and have shorter training than professional workers (Lehman & Sanders, 2007:3).

#### **4.1.2 Maternal**

Maternal refers to the women during pregnancy, childbirth and the postpartum period which entails six weeks after delivery (Perinatal Education Programme, 2008:23).

#### **4.1.3 Child**

A human being between the stages of birth and puberty (Clark, 2008:384), in this study the focus was on children under five (5) years of age. The reason for only including children under 5 years was because these children are treated according to IMCI guidelines (Hattingh *et al.*, 2012:258). These are the children the CHWs will find and screen at home, and refer if necessary.

#### **4.1.4 Woman**

A female human requiring holistic health services; this study focuses on Family Planning, cervical screening and Provider Initiated HIV counselling and Testing (PICT). Provider Initiated Counselling and Testing refers to HIV counselling and testing which is routinely recommended by health care professionals to persons attending health care facilities as a standard component of medical care (Moosa & Jeena, 2013:60-64).

#### **4.1.5 Health**

Health is a state of complete physical, mental and social well-being, and not only the absence of disease and infirmity (Hattingh *et al.*, 2012:5). In this study the health of women and children under the age of five (5) years were the focus. The understanding of CHW in ward based systems regarding rendering services to women and children were explored.

#### **4.1.6 Ward Based Outreach Team (WBOT):**

The Ward-Based Outreach Team is linked with a PHC facility that offers integrated services to households and individuals within its catchment area. In this study the focus was on the CHWs understanding of MCWH services they render to households and families. Ideally the team should provide PHC services at community level to families or households, which includes

health prevention, promotion, curative, palliative and rehabilitative services (Dennill & Rendall-Mkosi, 2012:68).

## **1.5 RESEARCH DESIGN**

A quality interpretive design as described by Thorne (2008:173) was used to describe and interpret the understanding of CHWs regarding their role in the provision of MCWH services. This design was chosen because it could assist the researcher not to only give a “pure” description, but rather seek to discover associations, relations and patterns of the CHWs’ experiences and vision with regard to their role in rendering MCWH services (Thorne, 2008:50). The interpretive descriptive strategy also assisted the researcher to search and integrate information about the role of the CHWs by using their reflective primary health care clinical reasoning skills. This in turn resulted in a deeper appreciation for what would ultimately be the optimal community based health care response (Thorne, 2008:50) e.g. in this study it describes whether the CHW understood the importance of referring a pregnant women to the PHC facility before 20 weeks of pregnancy.

## **1.6. RESEARCH METHODS**

The methodology for this research study consisted of a discussion regarding the population and sampling methods, inclusion and exclusion criteria, data collection, data management, data analysis and reliability

### ***1.6.1 Population and Sampling***

In the following paragraph, population and sampling are discussed.

#### **1.6.1.1 Population**

The North-West Province was selected purposely for its consistently high maternal mortality rate as outlined in the introduction and background. There were increasing neonatal death rates, ranging from 4 to 12 per 1000 live births for the period 2011 to 2013 (NDoH, 2014:57). The North-West Province consists of four districts, of which Dr Kenneth Kaunda District is one. This district was chosen for the study as it consists of two rural and two urban sub-districts, which will allow collected data to be more representative and rich. The researcher is the District primary health care clinical specialist with the focus on MCWH, and therefore MCWH was the focus of the research. The researcher did not work directly with the CHWs or OTLs but liaised with the PHC Re-engineering focal person at District level, thus the researcher did not have any conflict

of interest. The focal people for re-engineering at sub-district level report to the focal person at District level. The researcher oversees the MCWH performance at District level; in case of poor outcomes the researcher liaises with the PHC Re-engineering focal person at District level. The total number of CHWs within WBOTs in the sampled district was five hundred and ninety six (596). The Dr Kenneth Kaunda District consists of four sub-districts namely: Ventersdorp sub-district (N=61), Tlokwe sub-district (N=168), Matlosana sub-district (N=281) and Maquassi Hills sub-district (N=86). The researcher confirmed these numbers of CHWs indicated in brackets with the PHC re-engineering coordinator of the Dr Kenneth Kaunda District to ensure that the study was feasible.

#### 1.6.1.2 Sampling

The population (N) was CHWs that met the criteria and were willing to participate voluntarily in the study; cluster sampling was applied to group participants according to sub-districts. From these groups, a random purposive sampling technique was applied using the name lists provided by the Outreach Team Leaders (OTLs) who knew which CHWs fulfilled the inclusion criteria and were more experienced in each sub-district. This assisted the researcher to determine the first and the second focus group members in each sub-district. Each sub-district had a minimum of two focus groups and thus 8 focus groups were conducted in Dr Kenneth Kaunda District. Data saturation was reached by the end of the 8<sup>th</sup> focus group, thus no additional focus groups were conducted. The OTLs were purposefully left out of the study as they are professional nurses who understood what the role of the CHWs was. Their involvement as participants would have had a potential to introduce bias to the findings.

The inclusion criteria (Brink *et al.*, 2012:313) was as follows: The prospective participant had to be

- Willing to give voluntary informed consent (see Addendum A) to participate prior to commencement of the study;
- Willing to be recorded on a digital recorder;
- A CHW within a WBOT for at least six (6) months. This was to ensure that the CHW had enough experience working with MCWH services in order to obtain relevant and informative data;
- In a WBOT linked to an identified PHC facility in Dr KK District, meaning that the CHW should report every morning at a specific PHC facility and provide feedback to the OTL

about the previous day's activities and referrals, record actions and discuss the home visits that need to be done for the day;

- Able to communicate in English as focus groups were conducted in English. The requirement for recruitment of CHWs is that they possess Grade ten (10) and be able to speak and understand English as it is the language of instruction; and
- Open and willing to share their experience within a focus group as only agreed confidentiality could be ensured in a focus group.

The exclusion criteria (Brink *et al.*, 2012:313) was all CHWs whose focus was not community health work, e.g. those conducting the mentor mother programme. The mentor mother programme model is a sustainable peer-based model established in 2001 and implemented within PHC facilities for PMTCT education and psychosocial support.

### **1.6.2 Recruitment of participants**

The outreach team leader initially acted as a gatekeeper and informed all CHWs of the research to be undertaken after the necessary training. The gatekeeper determined which of those CHWs were interested in participating in the research and were eligible; the OTL then made a list with their names and phone numbers.

The researcher sourced the name list from the gatekeeper. The researcher contacted all interested CHWs and invited them to an information session being held per sub-district. The researcher presented a power-point presentation regarding the purpose of the study, objectives, data collection procedure, informed consent, all ethical considerations and the protection of participants relating to partial confidentiality. The power-point presentation included explaining the meaning of voluntary informed consent.

The researcher then determined who were still interested after the presentation. The researcher gave two informed consent forms to each interested CHW to take home, and informed them to ask further questions to their OTL at each PHC facility. It was indicated in the informed consent forms that their participation was at their own free will. The CHWs were given 24 hours to think about whether they still wanted to participate in the research study or not. After 24 hours, if they decided to participate in the research study they took the two consent forms to the OTL whose role then changed from gatekeeper to mediator. The mediator made sure they understood the contents of the informed consent, and signed the consent form with them. An additional witness also signed with them. The CHW kept one signed informed consent form and the other form was left with the mediator. The mediator forwarded the signed informed consent forms to the

sub-district office in a sealed envelope. The researcher collected the signed informed consent forms from the sub-district office.

## **1.7. DATA COLLECTION**

In the paragraphs below the researcher outlined the data collection methods.

### **1.7.1 *Methods of data collection***

The focus group method was used to collect data. According to Liamputtong (2011:5), focus groups as method of data collection is useful in exploring and examining what people think, how they think, and why they think the way they do about the issues of importance to them without pressuring them into making decisions or reaching a consensus. This method allowed for a large amount of rich informative data, based on the multiple responses that the researcher obtained on the topic during focus group sessions. Generally, it is recommended that there should be six (6) to ten (10) participants in a focus group session. It may be difficult to generate interest and one member may dominate the discussion in a focus group of less than six participants. A focus group of more than eight participants may be difficult to manage (Liamputtong, 2011:42), but eight (8) to ten( 10) participants were selected for a focus group to make provision for unforeseen circumstances when a CHW might not be able to attend on the scheduled day.

The study leader trained the researcher on how to conduct focus groups, including role play on facilitating focus groups using communication techniques such as reflection, paraphrasing and probing. The focus group session started with a welcoming and introduction of the researcher, fieldworker and participants (Israel *et al.*, 2013:258). Some participants felt uncomfortable or unsure about what to expect. The researcher offered the participants some refreshments and had small talk with them before the session started and identified personalities, such as talkative, quiet or domineering in order to accommodate all participants. Participants were fully informed about the research - both verbally and in writing and were also given the opportunity to ask questions. The air conditioners in the PHC facilities were utilized to regulate the temperature to comfortable levels. Only cushioned chairs were utilized for the focus group sessions. The researcher informed the focus group members about the importance of keeping confidentiality within the group (partial confidentiality) and emphasized that there was a risk in sharing information as it was possible that shared information could be leaked outside the group. The researcher facilitated the focus group within an average targeted time of about 60 minutes, as the participants were informed about the duration beforehand. The duration of the

focus group session should not be longer than two hours; this is to ensure that the focus group session does not tire out participants or inconvenience them regarding other important personal matters they may want to attend to (Liamputtong, 2011:46).

The discussions were digitally recorded using two recording devices to safeguard against equipment failure, and field notes were taken by the field worker. An explorative interpretive descriptive design required field notes which could be retraced to the development of abstractions and to ensure that the analytic findings were defensible. Field notes taken should provide sufficient information for the researcher, study leader and co-coder to assist them to follow the analytic reasoning process and to judge the degree to which the data analysis is grounded (Thorne *et al.* 2008:175). A diary was kept about data collection and field notes to ensure the coding themes derived from data analysis were defensible. Such a diary was used to record the time; place, date and demographic notes of participants. The researcher also recorded her own field notes just after the focus group session. A reflection on the focus group session was done by the researcher on the evening of the day the focus group session was held. Such notes were written down to reflect the researcher's own feelings and perceptions, including whether there was any deviation from the planned methodology. The field worker write descriptive field notes which included portraits of participants, description of the physical setting and how the dialogues unfolded (Yin, 2009:85; Krueger & Casey, 2009:105).

### **1.7.2 Setting**

A productive focus group discussion was enhanced by both the physical location and the internal environment of the venue. Essentially the group location and venue should set a positive tone for the focus group discussion, and provide a comfortable, relaxed and informal environment which is conducive to a productive focus group discussion (Liamputtong, 2011:57). Venues for data collection were chosen and arranged based on their ability to provide privacy, reasonable comfort and minimal distractions as well as taking into consideration the availability of CHWs. A "do not disturb" sign was posted outside the door of the focus group discussion room to minimize distractions. Refreshments were made available during focus groups. An airtime voucher of between R10 and R15, depending on the service provider the participant uses, was given to participants as a token of appreciation. Appointments were confirmed a day before gatherings.

### **1.7.3 Data collection interviews**

The interview questions that the researcher used for the focus groups are the following:

- Describe your role as a health care worker in providing services to mothers and children.
- What makes it easy for you to provide these services?
- What makes it difficult for you to provide these services?
- What challenges do you face every day while providing these services?
- How do you cope with these challenges every day?
- What suggestions do you have to better these services?

Focus group questions were developed by the researcher being a District PHC clinical specialist with focus on MCWH as well as a former sub-district Re-engineering focal person. The questions were based on the research question and refined with the input of subject specialists at the School of Nursing Science, North-West University (NWU). The interview schedule was approved by the scientific committee of INSINQ. The researcher could not find any focus group questions relevant to the study that were used before.

Taking of field notes ran concurrently with focus group discussions. The field notes were taken by the field worker who is a young unemployed graduated member of the community who also signed a confidentiality agreement. This community member was chosen in order to avoid taking personnel from the already under-staffed PHC facilities. The fieldworker was trained by the researcher (after the researcher was trained by the study leader) on how to take detailed descriptive field notes in order to give accurate descriptions of what was seen, heard and experienced (Liamputtong, 2011:63). More details about field notes will be found in chapter 2.

#### **1.7.4 Data management**

Data was managed **sensitively, privately, confidentially and anonymously** to **protect** all participants including the PHC facilities (DoH, 2015b:14). These aspects will be discussed in paragraphs below. The **informed consent forms** (see Addendum A: Informed Consent form) were sent to the sub-district offices from an independent professional nurse in a sealed envelope addressed to the researcher. The researcher personally obtained the informed consent forms from the sub-district offices. After random purposive sampling of participants, code numbers were assigned to each PHC facility and participant. The researcher had the list of all participants participating in the study and the assigned number of the PHC facility and the participant. This list was electronically designed on the researcher's computer to allow password protection. This was done to ensure that the names of PHC facilities and participants are kept confidential, private and anonymous (NDoH, 2015b:14). Personal information

regarding the participants and PHC facilities was not divulged during data collection or revealed in the research study, research report or any published article.

The informed consent forms, collected field notes and the two recording devices were transported and locked away in the researcher's office, directly after conducting a focus group. Only the researcher had access to the informed consent forms, field note documents and recording devices, in order to ensure confidentiality. The researcher uploaded the voice recordings on her laptop and on the transcriber's laptop as soon as it was possible. All voice recordings were password protected. The transcriber signed a confidentiality agreement form to ensure confidentiality. After the focus group discussions were transcribed it was e-mailed as a password protected document to the researcher and study leader. These transcriptions were printed out to be analysed. The informed consent forms, schedule for data collection, name list and cell phone numbers of participants, field notes, transcriptions and analysis documentation were locked away after data analysis in the study leader's office to be available for audit purposes. All hard copies were locked in a cupboard and electronic copies will be available for audit purposes for a period of five (5) years. The recorded focus group discussions on the recording devices were deleted after voice recordings were uploaded on the researcher's computer and password protected for a period of 5 years. A back up copy of focus group discussions was made in case of a virus or computer failure. After five years all hard copies will be shredded and the study leader will remove all electronic information from the computer with the assistance of an information technologist. These steps enhanced sensitivity in data management (NDoH, 2015b:14).

## **1.8 DATA ANALYSIS**

Data analysis was done by the researcher, study leader and an independent co-coder, Prof. E. du Plessis who also signed a confidentiality agreement. The co-coder has exceptional experience in the field of qualitative research and WBOTs. The inductive analysis strategy was followed and premature coding of data was avoided. The researcher followed the next four sequential cognitive processes that must precede the kind of conceptualisation that interpretive description requires (Thorne, 2008:165 - 166).

- **Comprehending** refers to striving to make sense of the data and to understand "what is going on". This stage occurs early in the analytic process. When comprehension is achieved, coders are able to prepare a thorough, rich description of CHW understanding of their role in MCWH and new data does not add much to that description; thus comprehension is completed once data saturation is achieved (Sharma, 2014:316;

Thorne, 2008:165). In order to learn everything about the setting or the role of CHW, the researcher passively absorbed everything remotely related to the performance of CHWs within WBOTs in relation to MCWH performance. If there were movements or activities during the session, a tape recorder cannot capture all the information; thus the fieldworker recorded the key issues that emerged in the session and other factors that may be important in the analysis and interpretation of the results (Liamputtong, 2011:63). The researcher made notes of important aspects of the focus group as soon as possible after the conclusion of the focus group, including CHWs' body language and emotional mood (Orcher, 2014:152).

- **Synthesising** involves “sifting data and putting pieces together” in order to make sense of what is typical regarding the CHWs understanding of their role in MCWH services (Sharma, 2014:316; Thorne, 2008:165-166). In this process the researcher merged various phrases to describe typical or amalgamated patterns within the data, allowing the significant data to be distinguished from the insignificant data.
- **Theorising** involves systematic sorting of data, developing alternative explanations of the typical patterns and hold this explanations to determine their fit with the data. Theorising continues to evolve until the best explanation is obtained and best guesses are developed (Sharma, 2014:316; Thorne, 2008:166). Additional questions were asked by the coder/s during this process, enabling the researcher to develop the best guesses about explanations received.

## **1.9 MEASURES TO ENHANCE CREDIBILITY**

According to Kuzel and Engel (*cited by* Thorne, 2008:221) it is essential that we have access to thoughtfully developed quality criteria to assist with both reading this kind of research and guiding the conduct thereof. This is based on the fact that the products of interpretive description are not inevitably accurate, relevant, or even socially responsible, and the knowledge deriving from them will be no more or less credible than knowledge derived from a range of alternative sources (Thorne, 2008:221). Credibility in qualitative research was enhanced by adhering to the following guiding principles:

### **1.9.1 Quality considerations**

According to Thorne (2008:222) position critique is a product of a review by someone of recognised authority rather than a method of comparison against some general evaluative standards. This view assumes the value of applying the critics “area of expertise” to the quality

judgement. The researcher as the district PHC clinical specialist with focus on MCWH has a recognised authority and broad knowledge of the research subject as both MCWH and PHC re-engineering are her main areas of expertise. In addition the adherence to methodological rules were of utmost importance as the researcher needed to derive actual and correct meaning out of the research findings (Thorne, 2008:223). Therefore careful documentation of all occurrences and findings was essential. Objectivity was enhanced by the study leader and an experienced co-coder in the data-analysis and interpretation of the research results.

### **1.9.2 Evaluation criteria**

According to Thorne (2008:223), the following general principles need to be applied when interpretive description findings are evaluated:

#### **1.9.2.1 Epistemological integrity**

For the findings of this study to be credible, the research process revealed a research question that was consistent with the epistemological standpoint and an interpretation of data sources and interpretive strategies follow logically from the research question (Thorne, 2008:224).

#### **1.9.2.2 Representative credibility**

According to Thorne (2008:224) study findings based on prolonged engagement with the phenomenon (in this study: CHWs) are more likely to afford credibility than those derived from more superficial engagement. Prolonged engagement was ensured through spending more time with the participants. Credibility in this study was enhanced through the taking of field notes by the fieldworker, voice recording of participants and reflection by the researcher.

#### **1.9.2.3 Interpretive authority**

Thorne (2008:225) suggests that in qualitative studies we need assurance that the researcher's interpretations are trustworthy, that they fairly illustrate some truth external to their own bias or experience. The researcher continued collecting data until no more new information emerged during focus group discussions, which was an indication that data saturation was reached (Klopper & Knobloch, 2010:319). Interpretive authority was enhanced by using multiple sources of data collection through digital recording, taking of field notes, reflection by the researcher, listening to voice recordings and reading through transcripts a few times. A true meaning was derived by integrating these different sources and honest analysis.

### **1.9.3 Beyond evaluation**

According to Thorne (2008:226), it has been pointed out by several critics that rigid adherence to textbook approaches in qualitative research can propagate weakness rather than strength in our research enterprises. The following evaluative standards were adhered to, in order to enhance research credibility of this study:

#### 1.9.3.1 Moral defensibility

According to Simmons (*cited* by Thorne, 2008:226) qualitative research within the applied practice disciplines aim towards knowledge that would eventually influence one or another form of practice. With the information extracted from participants during focus groups, there was clarity regarding the CHWs understanding of their role in relation to MCWH; which is likely to improve the performance of MCWH in Dr KK district. This was possible as CHWs obtained different views during focus group discussion and could identify ideas to implement in their electoral wards.

#### 1.9.3.2 Disciplinary relevance

Beyond the question of whether society requires the knowledge we seek, a critique of our research includes the issue of whether the knowledge is appropriate to the development of the disciplinary science (Thorne, 2008:227). This research was relevant because it allowed the researcher to come up with recommendations that are likely to improve community access to services and can also have a positive impact on MCWH performance in the Dr KK district.

#### 1.9.3.3 Probable truth

According to Thorne (2008:230), we conclude the full circle in our search for truth standards at the portals of moral defensibility, disciplinary relevance and pragmatic obligation. Certain kinds of knowledge claims, that appear to meet our very best truth criteria, may in the end prove untrue (Thorne, 2008:230), thus the researcher conducted this research not to find the truth, but to create meaning.

In the follow section the ethical considerations applicable to this research are outlined.

## **1.10. ETHICAL CONSIDERATIONS**

The importance of adherence to ethical considerations when conducting a research study is outlined in the NDoH research ethical guidelines (2015b:3). Ethical consideration was important to ensure that the research study was conducted in a responsible and ethical manner.

Permission to conduct research was obtained from the Health Research Ethics Committee (HREC) of the Faculty of Health Science and from the North-West University (See Addendum B), followed by the Policy and Research committee of the North West Provincial Department of Health (See Addendum C). Permission was also obtained from Dr KK District management. Goodwill permission was obtained from the WBOT leaders to act as gatekeepers with a role change to mediators before data collection started. CHWs within WBOTs were given an opportunity to deliberate on issues before they could make an informed decision to participate in the study. No deliberate harm was inflicted on any CHW.

### ***1.10.1 Ethical norms and standards of the study***

The ethical norms and standards that were applicable to this study are outlined in the paragraphs below.

#### **1.10.1.1 Relevance and value of research**

The relevance of this research study is outlined in the background and problem statement sections of this chapter. The study contributed to identify gaps in rendering MCWH services by CHWs in their electoral wards and the impact thereof on MCWH in Dr KK District. Suggestions to improve MCWH services were derived from the Dr KK district management and OTLs.

#### **1.10.1.2 Scientific Integrity**

The scientific integrity of this study was built into the study's design and methodology (DoH, 2015b:16) (see this Chapter, section five (5): Research Design and six (6): Methodology for detail). Thorne's interpretive description design was chosen as the researcher wished to generate methodological options to do justice to the primary health care clinical question that intrigue the researcher (Thorne, 2008:18). Thorne's interpretive descriptive design was likely to result in reliable and valid data and potential exposure to risk was medium, as the study involves health care workers.

#### 1.10.1.3 Role player engagement

The success of this study depended especially on the roles of the WBOT leaders to act initially as gatekeepers, with a delayed role change to mediators, the CHWs as participants who would be willing to share their opinion in a focus group discussion, and the researcher, study leader and co-coder of this study (DoH, 2015b:15). The researcher engaged the gatekeeper/mediator, participants, study leader, co-coder staff and management of the Dr KK District throughout the process by means of obtaining consent, providing information about the research study and by providing the necessary training to the WBOT team leaders to enable them to act as gatekeepers. Goodwill permission was obtained from team leaders who initially acted as gatekeepers and whose roles afterwards changed to mediators. The CHWs were informed about the research study by means of a Power-Point presentation and were given 24 hours to decide whether they would like to participate or not. This was done to ensure that the research project was acceptable to the relevant stakeholders.

#### 1.10.1.4 Favourable risk benefit ratio

The risk level for this study was estimated to be medium as some participants can be nervous to share their opinions in front of the group; there could also be minimal emotional discomfort that could occur during focus group discussions, as they were likely to “expose” each CHWs level of understanding of his/her role in rendering MCWH services. If this occurred, the researcher led the discussion by emphasising that there were no correct or wrong answers, as each individual has a unique opinion. If emotional discomfort became evident the researcher could also suggest a tea break to do some small talk and let participants feel at ease. The researcher had an agreement with the participants not to disclose information that was discussed within the group to people outside the group. There was a likelihood that all CHW within the WBOT would benefit from understanding their role and how their activities impact on MCWH services in Dr KK District. The indirect benefit for the participants was that they could identify whether they were at par with their colleagues in relation to their understanding of their role in rendering maternal, child and women’s health services. Refreshments were made available after focus group discussions. The researcher requested goodwill permission from the PHC managers of the four sub-districts to conduct the focus groups within working hours; thus there was no need to pay the CHW for working overtime. Based on the CHWs understanding of their role and its impact on the MCWH services, the sub-districts within Dr KK District benefited through having informed CHWs seeing clients at home and improving the MCWH indicators.

The following was given to a CHW as a token of appreciation for their contribution:

- An airtime voucher of between R10 and R15, depending on the service provider the CHW uses, was provided to each, at the end of the focus group.

The agreed-upon interview schedule was respected and adhered to by the researcher; and the researcher ensured that all participants got a chance to voice their opinion. The researcher verbally shifted attention from the dominant talkers by using statements like “That’s one point of view” or “let’s hear what others have to say” (Krueger & Casey, 2009:100). The researcher encouraged shy participants to talk by making direct eye contact. The researcher encouraged them to talk through statements like “X, I don’t want to leave you out of the conversation. What do you think?” (Krueger & Casey, 2009:100).

#### 1.10.1.5 Fair selection of participants

The participants were selected fairly and were not targeted unfairly. The population and the process of sampling have been clearly outlined in this chapter, (see section 6.1: Population and sampling). Purposive sampling was applied in order to obtain participants that would provide rich data. The exclusion criteria was solely based on CHWs who are not engaging in the activities as required by PHC Re-engineering e.g. those in the Mentor Mother programme (see exclusion criteria).

#### 1.10.1.6 Informed consent

A cover letter detailing an informed consent was formulated (see Addendum A). Letters to request participation and giving of consent were written to prospective participants to explain the research topic, the objectives of the research, as well as the researcher's expectations of their role. They were also informed about their voluntary participation, as well as their right to withdraw at any stage of the research process without any consequences whatsoever. Two informed consent documents were given to participants after attending the research information presentation. The participants were informed that they have 24 hours to decide and if they decided to participate in the study they could sign both consent forms in the presence of a professional nurse who would act as an independent person. The participant kept one consent form and gave one to the team leader who sent it to the district office in an envelope addressed to the researcher.

#### 1.10.1.7 Respect, privacy, anonymity and confidentiality

The respect, privacy, anonymity and confidentiality (NDoH, 2015b:17) applied in this study are discussed throughout but more specifically in the Data management section of this chapter. By using a gatekeeper in the recruitment of participants, the researcher ensured that no CHW felt obliged to participate in the study. The researcher ensured **privacy, confidentiality and anonymity** of all of the participant's information (see 7.5 data management). Participants participated in the focus group with a participant number and the researcher asked questions and identified the participant's number instead of using their names (NDoH, 2015b:14-17). All members of the research team that require access to data also signed a **confidentiality agreement** (fieldworker, co-coder and transcriber) (NDoH, 2015b:14).

The researcher informed participants that confidentiality cannot be guaranteed as information would be shared in each group (partial confidentiality). The importance of maintaining confidentiality was emphasised in a group. The researcher managed collected data in such a way that only researchers involved in the study has access to it. All collected raw data and transcripts are kept in a locked cupboard. The computer that was used for the research purposes is password protected (NDoH, 2015b:14).

#### 1.10.1.8 Researcher competence and expertise

The researcher works as a District Primary health care clinical Specialist, focusing on MCWH in Dr KK district. The researcher conducted a course and was found to be competent in her research methodology theory for Masters in Nursing Science. The researcher had undergone research ethics training in April 2016. The study was supervised by an experienced study leader who has also been part of a larger international research programme dealing with quantitative and qualitative methods for three years. The study leader attended a research internship in Kenya offered by the Canadian Institute for Health Research in 2009. The study leader specialises in PHC and has kept up to date regarding the PHC re-engineering as a new NDoH initiative and method of rendering PHC services at community level in South Africa. The WBOTs are one of the three streams of Primary Health Care re-engineering. The co-coder is an experienced qualitative researcher. The dissertation outline is provided under the next section.

### **1.11. OUTLINE OF STUDY**

Chapter 1: Overview of the study

Chapter 2: Research design and methodology

Chapter 3: Research results of study supported/compared with literature control

Chapter 4: Conclusion, recommendations and limitations

### **1.12 SUMMARY**

Chapter 1 provided an overview of the research study. The researcher motivated the background and the research problem. The problem statement was formulated as well as the research question, aim and objective of the research. Theoretical departure point of the study was outlined as well as key definitions. The reader was introduced into the research methodology and ethical considerations were discussed in detail. In the next chapter the researcher will discuss the research methodology in more detail.

**CHAPTER 2**  
**RESEARCH METHODOLOGY**

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## **2.1 INTRODUCTION**

In the previous chapter an overview of the research study was provided. In this chapter the research methodology will be discussed. Research methodology includes the research design and method used in this study. It starts by explaining the role of the researcher, meta-theoretical assumptions, theoretical statement, and methodological assumption. The research design and methods used including the study population and its eligibility criteria, sample size, sampling technique used, recruitment process, data collection method used, data analysis methods and ethical considerations.

This research can be classified as a health systems research. A health systems research explores how people get access to health care practitioners and health care services and what happens to the patients because of this. According to Thorne (2008:44) a good measure of what is worth studying is that which has relevance and utility to the mandate that has been granted to the discipline, in this study MCWH health services. Due to high maternal and child mortality rates in South Africa, the Minister of Health has announced maternal, child and women's health a priority for the Department of Health; thus the topic of this research. The objective for this study was to explore, interpret and describe the CHWs understanding of their role in rendering MCWH services in their electoral wards, in order to derive recommendations which can be implemented in line with current guidelines to improve MCWH services at grass root level.

## **2.2 THE ROLE OF THE RESEARCHER**

The role of the researcher began with the identification of a problem as identified in literature which contributed to meaningful research and in determining an appropriate research question, aim and objective of the study. The researcher then developed a comprehensive research framework which guided the execution of research in practice (Brink, 2006:24). The correct methodology to be used was decided on, see chapter 1, section 1.5 and 1.6. The methodology assisted the researcher to conduct the research in a scientific and ethical way with the purpose to reach the aim and objective of the research study. The aim of this study was to explore, interpret and describe the understanding of CHW's with regard to their role in rendering MCWH services within WBOTs, in order to derive recommendations which can be implemented in line with current guidelines to improve MCWH services. The context of the research study was all the sub-districts in the Dr Kenneth Kaunda district (Dr KK District) and due to the qualitative nature it cannot be generalised to other Provinces. The current employment position of the researcher at the Department of Health makes the researcher's contribution to this study

unique; Botma *et al.* (2010:212) suggest that it is important that the researcher should have adequate theoretical and practical knowledge of the topic under investigation, in order to place comments in perspective and follow-up on critical areas of concern. The researcher focuses on enhancing MCWH performance within the Department of Health (DoH). The researcher is well grounded in PHC services and the roll out of re-engineering programs. In the next paragraph the researcher introduced meta-theoretical and theoretical assumptions applicable to this study.

## **2.3 RESEARCH STUDY ASSUMPTIONS**

In the paragraphs below, the paradigmatic perspective of the researcher and the theoretical departure point of the study are discussed.

### ***2.3.1 Meta-paradigmatic assumptions***

Assumptions are beliefs held by the researcher that are implied or explicit and instinctive. According to Talbot (*cited* by Botma *et al.* 2010:106), assumptions are accepted as truths without proof or empirical evidence as it is stated from the view of the researcher. Certain kinds of knowledge claims that appear to meet our very best truth criteria may in the end prove untrue (Thorne, 2008:230), thus the researcher conducted this research not to find the truth, but to create meaning. The following were the assumptions that the researcher had about the following categories of people involved in this research:

- **Community Health Workers:**

According to Burch, 1989; Cohen, 1987 and Giorgi, 1970 (*cited* by Thorne, 2016:32), the most basic human truths are accessible through deep understanding of human subjective experience. CHW's were the participants in this study and they had "lived the experience" through providing maternal, child and women's health services at community and household level. CHW's during their home visits are expected to identify mothers and children that need to be referred to the clinic, thus preventing complications before they happen. The researcher's focus was on how CHW's render MCWH services in their respective communities. Before commencement of the study, the researcher assumed that the targets for some of the MCWH indicators (e.g. Post-natal visits within 6 days) were not met because CHW's do not understand what their role is in relation to MCWH services.

- **Mothers:**

The researcher viewed mothers as pregnant women and those that have delivered, with babies and children up to 5 years of age. The researcher viewed most mothers as not caring for their offspring e.g. that they are not taking their sick babies to the PHC facilities as soon as possible

because they did not get adequate health information from the CHW's. The bigger portion of mothers that the CHW's are normally attending to, have a low level of literacy, which makes it even more important for them to have access to PHC facility services.

- **Children:**

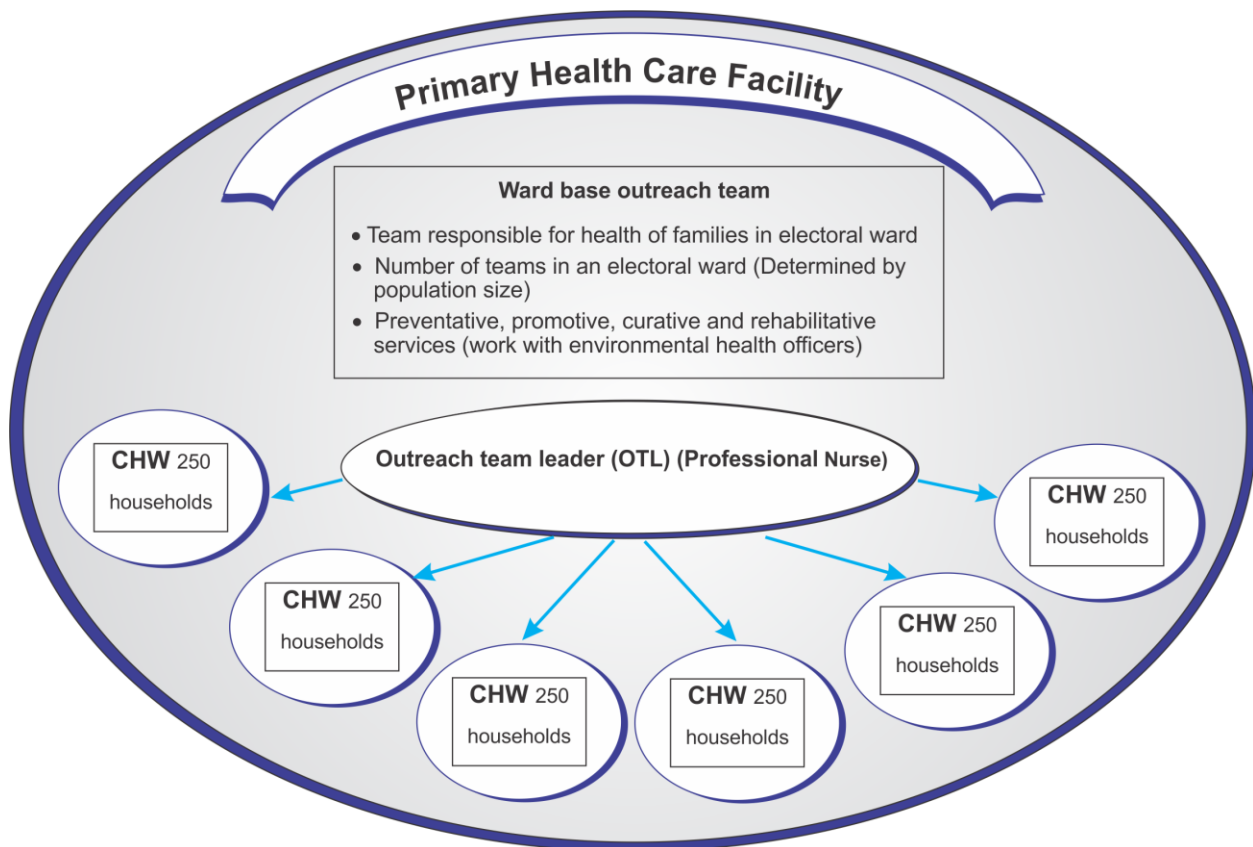
The researcher focused on services provided to children up to the age of 5 years. The researcher sees children of this age as the most vulnerable to childhood diseases like malnutrition, diarrhoea and pneumonia. The consistent high malnutrition incidence rate of children under 5 years at Maquassi Hills sub-district, led the researcher to assume that the CHW's are failing to identify underweight children and thus do not refer them as necessary.

- **Outreach Team Leaders:**

The outreach team Leaders are supervisors of CHW's. They are Professional nurses that would visit a household to follow-up on clients that are beyond the CHW's scope of management. They would further assist the CHW's to get through to clients that are not cooperating.

### ***2.3.2 Theoretical assumptions***

Theoretical assumptions are reflections of the researcher's view of valid knowledge which can be based on theories, conceptual frameworks or models. In this study the researcher departs from an existing re-engineering framework which was adopted by the NDoH (NDoH, 2011:2). The theoretical assumptions are epistemic in nature and are subject to testing with the intension of clarifying the research question, aim and objective. The conceptual framework, which this study is based on, is outlined in Chapter 1 (see section 1.4). WBOTs is the liaison between community based services and PHC services. Services are rendered at community base level and every WBOT is linked with a PHC facility. The DoH have many priority programs of which MCWH services is one which aims to reduce maternal, child and women's morbidity and mortality rates. Due to low performance in reaching set targets the researcher was intrigued by the question "Do CHW's really understand their role in rendering MCWH services in their respective communities". In figure 2.1 an example of a WBOT linked to a PHC facility is depicted as currently rolled out in an electoral ward.



**Figure 2.1: Ward Based Outreach Team, OTL, CHW's and households linked with PHC facility (Developed by researcher for clarity purposes)**

### **2.3.3 Methodological assumptions**

Methodology is the science of determining the design and method to ensure scientific investigation (Babbie, 2010:4). Methodological assumptions are based on science-philosophy and direct the researcher what is the most suitable design to address the research question (Klopper, 2008:67). The researcher premise for this study is the phenomenology claim. According to Newell and Burnard (2011:111), phenomenological research is concerned with how individuals view the world and how they live their lives, from inside. According to Burch, 1989; Cohen, 1987 and Giorgi, 1980 (*cited by* Thorne, 2008:29) phenomenology holds as a central value the premise that the most basic human truths are accessible through the understanding of human subjective experience. Phenomenology would ask questions such as what is the essence of experience of this phenomenon for these people; thus the best-suited approach to this particular research study came from the phenomenological perspective. LoBiondo-Wood and Haber (2006:132) see the goal of qualitative methods as to view the real world in the same way as those people with lived experience, in this study the experiences and perceptions of CHW's.

## **2.4 RESEARCH DESIGN**

The research design is a framework or specific plan used to meet the stated purpose of the study (Schmidt & Brown 2012:144). According to Creswell (2012:246), qualitative research is a means of exploring and understanding the meaning individuals or groups ascribe to a social or human problem. A good design is likely to assist the researcher to avoid bias whilst collecting data. Based on this reason, the interpretive descriptive design as a qualitative method was appropriate for this study. Chan *et al.* (2010:19) found that interpreting each participant's concern within each contribution as the best way to understand everyday practices; thus bracketing was used by the researcher. Bracketing refers to putting 'brackets' around the researcher's beliefs in order to put aside and visualise the experience from the CHW's viewpoint (LoBiondo-Wood and Haber, 2006:141). The facilitator of the focus group controlled researcher bias by not having the researcher's own personal beliefs influencing the study. Another technique to prevent bias was done by means of intuiting. Intuiting provides a momental perception of truth without conscious attention or reasoning (Schmidt & Brown 2012:6). Intuiting can also signify experience-based situation recognition, which can lead to early warnings of impending complications (Chan *et al.*, 2010:121). This was applied as the researcher remained open throughout the process of data collection.

### **2.4.1 Explorative Interpretive Descriptive design**

Thorne (2008:35) views explorative interpretive description as a way of naming and referencing the kind of well-founded logic that clinical researchers have been coming up with in many of the most highly respected applications of qualitative research within the health domain. The term "explorative" is used because descriptive designs are used when little is known about a phenomenon, thus exploration is required (Schmidt & Brown, 2012:176). With an interpretive+ approach it is important that we get assurance that the researcher's interpretations are credible and fairly illustrate truths external to their bias (Thorne, 2016:235). Thorne (2016:57) further suggests that interpretive description has an inherent value as it carefully and systematically analyse a phenomenon. A descriptive design describes in detail the phenomenon of interest without manipulation of any of the variables (Schmidt & Brown, 2012:176). According to Thorne (2016: 54) the term "description" is used to explain studies whose purpose is documenting something that one observed; and for the health field, description is important in making colleagues aware of the phenomena under study. A qualitative interpretive descriptive design was chosen because it could assist the researcher not to only give a "pure" description, but rather seek to discover associations, relations and patterns of the CHW's experiences and vision with regard to their role in rendering MCWH services (Thorne, 2008:50). This research

design assisted the researcher to search and integrate information about the role of CHW's using her reflective clinical reasoning skills which resulted in a deeper appreciation towards what ultimately became the optimal clinical response (Thorne, 2008:50).

Advantages or strengths of an explorative interpretive descriptive design

- This approach has the ability to uncover, highlight, articulate and bring recognition to embedded qualitative aspects of practice that are not apparent from a quantitative perspective (Chan *et al.*, 2010:114)
- Interpretive phenomenology fills gaps in understanding that are left by rational-empirical science research approaches and offers us plausible insights that brought us in direct contact with the lived world, engaged activities, concerns, embodied know-how and understanding (Plager 1994; van Manen, 1990) as cited by Chan *et al.* (2010:XX1)

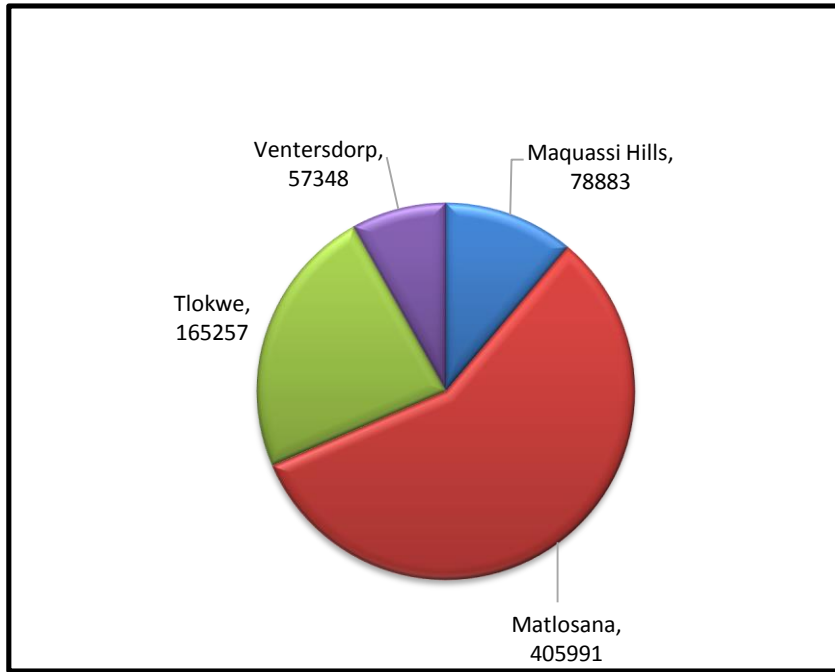
Disadvantages of an explorative interpretive descriptive design

- The major disadvantage of an explorative interpretive descriptive design is the inability to establish causality or the relationship between cause and effect (Schmidt & Brown, 2012:176). Sandelowski (*cited by Thorne, 2016:54*) has depicted descriptive research as the least valuable form of qualitative research.

To understand the context of the study an overall description of the context parameters is provided in the following section.

#### **2.4.2 Context of research area (Dr Kenneth Kaunda district)**

The Dr Kenneth Kaunda District is situated in the North West Province and its neighbouring districts are Dr Ruth Segomotsi Mompoti to the west, Ngaka Modiri Molema to the north, and Bojanala to the east. It covers geographically 14,767 square kilometres. The Dr Kenneth Kaunda District consists of four sub-districts i.e. Matlosana, Tlokwe, Maquassi Hills, and Ventersdorp. Two sub-districts are classified as rural (Maquassi Hills and Ventersdorp) and two are classified as urban (Matlosana and Tlokwe). The District has a total population of 707 479, of which 76% is uninsured, meaning that they are dependent on public health services (DHP, 2015/16:18). Of the total population of Dr Kenneth Kaunda District 196 184 are females 15 to 49 years of age, who are classified as child-bearing age by the NDoH (DHP 2015/16:19) and 63 961 are children under five years of age.



**Figure 2.2 Graphical presentation of population distribution among the Sub-Districts for Dr Kenneth Kaunda District, DoH (Dr Kenneth Kaunda District Health Plan 2015/16:19)**

The area covered by Dr Kenneth Kaunda District appears on the map below with depicted different sub-districts involved in this study (Figure 2.3).



Figure 2.3 Sub-districts of Dr Kenneth Kaunda district ([www.municipalities.co.za](http://www.municipalities.co.za))

## 2.5 RESEARCH METHODS

### 2.5.1 Population

North West province was selected purposely for its consistently high maternal mortality rate and increasing neonatal mortality rates, as outlined in the introduction and background (See chapter 1, section 1.6.1). Dr Kenneth Kaunda District was a district of choice as it comprised of two rural and two urban sub-districts.

The study population comprised of all CHW's working in Dr Kenneth Kaunda District (N=596). The (N) refers to the target population and the (n) refers to the actual population that participated in the focus group discussions. The target population is allocated to four (4) sub-districts; namely Ventersdorp (N=61; n=16), Tlokwe (N=168; n=13), Matlosana (N=281; n=14) and Maquassi Hills sub-district (N=86; n=13). Two focus groups were conducted in each sub-district. The eligibility criteria were as follows:

### 2.5.1.1 Inclusion Criteria

The inclusion criteria (Brink *et al.*, 2012:313) were as follows: The participants were:

- willing to give voluntary informed consent (see Addendum A) to participate prior commencement of the study
- Willing to be recorded on a digital recorder
- A CHW within a WBOT for at least six (6) months. This was to ensure that the CHW has had enough experience working with MCWH services in order to obtain relevant and rich data
- In a WBOT linked to an identified PHC facility in Dr KK District, meaning that the CHW should have reported every morning at a specific PHC facility and provided feedback to the WBOT leader about the previous day's activities and referrals, recorded actions and discussed the home visits that needed to be done for the day.
- Able to communicate in English. The entry requirement on recruitment of CHW's is that they possess Grade ten (10) and are able to speak and understand English as it is the language of instruction for the CHW course offered by sub-districts. The focus groups were conducted in English
- Open and willing to share their experience within a focus group as only agreed confidentiality could be ensured in a focus group.

### 2.5.1.2 The exclusion criteria

The exclusion criteria (Brink *et al.*, 2012:313) was all CHW's whose focus was more community health work, e.g. those that were conducting the mentor mother programme. The mentor mother programme model is a sustainable peer-based model established in 2001 and implemented within PHC facilities for PMTCT education and psychosocial support.

## **2.5.2 Sampling**

The population was CHW's that met the criteria and were willing to participate voluntarily in the study; cluster sampling was applied in order to group potential participants according to sub-districts. Thorne (2008:90) advocates for purposive sampling as specific individuals are recruited by virtue of some angle of the experience that they might help us to better understand. From these groups, random purposive sampling technique was applied using the name lists provided by the Outreach Team Leaders (OTLs) who know which CHW's fulfil the inclusion

criteria in each sub-district. This assisted the researcher to determine participants for the first and the second focus group members in each sub-district. Each sub-district had two (2) focus groups, thus a total of eight (8) focus groups were conducted in Dr Kenneth Kaunda District.

#### 2.5.2.1 Recruitment of participants and ethical issues related to sampling

The researcher started by presenting the research study aim, objectives, methodology and the manner in which results will be used to the Outreach Team Leaders (OTLs). The OTLs informed the CHW's about the research and provided the researcher with a name list of those that showed interest in participating. The researcher did a power point presentation at sub-district level to all CHW's that showed interest in the research. This was done so that all interested CHW's receive information and not only those that were purposely selected by the OTLs. They were further informed about the importance of voluntary informed consent and agreed confidentiality between focus group members were emphasised. The CHW's were informed that confidential information about participants will be protected and will not be shared with people that are not supposed to have access to it (Brink, 2006:35; Thorne, 2016:132). The CHW's were informed that the study would be used for scientific purposes and the results thereof may be published. After the information session the researcher provided each interested CHW with 2 informed consent forms for consideration. They had 24 hours to decide whether they would like to participate and then they handed their signed informed consent forms to the OTL of the PHC facility that they are linked with. The OTLs role then changed from gatekeeper to mediator as they explained the informed consent again to CHW's and clarified any queries.

#### 2.5.2.2 Sampling size

According to the departmental records, the total number of CHW's within WBOTs in Dr Kenneth Kaunda District at the time of data collection was 596. The amount of 5 (five) to 8 (eight) participants are sufficient for a homogenous group according to Kuzel 1999 (*cited by Thorne, S 2008:95* and Krueger & Casey (2009:67). The planned sample size for the study was a minimum of 8 focus groups consisting of 8-10 participants to make provision for non-attendance in unforeseen circumstances. Focus groups continued until data saturation was reached. Saturation is a term used to describe the point where you have heard the range of ideas and aren't getting any new information (Krueger & Casey, 2009:21). A total number of 8 (eight) focus groups consisting of a total of 56 participants were conducted. Table 2.1 below illustrates the number of participants and focus groups conducted in each sub-district.

**Table 2.1 Breakdown of focus groups and participants per sub-district**

	Name of sub-district	Targeted Focus groups	Focus groups conducted	Total number of participants
1	Ventersdorp sub-district	2	2	16 (8 + 8)
2.	Tlokwe sub-district	2	2	13 (5 + 8)
3.	Matlosana sub-district	2	2	14 (9 + 5)
4.	Maquassi Hills sub-district	2	2	13 (8 + 5)
	<b>Total number</b>	<b>8</b>	<b>8</b>	<b>56</b>

### 2.5.2.3 Establishing contact with participants

To ensure that the focus groups proceeded properly, the researcher secured and verified with the participants venues with adequate space and minimal disturbance. The researcher also verified the availability of the necessary equipment such as the digital recorder, extra batteries, pen, writing pad, and confirmed that all was in order the day before the set focus group date. Confirmation was further sought from OTLs to confirm their readiness for their designated roles. The OTLs had already given goodwill permission to act as “gatekeepers” and later as “mediators”.

The establishment of contact with selected participants began with the focus group session. The researcher introduced herself, verbally reviewed the purpose of the study, and read the consent form to the participants in order to verify their willingness to participate.

### **2.5.3 Data collection**

In the following section the steps followed with data collection is explained.

#### 2.5.3.1 Data collection process

Permission to conduct this research was granted by NWU HREC (NWU-00022-17-A1) in August 2017 and NWDoH (see addendum C and D). The data was collected between September and October 2017 by the researcher and the field worker. The focus group sessions were held in at PHC facilities in a private room. The participants were put at ease through “small talk” before the focus groups started. The researcher facilitated the discussions whilst

the co-facilitator took field notes of the discussions. Permission was sought from participants to have the conversation digitally recorded. The researcher used a digital recorder to capture the discussions. The digital recorder was placed in a conspicuous area to avoid distracting participants (Botma *et al*, 2010:214).

#### 2.5.3.2 Data collection approach and method

The question when deciding on a data collection method is “what is the most appropriate method of collecting data that will help the researcher to answer the research question or achieve the research aim?”(Newell & Burnard, 2011:71). A focus group method of data collection was used in this study. A focus group is a semi-structured group session, facilitated and moderated by the researcher a group leader, held in an informal setting, with the purpose of collecting information on a designated topic (Carey, 1994:226) *cited* by Speziale & Carpenter (2007:38).

According to Liamputtong (2011:5), focus groups as method of data collection are useful in exploring and examining what people think, how they think, and why they think the way they do about the issues of importance to them without pressuring them into making decisions or reaching a consensus. The one point where a focus group can be helpful is to evaluate after a programme is up and running (Krueger & Casey, 2009:9). CHW’s form part of the Ward Based Outreach Team programme which is up and running, and fairly new within the DoH.

- **Conducting focus groups**

Training on how to conduct focus groups was provided to the researcher by the study leader; that was done through role-play. After the first focus group was conducted, the study leader listened to the voice recording together with the researcher and discussed ways to improve. The study leader also advised the researcher on which other techniques could be used e.g. probing or paraphrasing to obtain rich information (Brink, 2006:153). Participants ranged from five (5) to nine (9) per focus group due to unforeseen circumstances. As suggested by Krueger & Casey (2009:105), the researcher continued with the focus groups and kept on capturing the researcher’s reflection as soon as possible after the focus group, reading through field notes and listening to voice recorders. This was done so that the researcher could get an idea of which themes and sub-themes emerged. All conducted focus group sessions were small enough for everyone to have an opportunity to share insights and yet large enough to provide diversity of perceptions (Krueger & Casey, 2009:6).

All focus groups were conducted at PHC facilities in private rooms as the previously sub-district booked boardrooms became unavailable for various reasons. The researcher arrived earlier than the participants at the applicable PHC facility to ensure minimal distractions and to have time to improvise if it was necessary (Krueger & Casey, 2009:105). At the beginning of each focus group session the researcher explained to the participants that their names will be kept confidential and will not be disclosed on any written material. The researcher emphasised to participants that the data that is collected will only be used for the intended purpose as explained during introduction of the research study. The purpose was to make sure that the CHW's understood that the information collected will not be used to determine the extension or termination of their contracts. There is currently a constant prevailing threat that the contracts of CHW's might not be extended by the DoH at the end of the current year.

The researcher reminded participants that they are free to withdraw from the study at any time, and that they will not be penalized for withdrawal. The researcher went through the informed consent form with the participants to make sure they understood every detail of it. Papers with any number from 1 to 10 were distributed to participants; such numbers were used to identify each participant to avoid using names of participants. This strategy also added in making participants comfortable to share their views as they felt it cannot be known who made which comment.

As most participants have a medium level of English literacy, and some were worried about expressing themselves in English, the researcher explained to participants that she is not expecting "perfect English". The researcher only needs them to try and put their thoughts across in such a way that it will be understood. An obvious relief was observed from participants in different focus groups after this statement.

The researcher reminded the participants that she will be digitally recording the interview sessions, as she will not be able to remember their inputs if not recorded. The researcher made participants aware when she would start recording the conversation. The researcher introduced herself again on record and allowed the participants to introduce themselves. In order to make it easy for the participants, the researcher drafted a guide for them on paper to remind them not to mention their names or names of PHC facilities they are attached to. The researcher informed the participants that she will ask a question, and any participant can raise a hand to answer the question. The participants were advised to wait for the researcher to call the participant's number before they can respond. The researcher probed further on some of the answers in order to get more information. To confirm that the researcher understood what the participant was saying, the researcher would summarise or follow-up with a clarity seeking question when

necessary, as suggested by Botma *et al* (2010:213). After the last question was answered, the researcher asked whether there is any participant who wants to add anything that is related to the questions that were asked.

At the end of the focus group session the researcher thanked the participants for their participation and availing themselves for the focus group session (Greeff, 2005:301 *cited by* Botma *et al.* 2010:213). The focus group sessions ranged from 55 minutes to 62 minutes. The researcher provided each participant with a snack; either a fruit or cake at the end of the session. As a token of appreciation, the researcher gave each participant a cell-phone airtime voucher of R15 or R12, depending on the service provider used by each participant. The incentive was given in order to communicate to the participants that their contribution was appreciated and important (Krueger & Casey 2009:77).

- **The advantages of a focus group**

It allowed for collection of a large amount of rich data, based on the multiple responses that the researcher obtained on the topic during focus group discussions. According to Speziale & Carpenter (2007:39), focus groups are more useful when the topic of enquiry is considered sensitive.

With a focus group, the researcher has the opportunity to meet distinct individuals with some experiential knowledge about a phenomenon, and see what happens when they engage in interaction with one another (Thorne, 2008:131).

Newell and Burnard (2011:80) suggest that focus group method of data collection allows for economical use of time through creating a platform where a large amount of data can be obtained in a short space of time.

- **The disadvantages of a focus group method:**

The major disadvantage of a focus group is *groupthink*, a process that occurs when stronger members of a group or segments of the group have major control or influence over the verbalisations of other group members (Carey & Smith, 1994) *cited by* Speziale & Carpenter (2007:39) and Newell & Burnard (2011:80). The researcher ensured that each participant had the opportunity to contribute to questions ask as explained in chapter 1, section 1.7.1.

### 2.5.3.3 Characteristics of effective focus group discussions

To gain a detailed depiction of the participants' perspectives regarding the understanding of their role in rendering maternal, child and women's health services, the researcher conducted

focus group discussions, each lasting more or less one hour. These focus groups were semi-structured and digitally recorded. In health, research questions derive from the universe of clinical problems for which the available knowledge is not yet sufficient (Thorne, 2008: 37)

- **Role of the researcher as focus group facilitator**

Thorne (2008:125) states that the goal with data collection is figuring out an appropriate and defensible means by which to get as close to that subjective experience as you reasonably can, so that you have a high probability of being able to access the kind of material that will allow you to answer your research question. The researcher's aim was to obtain spontaneous, specific, relevant and rich data. Broad-based set interview questions assist the researcher to focus the group member's attention to the question asked and using techniques to enhance the quality of data obtained (Thorne, 2008:133). In cases where there was a need for the researcher to follow up and clarify meanings of some aspects, the researcher asked the participants to elaborate on areas of non-clarity. The researcher always verified the interpretations of the participants' answers during the course of the focus group discussion. The questions asked during the focus group sessions were short, open-ended and clear enough so that they could not be interpreted in different ways by participants (Krueger & Casey, 2009:37)

The researcher tried to be absolutely neutral during focus group discussions. With neutrality the researcher tried not to affect the CHW's perception of a question or answer, or lead them in any way to give a certain answer. The researcher did not communicate, by word or gesture, an own opinion. If the researcher had not been neutral and had influenced the participants in any way, the data obtained would have been biased (Botma *et al.*, 2010:85) and could have led to wrong interpretations during data analysis.

- **Appearance and demeanour**

The interviewer and field worker dressed in such a way that their appearance was on a level similar to that of the participants interviewed with respect to dress and grooming i.e. as the CHW's do not earn much and are thus not in a position to be richly dressed, the researcher dressed as simple as possible, but yet professional. Dress and grooming are typically regarded as signs of a person's attitudes and orientations.

With regard to demeanour, the interviewer remained pleasant at all times in order to make participants comfortable. The researcher needed to pry into the participants' understanding of their role regarding MCWH services. This form of questioning could be experienced negatively by CHW's as there is a constant threat that their contracts might not be extended. They could

have seen the research as a way of deciding whose contracts should be terminated. It was therefore important for the researcher to make sure that participants feel secure about the topic (Schmidt & Brown, 2012:237). The researcher achieved that by not allowing any other category of personnel to form part of the focus groups or to sit-in during the focus group session. The researcher explained the purpose of the study again before the beginning of the focus group session.

- **Researcher should be familiar with the questions**

If a researcher is not familiar with the set questions, the data richness is likely to suffer. The focus group discussion is likely to take more time, so thorough preparation was of the utmost importance. The researcher needed to know the main aim of the research, the set questions and applicable probes that could be used to elicit rich qualitative information (Babbie, 2010:276).

- **Following question wording exactly as they are set**

Interview questions were formulated in such a way that the participants' opinions were obtained. The danger in not following question wording exactly is that it may lead a respondent to answer with a simple yes or no, which immediately changes the question nature from open-ended to closed-ended. If the researcher changes set questions from focus group to focus group, the analysis of data will be compromised as comparisons between focus groups cannot be made (Krueger & Casey, 2009:60).

- **Recording responses exactly**

Recording responses exactly is very important because the researcher does not know how the responses will be coded at that stage of the focus group discussion. For this study, digital voice recorders were used and a transcriber compiled an exact transcription from what was said during the interview. The second control over exact wording was the researcher, as every interview transcript was compared with the audio version and words filled in that the transcriber could not identify.

- **Probing for responses**

A probe is a technique the interviewer uses to elicit a more complete answer to a question. It is a non-directive phrase to encourage the participant to elaborate on an answer, e.g. "can you tell me more"? Probes are more frequently required in eliciting responses to open-ended than closed-ended questions. It is important to keep in mind that probes should be neutral and not

lead the participant in a specific direction. Krueger and Casey (2009:56) advise on being cautious when giving examples as they also limit the critical thinking of participants.

- **Scheduling focus group sessions**

The researcher made appointments and indicated to participants the average time required for the focus group discussion. The researcher, through working with Outreach Team leaders, identified the dates, times and places that will be convenient for participants, whilst they don't conflict with activities or functions of the CHW's (Krueger & Casey, 2009:75). That gave the participants the opportunity to schedule their activities. Researcher punctuality is of the utmost importance to prevent that participants become irritated.

- **Use of digital voice recorders**

The researcher is a novice, thus she needed some practice on how to use the digital recorder and how to up-load the voice recording after the focus group discussion. The study leader provided the necessary training in this regard. The training assisted the researcher to be confident to use the digital recorders during focus group discussions. Permission to record the focus groups was sought from participants through the voluntary informed consent form which each participant signed and handed in to their Outreach Team Leader. At the beginning of the focus group session, participants were reminded again of the need to use the digital recorder. The digital recorder was placed in a conspicuous place as it could distract both the researcher and the participants (Botma *et al*, 2010:214)

- **Communication skills**

Schmidt and Brown (2012:420) define communication as "a process in which participants create and share information with one another in order to reach a mutual understanding". The researcher must be able to communicate clearly. The researcher refrained from rushing into deviating from the question route by re-phrasing the questions when the participants took too long to respond. The rephrased question might sound like a different question to participants (Krueger & Casey 2009:87). During the focus group discussions the researcher used communication techniques that are effective in establishing trust and rapport with the participants. Krueger and Casey (2009:99) further suggest a 5 second pause rule, followed by probing. The five (5) second pause is often used after a participant's answer whereas probing requests for additional information. As suggested by De Jong and Berg (2008:21) the researcher listened attentively to participants in order to hear their comments without filtering it

during the focus group session as it could lead to bias as every researcher had a frame of reference.

Data was obtained with the use of different methods, i.e. data was obtained from participants through focus group discussions, field notes and the researchers reflection just after the focus group was done, but with the integration of the results during data analysis one can either note the convergence of the findings as a way how all these methods contributes to the richness of the data (Thorne, 2008:133).

#### 2.5.3.4 Ethical considerations related to data collection

Voluntary informed consent was obtained from all eligible prospective participants in order to protect the rights of the participants. Permission to have focus group discussion which needed to be digital recorded was sought from participants and was included in the Informed consent form signed by participants. The data was then collected in a PHC facility boardroom to ensure privacy. Participants were requested to refrain from sharing information that was discussed during focus group session as a measure of enhancing agreed confidentiality (NDoH, 2015:14). Participants were informed that confidentiality cannot be guaranteed as some participants may divulge information outside the focus group (NDoH, 2015:17).

The researcher observed participants for any sign of emotional discomfort during the focus group discussions; this was done in order to take a break and attend to affected participants in cases where the session becomes “too much” for other participants. The researcher can report that no need for in-between breaks were necessary as no emotional discomfort was experienced by participants. Qualitative data analysis procedures were discussed in the following section.

#### **2.5.4 Data analysis process**

Once data was collected through focus group discussion, digital voice recording was uploaded on the researchers' laptop, which was then password protected and send to the study leader and transcriber via electronic mail (E-mail). Each focus group discussion was sent separately which make provision for concurrent data analysis while data collection continued. The transcriber transferred voice recording from spoken to written word in order to further facilitate analysis.

According to Strauss and Corbin (*cited by* Schmidt & Brown, 2012:341), data analysis is the process of breaking down, examining, comparing, conceptualizing and categorizing data. The

analysis was based on the conducted focus group sessions in the four sub-districts of Dr Kenneth Kaunda District. Integration of data sources were done via field notes, voice recordings, verbatim transcriptions and researchers' reflective notes (Liamputtong, 2011:63; Newell & Burnard 2011:79; Orcher, 2014:152). Data analysis was done by the researcher, study leader and an independent co-coder (who also signed a confidentiality agreement). The co-coder has exceptional experience in the field of qualitative research and WBOTs. The inductive analysis strategy was followed and premature coding of data was avoided. The researcher followed the sequential cognitive processes as discussed in detail in chapter 1, section 1.8 (Thorne, 2008:165 - 166).

### ***2.5.5 Data Management***

Data management is discussed in chapter 1, section 1.7.4.

## **2.6 ETHICAL CONSIDERATIONS**

Ethics refers to a system of moral values that is concerned with the degree to which research procedures adhere to professional, legal and social obligations to the study participants (Polit & Beck 2008:753). Ethical consideration is important to ensure that the research study is conducted in a responsible and ethical manner. To ensure that ethical issues were taken into consideration, various steps were followed by the researcher:

- To protect the rights of the institution; ethical clearance was obtained from the Health Research Ethics Committees of NWU (see Addendum B) followed by the Policy and Research committee of the Northwest Provincial Department of Health (see Addendum C).
- The participants were clearly informed about the purpose of the study, its risks and benefits, and that their privacy and confidentiality will be maintained at all times (see Addendum A). Participants were requested to voluntarily participate and were informed that they could withdraw at any time from the research study without any consequences. This ensured that their rights to self-determination and full disclosure remained protected.

## **2.6 CONCLUSION.**

This chapter discussed the research methodology used in this research which included research design, sampling, recruitment, data collection, data analysis and ethical considerations. Chapter 3 presents data analysis and describes the research findings as well as research embedding.

**CHAPTER 3**  
**RESEARCH RESULTS SUPPORTED BY/COMPARED**  
**WITH LITERATURE CONTROL**

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### **3.1 INTRODUCTION**

In the previous chapter, the research methodology was reviewed. The aim of this chapter is firstly to determine CHWs opinions about the role they play regarding provision of MCWH services. This chapter provides an overview of measures taken to enhance credibility and to outline the research results.

### **3.2 CREDIBILITY**

Qualitative data analysis is a means to produce knowledge. It is critical for a qualitative researcher to know her biases and preconceptions, prior to analysing the data, in order to be able for fairly illustrate the truth external to her own bias (Thorne, 2016:235). Before any analysis on the transcripts could be done it is important to determine the credibility of the research, as this assists the researcher to defend and explain why the study is significant and describe what it adds to the body of knowledge (Schmidt & Brown, 2012:341-360).

The measures to enhance credibility as described by Thorne (2016:232-238) have been discussed in detail under chapter 1.9. A qualitative study report that is well written gives the reader a strong sense that the results are a true reflection of the findings (Mateo & Foreman, 2014:180); that is in line with the “truth value” as indicated by Lincoln and Guba (*cited* by Thorne, 2016:112). According to Thorne (2016:113), all those credibility measures create a means to demonstrate to others, evidence that will validate the conclusions reached by the researcher in the final report. Thorne (2016:112) further endorses those procedures that were articulated by Leininger (1994), who listed the evaluation criteria as credibility, meaning context, recurrent patterning, saturation and transferability, as well as trustworthiness elements. In qualitative research, claims must be more than just a mere opinion; they must be based on recognisable methods of empirical reasoning. It is the researcher’s obligation to ensure that all claims that will be made are based on the findings and have been well interrogated within the practice context of the audience to which they were addressed, which in this study the CHWs were rendering MCWH services in their respective communities (Thorne, 2016:111-112).

### **3.3 DATA ANALYSIS**

Data analysis in phenomenology involves searching for significant statements and meaning in the data (Mateo & Foreman, 2014:178). To address the objective of this study, the opinions of CHWs were obtained through voice recordings, field worker notes, researchers’ reflective notes, and analysis of the focus group transcripts. Table 3.1 outlines the objective that will be dealt with in this chapter.

**Table 3.1: Objective of this research**

<b>Objective</b> To explore, interpret and describe the CHWs understanding of their role in rendering MCWH services in their electoral wards.
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Qualitative data analysis is an active inquiry process in which conclusions do not emerge from the data unless the researcher is completely familiar with it. According to Strauss and Corbin (*cited by* Schmidt & Brown, 2012:341) data analysis is the process of breaking down, examining, comparing, conceptualizing and categorizing data. In interpretive descriptive studies, most aspects of data collection, processing, and analysis run concurrently, and are not just a number of consecutive steps to follow (Thorne, 2016:109).

**3.3.1 Integration of data sources**

Integration of data sources were done because the data collection entailed the use of multiple data sources. This was done in order to consider any contradictions or inconsistencies in the collected data (Mateo & Foreman, 2014: 293-294). Integration of data sources in this study was done through comparing voice recordings, field notes and the researcher’s reflective notes. The researcher often had to go back to transcripts and field notes to verify conclusions. Voice recordings contain more than just words; they contain feelings as well as cues of non-verbal communication (Burns & Grove, 2010:521) while the researcher’s reflective notes include personal thoughts, feelings, impressions and ideas (Botma *et al.*, 2010:218).

**3.3.2 Coding**

It is almost inevitable that coding will be required to sort and organise data into a manageable format. The researcher focused more on recurring data and theme patterns, rather than on fine-tuned level of words; thus the researcher’s initial coding was broad, to allow for creation of a collection from which the researcher could determine whether some of the statements refer to the “role” or the “challenge” (Thorne, 2016:160). Researchers often hear and believe that a participant’s statement is powerful and, they feel compelled to include it in the final product; that usually leads to premature coding. To avoid premature coding, the researcher wrote down such statements separately and revisited them only when ready to use them (Thorne, 2016:163).

The researcher prepared each transcript as soon as it was received back from the transcriber. The process of re-editing the transcript to be an exact representation of the voice recording

familiarized the researcher with the content. Corrections were done by listening to voice recording and correcting words, which the transcriber could not hear clearly, and open spaces were filled in. After corrections, the researcher coded the transcript according to the sub-district. PHC facility, focus group discussion, line and page numbering were then done. The transcript was now ready for reading through which assisted the researcher to become familiar with the collected data. During the process of data analysis, the researcher kept in mind what the purpose of the study is (Krueger & Casey 2009:114).

Each transcription was read as a whole to get a sense of emerging patterns. This step was then followed by “open coding”, whereby the researcher did line-by-line coding, identified a statement that carry a unique idea and coded the statement using a term that captured the essence of that statement in order to identify similarities and differences that emerged (Thorne, 2016:159). With the assistance of the supervisor, the researcher looked for ideas that come up repeatedly in the data and categorized them until clear patterns could be identified. This approach reduced the large volume of data in the transcripts to smaller segments that were further analysed.

All meaningful segments were assigned a code. This process continued until the researcher could identify themes that reflect the data that had been gathered without leaving any gaps (Mateo & Foreman, 2014:178; Thorne, 2016:156-157). In this study, the researcher used descriptive words to code transcripts.

After initial coding the researcher followed-up with “axial coding” trying to summarize and organize the data and this step resulted in refining and revising initial codes, categorizing and searching for relationships and patterns in the data. The next step in the coding process was “selective coding”, where the researcher combined related codes into themes, and each theme was assigned identifying words (Thorne, 2016:159-160). A brief description of each theme was written down and outstanding quotes were marked with a coloured highlighter to illustrate the meaning of the theme.

The researcher and study leader went through data more than once and ended up refining themes into sub-themes. After the emergence of the themes and sub-themes, the researcher and study leader looked at the entire data and painted the picture of the underlying meanings (Schmidt & Brown, 2012:343). Original transcripts, voice recordings, field notes and researcher reflective notes were given to co-coder for independent analysis. A consensus discussion between the researcher, study leader and co-coder was held regarding the final themes and sub-themes.

### 3.4 DISCUSSION OF THEMES AND SUB-THEMES EMERGED IN THIS STUDY

In this section, Table 3.2 provides an outline of themes and sub-themes, and each theme was discussed separately. With data analysis there were five themes identified. Table 3.2 elucidates the five themes and fifteen sub-themes identified with qualitative data analysis.

The researcher broadened each sub-theme by eliciting the main quotes and stressing the sub-theme. The code appearing at the end of the excerpt, for example 1/2/3:5, refers to sub-theme 1, Focus group discussion number 2, followed by the page number of the interview and the line number from where the excerpt was drawn – in this example page 3 and line number 5 respectively.

**Table 3.2: Themes and sub-themes identified with focus group interviews of CHWS regarding understanding of their role in rendering maternal, child and women’s health**

THEMES	SUB-THEMES
1. Understanding of their role in rendering MCWH services	1. Services rendered under MCWH include the following: <ul style="list-style-type: none"> <li>• Breastfeeding</li> <li>• Early ANC booking</li> <li>• Danger signs during pregnancy</li> <li>• Mom-Connect service: Registration</li> <li>• Immunization: Birth Polio and BCG vaccination confirmation</li> </ul>
2. Support network to assist in MCWH service delivery	2.1 Meeting with the client’s family as a whole
	2.2 Support of the OTL
THEMES	SUB-THEMES
3. Barriers hindering MCWH service rendering	3.1 Cultural barriers
	3.2 HIV & AIDS stigmatization
	3.3 Inaccessible residential areas, e.g. flats, where security guards do not allow CHWs access to do home visits
	3.4 Clients on medical aid are not interested in services rendered by CHWs
	3.5 Women are part of workforce

4. Coping mechanisms	4.1 Not coping, overwhelmed and stressed
	4.2 Debriefing <ul style="list-style-type: none"> <li>• Among themselves</li> <li>• During meetings with other team members and the OTL</li> </ul>
	4.3 Inner motivation of CHWs
5. Suggestions to better the MCWH services	<u>Realistic suggestions</u>
	5.1 The PN at PHC facilities can prepare ANC clients and mothers to expect home visits from the CHWs.
	5.2 Refresher courses or more training was requested, if possible at a Further Education Training (FET) college: a course, which is accredited by SETA.
	<u>Unrealistic suggestions</u>
	5.3 The CHWs want to be introduced to ANC clients when they visit the clinic.
	5.4 The CHWs do not want to move about with bicycles as residents laugh at them.

### Theme 1: Understanding of their role in rendering MCWH services

Theme 1 deals with the level of understanding of CHWs regarding what their role is in relation to MCWH services. The theme “understanding of their role” refers to whether CHWs know what is expected of them when rendering MCWH services in their respective communities. The recruitment of CHWs into the South African health system increased expectations by the communities in relation to positive health outcomes, including maternal and child health outcomes. The CHWs are conversant with what is expected of them in rendering MCWH services. The situation in Dr Kenneth Kaunda is that the number of nurses in PHC facilities are less than what is required, which puts more pressure on CHWs, and to the OTL’s, who are meant to support them, but are not always available due to being utilised to assist in PHC facilities. The CHWs need constant support from OTL’s as their scope of practice is very limited.

## Theme 1, sub-theme 1: Services rendered to MCWH

The following MCWH services were discussed by CHWs during the focus group as part of the services they render to the community.

1. The CHWs had knowledge on:

- **Breastfeeding:** Exclusive breastfeeding for the first six months are promoted. Infants are not to be given food or drink other than breast milk for the first six months of life, unless medically indicated (NDoH, 2014:57). Introduction of complementary feeds usually starts at six months. Continue with breastfeeding for up to two years of age. According to Iliff *et al.*, 2005 (*cited by* Haffejee *et al.*, 2016:176) and WHO, 2003a (*cited by* Janse van Rensburg *et al.*, 2015:133) the current measure is to promote exclusive breastfeeding as opposed to mixed feeding. The rate of Mother-To-Child Transmission of HIV is higher in babies who receive both breast milk and formula compared to those who are exclusively breastfed.

According to Coutsoudis *et al.*, 2001(*cited by* Haffejee *et al.*, 2016:176), an additional disadvantage is that contaminated fluids in mixed-fed babies may damage the bowel, tear mucosal lining and facilitate the entry of the virus into the infant's tissues from the breast milk. Exclusive breastfeeding can only benefit infants, as it is a complete form of nutrition that also prevents new cases and the severity of diarrhoea, respiratory infections and ear infections, which are the most common diseases, included for treatment according to the Integrate Management of Childhood Illnesses (IMCI) (Davis *et al.*, 2012:462).

A study conducted revealed that although exclusive breast-feeding are promulgated in Ethiopia, only 58% of infants under six months are exclusively breast fed and therefor CHWs needs to re-enforce information about this practice. Some factors the CHWs should know are which health education to give when they get complaints that the baby under 6 months were hungry, that the mother produces too little milk, advise given by the traditional birth attendant and/or relatives that the mother should introduce other fluids and solids as well as for the treatment of constipation (Adugna *et al.*, 2017)

“Maybe mother is negative so he must exclusive breastfeeding from six months. Even if he is on treatment he must put the children on the breast milk” (1/6/3:32-34)

“...and just teaching how to breast feed the child....” (1/2/2:55)

“So I encourage the breastfeeding because the mixed feeding is not important. So I need to encourage the mother to use only breast-feeding because is important”. (1/3/4:113-115)

“Is our role to teach the mother how to handle the family for the babies. How to breastfeeding their babies”. (1/5/2:56-57)

- Early ANC booking: The DOH encourages booking for ANC as soon as pregnancy is diagnosed. It allows early detection of problems in pregnancy. The CHW must screen all women of childbearing age for pregnancy and refer those that are eligible to the nearest PHC facility. The screening tool consists of five questions that were developed in Dr Kenneth Kaunda District and are now used for pregnancy screening purposes. Early ANC booking allows early ANC HIV counselling and testing, followed by initiation of Ante-Retro Viral Therapy. CHWs must screen pregnant women for tuberculosis using the NDoH screening tool. TB is the leading cause of maternal deaths due to non-pregnancy related infections in South Africa (NDoH, 2016:119).

“OK, (laugh) as I’m a community health worker my role for the mother and child is to teach the mother that if the mother is pregnant for early booking at the clinic.” (1/2/3:5)

They must book earlier than four or eight weeks. That’s an early booking.... Or if you see that this month he did not get his menstruation, she must just go to the clinic and make a pregnancy test”. (1/2/3:87,89-90)

“So we have to teach them the importance of the early booking... ” (1/6/2:61-62)

“If you found out that the mother is pregnant you are going to make sure that she make an early booking for her”. (1/4/3:72-73)

- Danger signs on pregnant women and children under 5 (five) years: Diarrhoea, headache, dizziness, blurred vision in pregnancy can be indicative of imminent eclampsia, which is a phase just before the patient has eclampsia. Eclampsia is generalised seizures or fits after 20 weeks of pregnancy and within 7 days after delivery; it is associated with high blood pressure and the presence of protein in the urine (NDoH, 2016:32). Persistent vomiting can result in the pregnant mother becoming dehydrated. Dehydration can lead to renal problems and even premature labour. It is important for the CHWs to ask the mother about these symptoms, in order to refer her to the PHC facility urgently if necessary. Failure to promptly and correctly recognize the symptoms that require a birthing mother to be referred to a formal health facility could act as a barrier or a source of delay (Essendi *et al.*, 2010:

360). Dehydration has claimed the lives of many children under five (5) years though it can be managed with oral rehydration therapy (ORT). ORT is one of the simplest but most effective non-drug management of dehydration in children (Hattingh *et al*, 2012:246). Preparation of ORT requires one (1) litre of cooled boiled water, with 8 (eight) teaspoons of sugar and half (1/2) a teaspoon of salt added. The ORT solution must be given to the child orally to replace lost nutrients. A study in Nigeria developed pictograms to represent the danger symptoms of pre-eclampsia: abdominal pain, chest pain, nausea, vomiting, seizures, stroke, unconsciousness, vaginal bleeding, visual disturbances, headache, and two images to represent shortness of breath. Symptoms were selected based on those shown to be predictive of adverse maternal outcomes as well the consequences of pre-eclampsia. Pictograms were developed from literature reviewed by and in consultation with clinical experts in midwifery. This together with health information can teach women a lot on why to report early to the PHC facilities (Dada *et al.*, 2016:179).

These findings suggest that women understood only a few of the tested pictograms when shown in the absence of health information. Some pictograms were revised to improve understanding of the complications of pre-eclampsia. In addition, pregnant women should be provided these pictorial aides in conjunction with basic health teaching related to pregnancy and its complications (Dada *et al.*, 2016:179).

“Swelling the...she must see the ... .the danger sign will be the swelling of the face and the feet and the hand.”(1/2/4:117-118)

“...also teach her about the danger signs. And if she sees one or maybe two danger signs in her body she must quickly come to the clinic.” (1/2/3:98-99)

“I teach the mother the danger signs and how to eat healthy food and to exercise”. (1/1/2:68-69)

“My role as a CHW is to teach the pregnant women about the danger sign. Vomiting, blood and swollen feet”. (1/4/6:170-171)

- Mom-Connect service:

It's a collaborative pilot project between the National Department of Health and many other organisations, including Praekelt Foundation, Jembi Health Systems, the Council for Scientific and Industrial Research (CSIR), mHealth Alliance, GSMA, CHAI and Soul City. The Department is also working closely with all the mobile network operators in South Africa. Mom-Connect is a free service that builds on the success of the Mobile Alliance for Maternal Action (MAMA) and aims to use mobile health tools, messaging services and other platforms to create awareness among pregnant women about the available health services for their infants (NDoH: Mom-connect, 2017).

On 21 August 2014, the national Minister of Health, Dr Aaron Motsoaledi, officially launched the Mom-Connect Project at the KT Motubatse Clinic in Shoshanguve, Tshwane (NDoH: Mom-Connect, 2017).

Registration of the pregnant mother to this service is required to receive weekly guiding health messages via her cell phone. Messages are received up to 1 year after birth; the mother receives messages that are in line with her gestational age weekly. The Mom-connect platform can also be used by pregnant mothers and new mothers to register their concerns, complaints or compliments. The mother has an option to stop receiving the messages when no longer required. The messages may be stopped in cases where the mother has had a miscarriage or a stillborn baby, or where the mother does not want to receive the messages anymore. The mother must send the word “baby” when the baby is born, in order for the messages to be converted to appropriate messages (NDoH: Mom-connect, 2017).

“I just want to add that if she is already booking we also make sure that she has a mom-connect so that she can update with the doulas” (1/4/3:21-22)

- Immunisation: Vaccination confirmation must be done during the first postnatal visit, within 6 days. The newborn receives BCG and polio drops at birth. The baby must further receive Polio drops, Rotavirus (RV1), Diphtheria, Tetanus, Pertussis, inactivated Polio vaccine, Haemophilus influenza and Hepatitis B combined (DTaP-IPV-HBV(1) and Pneumococcal Conjugated vaccine (PCV 1) at 6 weeks, DTaP-IPV-HBV(2) at 10 weeks, RV(2), PCV(2) and DTaP-IPV-HBV(3) at 14 weeks, Measles vaccine(1) at 6 months, PCV 3 at nine months, Measles vaccine 2 at 12 months, (DTaP-IPV-HBV(4) at 18 months according to the current Expanded Programme on Immunization (EPI) schedule, to be recognized as fully immunized at 1 year of age (DOH, 2015c:66). Additional booster vaccines should be given to the baby at 6 years (Tetanus and reduced strength of Diphtheria vaccine) and the last vaccination at 12 years (Tetanus and reduced strength of Diphtheria vaccine) (NDoH, 2015c:2).

“We also see that... to make sure that the mothers have to take their children to the facility so that the child can be properly immunised”. (1/8/2:31-32)

“And also to take their children under five to clinic because it is very important for the children to get immunised. Fully immunised so we have to teach the mothers of the importance of the immunisation”. (1/6/2:24-26)

“...to teach her about the immunisation and you go there to check the road to health card that the child is up to date with immunisations”. (1/1/4:121-123)

“And if the child don't have immunisation I tell the mother to take the child to the clinic for immunisation”. (1/3/2:66-67)

- Malnutrition in children under five (5) and pregnant women. CHWs were trained on identification of problems in children e.g. malnutrition and childhood illnesses, although the focus group interviews did not reveal much of that. The latest strategy introduced to identify malnutrition in pregnant women and children, is the use of a mid-upper arm circumference (MUAC) tape. The MUAC tape is placed lengthwise between the acromion (shoulder) and olecranon (elbow). The figure on the middle of the two bones is used to identify the middle part of the arm and that spot is marked. The MUAC tape is placed around the arm, on the marked spot, and the measurement of the arm circumference is taken. For a child under five, a colour-coded MUAC tape is used. A MUAC of less than 11.5 cm (red colour) indicates severe acute malnutrition (SAM) and should be referred immediately for treatment. A MUAC of between 11.5 cm and 12.5 cm (orange colour) indicates moderate acute malnutrition, and the child should be referred immediately for supplementation. A MUAC of between 12.5 cm and 13.5 cm (yellow colour) indicates that the child is at risk for acute malnutrition and should be followed up for growth promotion monitoring and the mother should be counselled. A MUAC of above 13.5cm (green colour) indicates that the child is well nourished (WHO, 2009:2)
- In pregnant women, this method is believed to be more accurate in identifying malnutrition than the previous methods, as the increasing weight of the baby has no bearing on the size of the mother's arm. For a pregnant woman, the normal MUAC measurement is between 23 cm and 33cm (NDoH, 2016:30-31).

“So we do have problem of malnutrition children at our area ”. (1/6/7:214-215)

## **Theme 2. Support network to assist in MCWH service delivery**

The research identified two sub-themes under factors, which according to CHWs enhances MCWH services, namely:

### Theme 2, sub-theme 1

Meeting with the client's family as a whole: This initiative creates a relationship between the CHW and family members; it makes it easy to access the client and to get the “buy-in” of family members to support the client. A study by Weidle *et al.* (2006:1588), revealed that patients on ARV treatment adhered better to treatment when their families were engaged before commencement of treatment. According to literature a well-established and functional relationship between the CHWs and their MCWH clients and the families of these clients, is likely to yield desired results. Greenspan *et al.*, 2013:1485; Maes & Kalofonos, 2013:8 (*cited by* Okeyo & Dowse, 2016:250), stated that good patient relationships and appreciation received from patients contributed to the belief of CHWs that they were well positioned and able to positively influence health outcomes, despite occupying a low position in the health care worker hierarchy. If plans are not properly discussed and shared, the exerted effort will be defeated (Hattingh *et al.*, 2012 54-55). Proper guidance and support are required for any team or community to function well. Lack of guidance, coupled with support will result in a demotivated team.

“To meet with the family, all the family to discuss my role as a community health

worker”. (2.1/5/3:7-8)

“What makes it easy for bring services is to go in the household. Just to meet the whole family inside the house and make a good relationship with them”. (2.1/5/3:25-26)

## Theme 2, sub-theme 2

Support of the OTL: The OTL is available to go with the CHWs to the households to support them where they don't manage. According to Okeyo and Dowse (2016:246), the effectiveness of CHW role in contributing to improved health outcomes depends on adequate supervision and support by professional nurses who have received formal training at a higher educational institution.

“I will also do that. I will take my OTL to go at that household to talk to that mother”. (2.2/1/10:28-29)

“If there is some problems, maybe the patient doesn't want to come to the clinic, the mother don't want to bring the child to the clinic, so OTL go there and talk to them. Then they come to the clinic” (2.2/6/2:26-28)

## Theme 3: Barriers hindering MCWH service rendering

The following barriers, which hinder CHWs to render an effective MCWH service, were identified. They are cultural barriers, HIV/AIDS stigmatisation, inaccessible residential areas

### *Theme 3, sub-theme 1*

*Cultural barriers:* The new mother goes with the newborn baby to her mother or any elderly female close relative immediately after birth. This practice is done, with a belief that the new mother will be taught and guided by the “experienced elder”. The mother and her newborn baby are not allowed exposure to the CHWs within the first month of the baby's life. This belief prevents the CHWs from doing the post-natal visit within 6 days of the baby's birth. According to Arba *et al.* (2016:2), lack of access to appropriate obstetric care increases the risk of adverse obstetric outcomes such as death or disability. Culture is a way of life; it directs what people do through what it prescribes, and has an influence on the health of a community (Hattingh *et al.*, 2012:30-31). Cultural beliefs and the stigma attached to HIV/AIDS are likely to become barriers to service delivery when they are not handled sensitively (Dennill & Randall-Mkosi 2012:36; Hattingh *et al.*, 2012:132). According to Rodlach (2010:426), family caregivers hide their sick family members when Home-based caregivers visit households. Stigma around HIV/AIDS leads to non-disclosure of the condition and remains a hindrance to the constructive utilization of health services.

“What makes it difficult that when the body’s pregnant there is not big difficulty but once she give birth some of them... They tell you, no, you must come after a month or six weeks”. (3/1/5:14-16)

*Theme 3, sub-theme 2*

HIV/AIDS stigmatization: HIV + mothers do not want CHWs to access their Maternity Case Records and the babies’ RTHB as the HIV status is indicated in those files. Psychological support of HIV positive patients can encourage patients’ acceptance and disclosure of their status. Educating the family can enable patients to cope in terms of positive living and planning for the future (NDOH, 2002:29).

“To be more difficult again is if the mother does not have disclose on me if she is HIV+ and then it would be more difficult to come and check her because she know I must go through that road to health card”. (3/1/7:2-4)

*Theme 3, sub-theme 3*

Inaccessible residential areas, e.g. flats, where the security guards do not allow the CHWs access to do their home visits.

“Me, at my wards, the challenge that I have is the flats. And so the people who are living in that flats, they don’t allow us to enter”. (3/2/9:8-9)

*Theme 3, sub-theme 4*

Clients on medical aid are not interested in services rendered by CHWs.

“I’m not sure exactly about the reason because some they are telling us they have medical aids they don’t want our service because they have medical aid”. (4/7/4:31-32)

*Theme 3, sub-theme 5*

Women as part of workforce: Pregnant women are not all accessible to the CHWs as they are at work during the day, and the CHWs do not work after hours.

“Everywhere I’m working that area called (African name) is where the people of (African word) are working for the government, other teachers, police, nurses. Always are not there”. (5/7/9:11-13)

## Theme 4: Coping mechanisms

The CHWs need basic coping skills in order to be able to withstand the pressure that comes with the job they do. The OTL may assist the overwhelmed CHW to develop ways of coping with stress (Clark, 2008:875).

### Theme 4, sub-theme 1

Not coping, overwhelmed and stressed: CHWs are expected to do 6-8 household visits per day. One household may have occupants with multiple conditions that the CHW must deal with, e.g. hypertension, diabetes and TB. Due to the registration of multiple clients per household, the CHWs are unable to reach the set target.

“I don’t cope”. (1/6/8-9)

### Theme 4, sub-theme 2

#### Debriefing

- Among themselves: CHWs talk to each other about the difficulties they experience and challenges they come across.
- During meetings with other team members and the OTL: The meetings that are held in the facilities that the CHWs are attached to, create a platform where CHWs can open up on their frustrations, challenges and difficulties.

“We only cope by discussing it, with like just looking at family, raising it within ourselves”. (2/8/7:15)

### Theme 4, sub-theme 3

- Inner motivation: Some CHWs just tell themselves that they are going to get the job done, despite the challenges they experience.

“(laugh) I am just telling myself that I want to help the community with love and caring. So I counsel myself before so I feel better. That is why I’m dealing with the situation”. (3/3/12:27-29)

“Giving up is not an option so I believe that you have to pursue that person and make her see reasons of the dangers” (3/2/10:7-8)

## Theme 5: Suggestions to better the MCWH services

The involvement of a community at hand (in this case; CHWs) is critical in getting the cooperation and success that is aimed for. According to Morgan, 2001 (*cited by* Dennill & Randall Mkosi, 2012:129), activists see participation as a principle and process that is necessary for any empowerment to take place among community members. In relation to the suggestions to better the rendering of MCWH services by CHWs, the following were put forward:

### Realistic suggestions

- PN at PHC facilities can prepare ANC clients and mothers to expect home visits from the CHWs.
- More training was suggested, if possible at a Further Education Training (FET) college: a course that is accredit by SETA. The same suggestion was echoed by respondents in a quantitative study conducted by Moetlo *et al.* (2011:39), where the majority of respondents (89%) indicated that a refresher-training course would be helpful.

“...at the ANC clinic there, they must tell this clients who comes at the facility... the CHW, they are gonna come and visit you at home. So you must work together with this CHW.” (2/4/14:483&486)

“... if maybe we can go to those refresher course they must please provide us with certificate that are accredited, neh” (2/7/16:16-17)

### Unrealistic suggestions

- Introduction to ANC client when they visit the clinic: ANC clients are seen daily, throughout the day, according to appointment. For this suggestion to materialize, CHWs will have to be at the clinic the whole day. When will they conduct home visits?
- The CHWs do not want to move about with bicycles, as they believe the residents are laughing at them. They request that the stipend be increased so that they can buy themselves cars. The questions that arise are the following: Who is going to cater for fuel and general vehicle maintenance? The employer brought it to their attention when they accepted the position, that it will be expected of them to use

bicycles. OTL's need to address this issue: not every employee gets car allowance; such a benefit is only applicable to high positions within the DoH.

“They sit there, then the manager of the clinic must introduce those mother and child to us. That this people are going to go to your house. They are doing this and this. So it will be simple to us to reach them”. (3/4/15:25-28)

“They must not provide us with bicycles because some of us we don't know how to ride bicycles, neh. Just bring one transport and put us in different wards”. (4/7/11:32-34)

## **SUMMARY**

In this chapter, the opinions of CHWs within WBOTs about the role they play, regarding provision of MCWH services, were obtained. Themes and sub-themes were identified and discussed. This chapter further provided an overview of measures taken to enhance credibility. In the following chapter, the conclusion, recommendations and limitations of the study will be discussed.

**CHAPTER 4**  
**CONCLUSIONS, RECOMMENDATIONS AND**  
**LIMITATIONS**

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## **4.1 INTRODUCTION**

In this chapter the study is evaluated with reference to the achievement of its objectives. The perceptions of CHWs on factors affecting how they execute their functions and, their suggestions on how to improve the service they provide to mothers and children are highlighted. The limitations are identified and recommendations are made for further research, education and clinical practice.

## **4.2 SUMMARY OF PROCEDURES**

The study sample consisted of 56 CHWs within WBOTs, who had been in service for a minimum of six months. The ages of participants ranged from 25 to 47 years. A total of 6 males and 50 females voluntarily participated in the study. Of the 56 participants, 50 had children, suggesting that the majority of participants understood the experiences of mothers and children.

The main purpose of this study was to determine if CHWs within WBOTs understood their role with regards to rendering MCWH services. The study also explored the factors that enhance MCWH services provision, what are the barriers to MCWH service provision, how CHWs cope with challenges and what suggestions they have to improve MCWH services.

The conclusions, based on the derived themes and sub-themes discussed in chapter 3 of this dissertation will be used to answer the research question which was formulated in chapter 1 as follows:

- What is the CHW understanding of their role in rendering MCWH services in their electoral wards?

The findings of the study have revealed that the majority of CHWs understood their role in relation to rendering MCWH services. The study further revealed that participants believed that meeting the families of clients makes it easy for CHWs to render MCWH services at household level.

Participants suggested that CHWs be sent for refresher courses and trainings that will provide them with accredited certificates. Some of the participants suggested that the CHWs be introduced to ANC clients as they visit the clinic.

The dissatisfaction of some participants about CHWs using bicycles to move about was also revealed in the study, thus they suggested that they get an increase in stipend in order to buy themselves cars. The last two suggestions are unrealistic as 1) mothers and babies come to the

clinic throughout the day and CHWs are working in the community during that time; 2) the Department of Health cannot afford to increase a stipend to a point where CHWs can be able to buy cars and sustain maintenance thereof.

Some of the CHWs do not cope with the challenges they experience whilst rendering the MCWH services, whilst some have inner motivation to continue despite the challenges that they come across.



**Figure 4.1: Ward-based community health worker outreach teams: The success of the Sedibeng Health Posts (Policy Brief 2014:1)**

#### ***4.2.1 Conclusions on the Objectives***

The objective of the study was evaluated to determine whether it has been achieved. The conclusions will be made in relation to the specified objective:

- To explore, interpret and describe the CHWs understanding of their role in rendering MCWH services in their electoral wards.

#### 4.2.1.1 Participants' understanding of their role in providing services to mothers and children.

This element was looking at what participants understand their role to be in relation to providing MCWH services at community level. The findings revealed that there was a general understanding of the role of the CHWs regarding rendering MCWH services, amongst participants.

#### 4.2.1.2 Factors perceived to be making it easy for CHWs to provide MCWH services?

Participants throughout focus groups indicated that the support of OTLs as making it easy for them to overcome the obstacles that they sometimes encounter. The DOH approach to PHC Re-engineering is that CHWs should be assigned to areas to which they reside (Dennill & Rendall-Mkosi, 2012:71). The fact that they work in their own communities was further cited as a factor that makes it easy for them to function within communities, as they already have a relationship with community members.

Some participants stated that community members trust CHWs more if they see them in PHC facilities, and not only in the community.

#### 4.2.1.3 Perceived barriers to rendering MCWH services

Some participants indicated that the nurses have a bad attitude, which makes it difficult for pregnant mothers to come to the clinics early for ANC. According to Thorne (2016:285), the engagement of clients with practitioners in the health care system, plays a major role in determining what it is they had to do.

Thorne (2016:108) stated that the stigma attached to TB and HIV has a negative impact on those affected as well as on the delivery of appropriate health services. Participants in Focus groups 3 and 5 stated that when they enter households, residents conclude that the people in that household have TB or HIV. This impression is likely derived from the fact that some of the CHWs within WBOTs were recruited from NGO's working with TB and HIV patients.

A mother must access health care service within 3 to 6 days after delivery, in order for both mother and newborn baby to be assessed for any complications. This is a proactive approach, to prevent complications (DoH, 2016:136; Dennill & Rendall-Mkosi, 2012:67). Some participants found that the migration of mothers post-delivery makes it difficult to access the mother and the

newborn post-delivery. In cases where mothers migrated to areas within the same sub-district, CHWs stated that they liaise with their colleagues to ensure that the mother and newborn have access to the service.

Some participants indicated that the OTLs attached to certain WBOTs are not always available to assist CHWs, as they work in clinics when there is shortage of personnel. The unavailability of OTLs in WBOTs is likely to have detrimental effects as they were selected and appointed to lead the teams (Dennill & Rendall-Mkosi, 2012:68-69).

#### 4.2.1.4 Perceived suggestions to better the MCWH services

The participants believed that the introduction of the CHW to the pregnant mother and the involvement of families in the care of the mother and child under 5, are strategies that could enhance the rendering of MCWH services by CHWs.

Some participants suggested provision of Information, Education and Communication (IEC) materials. IEC materials for early ANC booking are available at clinics in two different languages; they need to be distributed to the clinic attendees. IEC materials regarding immunization, danger signs and postnatal care need to be developed and distributed to the community at large.

#### 4.2.1.5 Coping mechanisms applied by CHWs

There was a general feeling that the CHWs are not coping with the challenges that they come across as they provide the service in the community. The excessive pressure applied by OTLs on the CHWs in relation to reaching a targeted number of households was sighted by participants in focus group 7. Each WBOT is allocated approximately 7660 people (NWDoh 2011:24); each district in the country further determines how many households are to be seen by a CHW per day. Most participants indicated that they normally talk and share their frustrations amongst themselves in order to feel better, while a few displayed signs of inner motivation, which helped them to cope with the challenges. Some participants in focus group 6 suggested that CHWs must be offered 'debriefing' sessions. Psychosocial support and counselling is known to improve the quality of life. Individual or group counselling is important for everyone involved in care within households. Providing emotional support is very difficult for CHWs if they do not feel supported themselves (WHO, 2002:40).

The discussion above indicates that the researcher reached the aim and objective of the study. All studies have limitations, and the researcher declares the limitations of this study in the following section.

### **4.3 LIMITATIONS OF THE STUDY**

The limitations of this study are declared below.

#### **4.3.1 *Limitations of the method used***

This study was conducted with eight (8) focus group from all four (4) sub-districts of Dr Kenneth Kaunda District. Three of the eight focus groups consisted of five participants who might have resulted in a smaller pool of ideas (Krueger & Casey, 2009:6).

The question on “what makes it difficult for CHWs to render the MCWH services” and the one on “What challenges do the CHWs come across as they render the service” were interpreted as the same thing, therefore they elicited the same responses from most participants. Some participants viewed these two questions as providing a platform for them to complain. The researcher explained again what the purpose of the study was, if necessary.

Due to the nature of the method used, the results of this study cannot be generalised in the entire province, or country. However, they could be locally generalised for Dr Kenneth Kaunda District.

Focus group 5 was conducted on the same day that a colleague of the participants lost her husband to death. Some of the participants were not saying much, even on researcher probing; whilst others were fully participative. The participants that were responsive could have done so in order to get the focus group session over as quickly as possible, and thus may have provided minimal information.

The CHWs uncertainty around extension of their contracts might have influenced answers provided, as they could have viewed the focus group sessions as an opportunity to have their contracts extended.

### **4.4 RECOMMENDATIONS**

Based on the study findings, the following recommendations were made:

Train CHWs on Maternal Baby Friendly Initiative (MBFI) strategy

- One of the main elements that the MBFI strategy focuses on is the promotion of breastfeeding. In a case where the mother chooses formula feeding, cup-feeding is encouraged. Focus group sessions revealed that not all CHWs are conversant with the strategy. E.g. indicating how they will teach mothers to wash the feeding bottles and teats.

Purchase uniform for all CHWs and enforce wearing thereof when on duty.

- The researcher identified during focus group interviews that some of the CHWs were not issued with uniform, whilst other participants indicated that they do not wear uniform because they do not like it. The dissatisfaction of CHWs on not being involved in choosing their uniform was also revealed during focus group sessions.

Avail IEC materials

- Develop and distribute IEC materials for pregnancy and early childhood danger signs, immunization and post-natal care.
- Distribute the early ANC booking pamphlets to the larger community

Provide information about renewal of CHW contracts timeously.

- Uncertainty about whether contracts are going to be renewed or not creates anxiety and despondency among CHWs. This is likely to result in poor output, and eventually poor outcomes.

Provide information about benefits provided according to hierarchal structure.

- The focus group interviews revealed that most CHWs do not understand which benefits are due to which personnel level, thus the participants suggested that the Department of Health must provide them with enough salary for them to buy themselves cars.

Utilise mass media to educate the community about:

- The importance of targeted CHW visits at household level. Participants during focus group interviews revealed that some community members do not allow CHWs into their households within the first month of the baby's life.

- The importance of disclosing their HIV positive status at home. Participants indicated that some HIV positive patients are defaulting on taking treatment because they have not disclosed their HIV status at home.

Increase the number of WBOT

- DoH to appoint and avail WBOT financing of all municipal wards within the district, including farming areas

#### **4.5 SUGGESTIONS FOR RESEARCH, EDUCATION AND PRACTICE**

In the following section, the researcher outlines suggestions for further research, education and practice.

Suggestions for further research

- Duplicate this study in other districts and provinces prior to generalisation of these research findings.
- Explore how CHWs can be assisted to cope with the challenges they experience.

Suggestion for education

- Incorporate PHC Re-engineering into the curriculum of the nursing students. This initiative will assist the current students' understanding to be in line with what is implemented in practice and prepare them for the role of an OTL as well.

Suggestion for clinical practice

- Operational Manager of PHC facility can facilitate in-service training for CHWs by different expert professional nurses to keep them informed about changes in health service delivery.
- Students from multi-disciplinary health teams need to accompany WBOTs to the community when they are placed in PHC facilities during their clinical practice period. This practice will expose students to activities taking place at community level.

## **5. SUMMARY**

This chapter focussed on outlining the limitations and recommendations of this study; the conclusions on the objective of the study were also examined. The chapter further elaborated on perceptions of CHWs in relation to occurrences affecting their day-to-day activities. The researcher provided recommendations to address the identified challenges as well as suggestions for further research, education and clinical practice. The importance of CHWs understanding their role in rendering MCWH services cannot be understated in the fight to reduce maternal and child mortality. The fundamental nature of this study would be best summarised by the National DoH CARMMA Strategy theme of “South Africa cares: No woman should die while giving life”.

## REFERENCE LIST

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Adugna, B., Tadele, H., Reta, F. & Berhan, Y. 2017. Determinants of exclusive breastfeeding in infants less than six months of age in Hawassa, an urban setting, Ethiopia. *International breastfeeding journal*, 12(1):45.

<https://internationalbreastfeedingjournal.biomedcentral.com/track/pdf/10.1186/s13006-017-0137-6?site=internationalbreastfeedingjournal.biomedcentral.com> Date of access: 8 Nov. 2017.

Arba, M.A., Darebo, T.D., & Koyira, M.M. 2016. Institutional delivery service utilization among women from rural districts of Wolaita and Dawro zones, Southern Ethiopia; a community based sectional study. *PloS ONE journal*. 11(3):2

Babbie, E. 2010. The practice of social research. 12<sup>th</sup> ed. CA Belmont ; Wadsworth.

Botma, Y., Greeff, M., Mulaudzi, F.M. & Wright, S.C.D. 2010. Research in health sciences. Cape Town: Pearson Education South Africa.

Brink, H, van der Walt, C. & van Rensburg, G. 2006. Fundamentals of research methodology for healthcare professionals. 2nd ed. Pretoria: Juta & Company Ltd.

Brink, H, van der Walt, C. & van Rensburg, G. 2012. Fundamentals of research methodology for healthcare professionals. 3rd ed. Cape Town: Juta & Company Ltd.

Burns, N & Grove, S.K. 2009. The practice of nursing research: Conduct, critique and utilization. 6th ed. St. Louis: Elsevier

Burns, N & Grove, S. 2010. Understanding Nursing Research: Building an Evidence-based practice. 5<sup>th</sup> ed. (USA) Philadelphia: St Louis: Elsevier

Chan, G.K., Brykczynski, K.A., Malone, R.E. & Benner, P. 2010. Interpretive Phenomenology in Health Care Research. Indianapolis: Sigma Theta Tau International

Clark, M.J. 2008. Community health nursing: advocacy for population health. 8th ed. New Jersey, CA.: NJ: Pearson Education.

Creswell, J.W. 2012. Research design: qualitative, quantitative & mixed methods approaches. 4th ed. (UK) California: Sage publications.

Dada, O.A., Odubena, O., Adepoju, A.A., Vidler, M., Orenuga, E.A., Osiberu, B., Ibiezugbe, B.O., Oladapo, O.T., Payne, B.A., Chapman, K. & Hayashida, N. 2016. Development and

testing of pictograms for the symptoms of pre-eclampsia in Ogun State, Nigeria. *Pregnancy hypertension: an international journal of women's cardiovascular health*, 6(3):179.

Davis, S.K., Stichler, J.F. & Poeltler, D.M. 2012. Increasing exclusive breastfeeding rates in the well-baby population: an evidence-based change project. *Nursing for Women's Health*, 16(6):460-470.

De Jong, P. & Berg, I.K. 2008. Interviewing for solutions. 3<sup>rd</sup> ed. USA: Thomson Brooks/Cole

Dennill, K & Rendall-Mkosi, K. 2012. Primary Health Care in Southern Africa. 3<sup>rd</sup> ed. Cape Town: Oxford University Press

Essendi, H., Mills, S & Fotso, J-C. 2010. Barriers to formal emergency obstetric care services utilization. *Journal of urban health: Bulletin of the New York Academy of Medicine*, Vol. 88(2):360

Haffejee, F., Ports, K.A., & Mosavel, M. 2016. Knowledge and attitudes about HIV infection and prevention of mother to child transmission of HIV in an urban, low income community in Durban, South Africa: Perspectives of residents and health care volunteers. Elsevier B.V

Hatting, S., Dreyer, M. & Roos, S. 2012. Community nursing: A South African manual. 4<sup>th</sup> ed. Cape Town: Oxford University Press

Holzemer, W.L., Uys, L.R., Makoae, L., Stewart, A., Phetlhu, R., Dlamini, P.S., Greeff, M., Kohi, T.W., Chirwa, M., Cuca, Y. & Naidoo, J. 2007. A conceptual model of HIV/AIDS stigma from five African countries. *Journal of advanced nursing*, 58(6):541–551.

HST (Health Systems Trust). 2011. Community Health Workers: A brief description of HST experience.

HST (Health Systems Trust). 2013. District Health Barometer 2012/13: Focus on maternal mortality.

Israel, B.A., Eng, E., Schultz, A. & Parker, E.A. 2013. Methods for community-based participatory research for health. 2<sup>nd</sup> ed. USA: John Wiley & Sons Inc.

Janse van Rensburg, L., Nel, R., & Walsh, C.M. 2015. Knowledge, opinions and practices of healthcare workers related to infant feeding in the context of HIV. Elsevier

Kibel, M, Saloojee, H & Westwood, T. 2012. Child Health for all. 4th ed. Cape Town: Oxford University Press

Klopper, H.C. 2008. The qualitative research proposal. *Curationis*, 31(4):62-72.

Klopper, H.C. & Knobloch, S. 2010. Validity, reliability and trustworthiness (*In Jooste, K., ed. The principles and practice of nursing and health care. Pretoria: Van Schaik. p. 317-323.*)

Krueger, R.A, & Casey, M.A. 2009. Focus groups: A practical guide for applied research. 4<sup>th</sup>ed.USA: Sage publications

Lehmann U & Sanders D. 2007. Community Health Workers: what do we know about them? [http://www.who.int/hrh/documents/community\\_health\\_workers.pdf](http://www.who.int/hrh/documents/community_health_workers.pdf). Date of access: 10 Feb 2017

Lema, I.A., Sando D., Mageza, L., Machumi, L., Mungure E., Sando M.M., Geldsetzer, P., Foster, D., Kajoka, D, Nabur, H., Ekstrom, A.M., Spiegelman, ., Li, N., Chalamilla, G., Fawzi, W & Barnighausen T. 2014. Community Health Workers to Improve Antenatal Care and PMTCT Uptake in Dar es Salaam, Tanzania: A Quantitative Performance Evaluation. *Journal of Acquired Immune Deficiency Syndrome*, 67(4):196

Liamputtong, P. 2011. Focus group methodology. London: SAGE publications

Lobiondo-Wood, G. & Haber, J. 2006. Nursing Research: Methods and Critical Appraisal for Evidence-Based Practice. 6<sup>th</sup> ed. USA: Mosby Elsevier Inc.

Louwrens, M.H., Greeff, M. & Manyedi, E. 2016. A community-based HIV stigma reduction intervention for people living with HIV and their partners. *Africa journal of nursing and midwifery*, 18(2):6-26.

Makado, M. & Davhana-Maselesele, M. 2016. Knowledge and psychosocial wellbeing of nurses caring for people living with HIV/AIDS (PLWH). *Health S.A.* (21):1-10

Mateo, M.A. & Foreman, M.D. 2014. Research for Advance Practice Nurses. From Evidence to Practice. 2<sup>nd</sup> ed. USA:Springer Publishing Company, LLC

Moetlo, G.J. Pengpid, S & Peltzer, K. 2011. An Evaluation of the Implementation of Integrated Community Home-Based Care Services in Vhembe District, South Africa. *Indian Journal of Palliative Care*. 17(2):140

Moosa, M.Y.H & Jeena, F.Y. 2013. *South African Journal for Psychiatry*. 19(3): 60-64

- Nanyonjo, A., Ssekitooleko, J., Counihan, H., Makumbi, F., Tomson, G. & Källander, K. 2015 *International Journal for Equity in Health*. 14 (1):1-11
- NDoH (National Department of Health). 2002. Integrated Community-based Home Care (IHC) in South Africa. The National Department of Health.
- NDoH (National Department of Health). 2009. Negotiated Service Delivery Agreement. The National Department of Health. [http://pdf.usaid.gov/pdf\\_docs/Pnac944.pdf](http://pdf.usaid.gov/pdf_docs/Pnac944.pdf) Date of access: 12 October 2017)
- NDoH(National Department of Health). 2010. South Africa's National Strategic plan for a Campaign on Accelerated Reduction of Maternal and Child Mortality in Africa. [http://www.kznhealth.gov.za/family/CARMMA\\_south\\_africa\\_strategy.pdf](http://www.kznhealth.gov.za/family/CARMMA_south_africa_strategy.pdf) Date of access: 18 April 2016
- NDoH (National Department of Health). 2012. National Contraception and Fertility Planning Policy and Service Delivery Guidelines. The National Department of Health. <https://www.health-e.org.za/wp-content/uploads/2014> Date of access: 20 Feb 2016
- NDoH (National Department of Health). 2013. National Indicator Data Set. The National Department of Health. <https://www.sanca.org.za/product/south-africa-health-national-indicator-data-set-elements> Date of access: 12 March 2017
- NDoH (National Department of Health). 2014. National Perinatal Morbidity and Mortality committee. The National Department of Health.
- NDoH (National Department of Health). 2015a. Sustainable Development Goals. The National Department of Health. [www.google.co.za/?ei=VDWRWs3MFarikqWh1pVY&q=sustainable+develpoment+goals+2015+pdf](http://www.google.co.za/?ei=VDWRWs3MFarikqWh1pVY&q=sustainable+develpoment+goals+2015+pdf) &0q= Sustainable+Development+Goals Date of access: 16 July 2017
- NDoH (National Department of Health). 2015b. Ethics in research: Principles, processes and structures. 2<sup>nd</sup> ed. The National Department of Health. <https://ahrecs.com/resources/ethics-health-research-principles-processes-structures-2nd-ed-south-africa> Date of access: 11 Nov 2016
- NDoH (National Department of Health) 2015c. Expanded Programme on Immunisation- EPI (SA): Revised Childhood immunization schedule from April 2015. The National Department of

Health. <http://www.nicd.ac.za/assets/files/Measles%20vaccine.pdf> Date of access: 12 March 2017

NDOH (National Department of Health). 2016. Guidelines for Maternity Care in South Africa: A manual for clinics, Community Health Centres and District hospitals. 4<sup>th</sup> ed. The National Department of Health

NDOH (National Department of Health). 2017. Mom connect. <http://www.health.gov.za/index.php/mom-connect> Date of access: 10 November 2017

Newell, R. & Burnard, P. 2011. Research for Evidence-Based Practice in Healthcare. 2<sup>nd</sup> ed. UK: Blackwell Publishing

NWPDoh (North-West Provincial Department of Health). 2011. Guidelines for the implementation of the three streams of PHC re-engineering. The North-west Provincial Department of Health <http://www.jpcof.co.za/wp-content/uploads/2014/06/GUIDELINES-FOR-THE-IMPLEMENTATION-OF-THE-THREE-STREAMS-OF-PHC-4-Sept-2.pdf> Date of access: 12 Jan 2017

NWPDoh (North-West Provincial Department of Health). 2013. PHC Re-engineering experiences from the Northwest Province. HST [http://www.anovahealth.co.za/Muzi\\_Gauteng\\_Symposium](http://www.anovahealth.co.za/Muzi_Gauteng_Symposium). Date of access: 20 July 2015.

NWPDoh (Northwest Provincial Department of Health). 2014. District Health Information System. The National Department of Health. <http://www.hisp.org/services/dhis-2/> Date of access: 22 August 2017

NWU (North-West University). 2012. NWU Referencing guide: NWU Harvard Reference guide for the Faculty of Law APA. Potchefstroom: NWU Potchefstroom campus Library services

Orcher, L.T. 2014. Conducting research: Social and behavioural science methods. 2<sup>nd</sup> ed. California: Pyrczak Publishing

Okeyo, I. & Dowse, R. 2016. Community Care Worker perceptions of their role in tuberculosis care and their information needs. *Health S.A.* (21): 245-252

PEP. (Perinatal Education Programme). 2008. Saving mothers and babies. A learning program for professionals. Cape Town: EBW.

Polit, D.F. & Beck, C.T. 2008. Nursing Research: Generating and Assessing Evidence for Nursing Practice. 8th Edition, Philadelphia: Wolters Kluwer Health

Rodlach, A. 2010. Home-Based care for people living with AIDS in Zimbabwe: Voluntary caregivers' motivations and concerns. *African journal of AIDS research*. 8(4): 423-431

Sharma, S.K. 2014. Nursing research & statistics. 2<sup>nd</sup> ed. New Delhi: Reed Elsevier India Private Limited

Sampaio L.F.R. 2010. The Brazilian health system: highlighting the primary health care reform. *Italian journal of public health*, 7(1): 365.

Schmidt, N.A. & Brown, J.M. 2012. Evidence-Based Practice for nurses: Appraisal & Application of research: 2<sup>nd</sup> ed. USA: Jones & Bartlett Learning. LLC

South Africa. National Department of Health. 2014. Mom-Connect.

<http://www.health.gov.za/index.php/mom-connect#momconnect> Date of access: 14 Oct. 2017

Statistics South Africa .Mortalities and causes of death in South Africa. 2013: Findings from notification register. 2013:18 <http://www.statssa.gov.za/?cat=19> Date of access: 21 Nov 2016

Statistics South Africa. Perinatal deaths in South Africa. 2015: Findings from notification register. 2015:23 <http://www.statssa.gov.za/publications/P030942015.pdf> Date of access: 3 August 2016

Speziale, H.J.S & Carpenter, D.R. 2007. Qualitative Research in Nursing: Advancing the humanistic imperative. 4<sup>th</sup> ed. USA:Lippincott Williams & Wilkins

Thorne, S. 2008. Interpretive description. USA: Left Coast Press, Inc.

Thorne, S. 2016. Interpretive description: Qualitative Research for Applied Practice. 2<sup>nd</sup> ed. New York: Routledge

Weidle, P.J., Wamai, N., Solberg,P., Liechty, C., Sendagala,S., Were,W., Mermin, J., Buchacz,K. Behumbiize,P Ransom,R.L & Bunnell.R. 2006. Adherence to antiretroviral therapy in a home-based AIDS care programme in rural Uganda. *The Lancet journal* (368):1587-94

WHO 2002, Community Home-Based Care in Resource-Limited settings: A framework for action. 2002a

WHO 2009. WHO child growth standards and the identification of severe acute malnutrition in infants and children: A joint statement by the World Health Organization and the United Nations Children's Fund. 2009

WHO 2013. World Health Statistics. 2013

[http://www.who.int/gho/publications/world\\_health\\_statistics/EN\\_WHS2013\\_Full.pdf](http://www.who.int/gho/publications/world_health_statistics/EN_WHS2013_Full.pdf) Date of access: 7 February 2016

WHO 2014. World Health Statistics. 2014

[http://www.who.int/gho/publications/world\\_health\\_statistics/2014/en/](http://www.who.int/gho/publications/world_health_statistics/2014/en/) Date of access: 10 March 2016

WHO 2015. World Health Statistics: Global Health Indicators part 2.

[http://who.int/iris/bitstream/10665/170250/1/9789240694439\\_eng.pdf](http://who.int/iris/bitstream/10665/170250/1/9789240694439_eng.pdf) Date of access: 14 May 2016

Yin, R.K. 2009. Case study research: Design and methods. 4<sup>th</sup> ed. USA: Sage publications.

**ADDENDUMS A, B, C, D, E and F**

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# ADDENDUM A: Cover letter and Informed consent

**The role of the community health workers in rendering Maternal, Child and Women's Health Services**

by

**Mrs T. Zenzile, Student researcher in Magister Curationis in Nursing Science 2017  
North-West University, Potchefstroom Campus**

Dear Mr/Ms

The role of Community Health Workers (CHWs) in Ward-Based Outreach Teams is important in providing Maternal, Child and Womens' services in Dr KK district. The understanding of the role of CHWs in rendering maternal, child and womens' health in the community is the focus of this research. The researcher would like to invite you to participate in this study if you have been working as a CHW in a WBOT for 6 months or more and if you are able to speak English. You should also be willing to form part of a focus group that will be voice-recorded during the focus group discussion. By participating in this study you can get a broader understanding of your role in rendering maternal, child and womens' health services in the Dr Kenneth Kaunda District as innovations and ideas will be shared in the group. The research will assist the researcher to make suggestions to the Dr KK District if gaps are identified which can be addressed within your training program.

You attend the information session about the research today because you have shown interest in the study. The researcher will give you two informed consent forms which will be explained to you. You are kindly requested to use a week to decide whether you would like to participate in the study. If you are still interested please read through the informed consent, sign both forms with two witnesses and take the two forms to your team leader. The team leader will send it to the sub-district office. Save the researchers cell phone number on your phone and remember to provide your cell phone number so that the researcher can phone you if you are selected to participate in a focus group.

Thank you in advance for agreement to participate in this research project and please know that all interested CHWs have an equal opportunity to be chosen for the focus group. There will possibly be more than one focus group in your sub-district.

-----  
Mrs. T. Zenzile  
Researcher and magister student



## **INFORMED CONSENT DOCUMENTATION FOR COMMUNITY HEALTH WORKERS**

TITLE OF THE RESEARCH STUDY: Community health workers' understanding of their role in rendering Maternal, Child and Women's Health Services

**ETHICS REFERENCE NUMBERS:** NWU-00022-17-S1

**PRINCIPAL INVESTIGATOR:** Dr CE Muller

**POST GRADUATE STUDENT:** Mrs TG Zenzile

**ADDRESS:** North-West University  
INSINQ  
Private bag X6001  
Potchefstroom  
2522

**CONTACT NUMBER:** 018-299 1832 / 299 1836

You are being invited to take part in a **research study** that forms part of my Master's degree. Please take some time to read the information presented here, which will explain the details of this study. Please ask the researcher or person explaining the research to you any questions about any part of this study that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research is about and how you might be involved. Also, your participation is **entirely voluntary** and you are free to say no to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part now.

This study has been approved by the Health Research Ethics Committee of the Faculty of Health Sciences of the North-West University (NWU-00022-17-S1) and will be conducted according to the ethical guidelines and principles of Ethics in Health Research: Principles, Processes and Structures (DoH, 2015) and other international ethical guidelines applicable to this study. It might be necessary for the research ethics committee members or other relevant people to inspect the research records.

**What is this research study all about?**

- *This study will be conducted in Dr Kenneth Kaunda District, in a boardroom of the sub-district you are in and will involve a focus group interview with experienced health researchers trained in focus group interviewing. Eight (8) to ten (10) participants will be included in each focus group of this study.*
- *We plan to find out whether the Community Health Workers understand what their role is in rendering of mother, child and women's health services*

**Why have you been invited to participate?**

- *You have been invited to be part of this research because you are a Community Health Worker working within a WBOT in Dr Kenneth Kaunda District.*
- *You also fit the research because you have been a Community Health Worker for more than six months in a WBOT that is linked to a clinic; you are willing to give permission freely to take part in the study, after understanding what the study is about; you are able to communicate in English. You are also willing to share your experiences during the focus group interview session and be recorded whilst taking part in the focus group.*
- *You will not be able to take part in this research if you are not rendering community health work services in households anymore e.g. Mentor Mothers*

**What will be expected of you?**

- *You will be expected to take part in a one hour long focus group interview session. You will only be included in one focus group. A follow-up interview may be held with you and/or others where necessary. You will also be expected to raise your views on questions posed by the group facilitator. A total of 6 questions will be asked.*

**Will you gain anything from taking part in this research?**

- *The gains for you if you take part in this study will be: understanding your role and how your activities impact on MCWH services in Dr Kenneth Kaunda District*
- *The other gains of the study are: The community of Dr Kenneth Kaunda District will benefit through being attended to by informed Community Health Workers. Dr Kenneth Kaunda District is likely to benefit through the improved MCWH indicators.*

**Are there risks involved in you taking part in this research and what will be done to prevent them?**

- *The risks to you in this study are possible emotional discomfort that can occur during focus group discussions as the discussions are likely to "expose" each CHW's level of understanding of their role in rendering MCWH services. That will be limited by the researcher leading the discussion by emphasising that there are no correct or wrong answers, as each individual has a unique opinion. If emotional discomfort becomes evident the researcher will also suggest a tea break to do some small talk and let participants feel at ease. The researcher will have an agreement with the participants not to disclose information that was discussed within the group to people outside the group.*
- *There are more gains for you in joining this study than there are risks.*

#### **How will we protect your confidentiality and who will see your findings?**

- *Anonymity of your findings will be protected by allocating numbers to participants; the researcher will ask questions and identify the numbers of participants instead of using their names. Personal information regarding the participants and PHC facilities will not be divulged during data collection or revealed in the research study, research report or any published article. The researcher will inform participants that confidentiality cannot be guaranteed as information will be shared in a group setting. The importance of not sharing focus group information outside the group will be emphasized.*
- *Your privacy will be respected by ensuring you are not connected to what you said or how you acted during the focus group session. The researcher will upload the voice recordings on her laptop and on the transcriber's laptop as soon as possible; all voice recordings will be password protected. The transcriber will have signed a confidentiality agreement form. After the focus group discussions are transcribed, the transcription will be e-mailed as a password protected document to the researcher and study leader. The informed consent forms, schedule for data collection, name list and cell phone numbers of participants, field notes, transcriptions and analysis documentation will be locked after data analysis in the study leader's office.*
- *Your results will be kept confidential by letting all members of the research team that require access to information sign a confidentiality agreement. Only the researchers and transcriber, who signed the confidentiality agreement will be able to look at focus group interview findings. Findings will be kept safe by locking hard copies in locked cupboards in the researcher's office and for electronic data it will be password protected. (As soon as data has been transcribed it will be deleted from the digital recorders.) Data will be stored for five (5) years.*

#### **What will happen with the findings or samples?**

- *The findings of this study will only be used for this study. All anonymised data will be stored on the supervisor's computer which is password protected. Written field notes and hard copies of transcriptions will be locked in a cupboard in the supervisor's office and can only be accessed through the supervisor. All information will be deleted and destroyed (shredded) after 5 years of the research.*

#### **How will you know about the results of this research?**

- *We will give you the results of this research during the first CHW MCWH training session held after the results are available, by doing a Power-Point presentation and the researcher.*
- *You will be informed of any new relevant findings by face-to-face discussions during the Power-Point presentation*

#### **Will you be paid to take part in this study and are there any costs for you?**

- *No, you will not be paid to take part in the study. You can assist the researcher to contribute to the study by sharing your valuable experience.*
- *Travel expenses will be paid for participants to travel to the site. The focus group sessions will be conducted during your work time so that you do not spent longer time than required at work. Refreshments will be served after the focus group discussion. You will be provided with an airtime voucher of between R10 and R15 as a token of appreciation for your participation.*
- *There will thus be no costs involved for you, if you do take part in this study.*

**Is there anything else that you should know or do?**

- You can contact Mrs Thembeke Zenzile at 018-462 5744, if you have any further questions or have any problems.
- You can also contact the Health Research Ethics Committee via Mrs Carolien van Zyl at 018 299 1206 or [carolien.vanzyl@nwu.ac.za](mailto:carolien.vanzyl@nwu.ac.za) if you have any concerns that were not answered about the research or if you have complaints about the research.
- You will receive a copy of this information and consent form for your own purposes.

**Declaration by participant**

By signing below, I ..... agree to take part in the research study titled: Community health workers' understanding of their role in rendering Maternal, Child and Women's Health Services.

I declare that:

- I have read this information/it was explained to me by a trusted person in a language with which I am fluent and comfortable.
- The research was clearly explained to me.
- I have had a chance to ask questions to both the person getting the consent from me, as well as the researcher and all my questions have been answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be handled in a negative way if I do so.
- I may be asked to leave the study before it has finished, if the researcher feels it is in the best interest, or if I do not follow the study plan, as agreed to.

Signed at (*place*) ..... on (*date*) ..... 20....

.....  
**Signature of participant**

.....  
**Signature of witness**

**Declaration by person obtaining consent**

I (*name*) ..... declare that:

- I clearly and in detail explained the information in this document to  
.....
- I did not use an interpreter.
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I gave him/her time to discuss it with others if he/she wished to do so.

Signed at (*place*) ..... on (*date*) ..... 20....

.....  
Signature of person obtaining consent

.....  
Signature of witness

**Declaration by researcher**

I (*name*) ..... declare that:

- I had the information contained in this document explained by ..... who I trained for this purpose.
- I did not use an interpreter
- I was available should he/she want to ask any further questions.
- The informed consent was obtained by an independent person.
- I am satisfied that he/she adequately understands all aspects of the research, as described above.
- I am satisfied that he/she had time to discuss it with others if he/she wished to do so.

Signed at (*place*) ..... on (*date*) ..... 20....

.....  
Signature of researcher

.....  
Signature of witness

# ADDENDUM B: Ethics Approval North-West University



Private Bag X6001, Potchefstroom,  
South Africa, 2520

Tel: (018) 299-4900  
Faks: (018) 299-4910  
Web: <http://www.nwu.ac.za>

**Institutional Research Ethics Regulatory Committee**

Tel: +27 18 299 4849  
Email: [Ethics@nwu.ac.za](mailto:Ethics@nwu.ac.za)

## ETHICS APPROVAL CERTIFICATE OF STUDY

Based on approval by **Health Research Ethics Committee (HREC)** on **25/08/2017** after being reviewed at the meeting held on **16/03/2017**, the North-West University Institutional Research Ethics Regulatory Committee (NWU-IRERC) hereby **approves** your study as indicated below. This implies that the NWU-IRERC grants its permission that provided the special conditions specified below are met and pending any other authorisation that may be necessary, the study may be initiated, using the ethics number below.

<b>Study title:</b> Community health workers' role in rendering Maternal, Child and Women's Health Services																														
<b>Study Leader/Supervisor:</b> Dr CE Muller																														
<b>Student:</b> TG Zenzile-12896640																														
<b>Ethics number:</b> <table border="1"><tr><td>N</td><td>W</td><td>U</td><td>-</td><td>0</td><td>0</td><td>0</td><td>2</td><td>2</td><td>-</td><td>1</td><td>7</td><td>-</td><td>A</td><td>1</td></tr><tr><td colspan="3">Institution</td><td colspan="5">Study Number</td><td colspan="2">Year</td><td colspan="5">Status</td></tr></table> <small>Status: S = Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation</small>	N	W	U	-	0	0	0	2	2	-	1	7	-	A	1	Institution			Study Number					Year		Status				
N	W	U	-	0	0	0	2	2	-	1	7	-	A	1																
Institution			Study Number					Year		Status																				
<b>Application Type:</b> Single Study	<b>Risk:</b> <b>Medium</b>																													
<b>Commencement date:</b> 2017-08-25																														
<b>Continuation of the study is dependent on receipt of the annual (or as otherwise stipulated) monitoring report and the concomitant issuing of a letter of continuation.</b>																														

### Special conditions of the approval (if applicable):

- Translation of the informed consent document to the languages applicable to the study participants should be submitted to the HREC (if applicable).
- Any research at governmental or private institutions, permission must still be obtained from relevant authorities and provided to the HREC. Ethics approval is required BEFORE approval can be obtained from these authorities.

### General conditions:

While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, please note the following:

- The study leader (principle investigator) must report in the prescribed format to the NWU-IRERC via HREC:
  - annually (or as otherwise requested) on the monitoring of the study, and upon completion of the study
  - without any delay in case of any adverse event or incident (or any matter that interrupts sound ethical principles) during the course of the study.
- Annually a number of studies may be randomly selected for an external audit.
- The approval applies strictly to the proposal as stipulated in the application form. Would any changes to the proposal be deemed necessary during the course of the study, the study leader must apply for approval of these amendments at the HREC, prior to implementation. Would there be deviated from the study proposal without the necessary approval of such amendments, the ethics approval is immediately and automatically forfeited.
- The date of approval indicates the first date that the study may be started.
- In the interest of ethical responsibility the NWU-IRERC and HREC retains the right to:
  - request access to any information or data at any time during the course or after completion of the study;
  - to ask further questions, seek additional information, require further modification or monitor the conduct of your research or the informed consent process.
  - withdraw or postpone approval if:
    - any unethical principles or practices of the study are revealed or suspected,
    - it becomes apparent that any relevant information was withheld from the HREC or that information has been false or misrepresented,
    - the required amendments, annual (or otherwise stipulated) report and reporting of adverse events or incidents was not done in a timely manner and accurately,
    - new institutional rules, national legislation or international conventions deem it necessary.
- HREC can be contacted for further information or any report templates via [Ethics-HRECApplv@nwu.ac.za](mailto:Ethics-HRECApplv@nwu.ac.za) or 018 299 1206.

The IRERC would like to remain at your service as scientist and researcher, and wishes you well with your study. Please do not hesitate to contact the IRERC or HREC for any further enquiries or requests for assistance.

Yours sincerely

Prof LA Du Plessis  
Digitally signed by Prof LA Du Plessis  
Date: 2017.08.30  
10:46:04 +02'00'

**Prof Linda du Plessis**

Chair NWU Institutional Research Ethics Regulatory Committee (IRERC)

# ADDENDUM C: Ethics Approval North West Province DoH



**health**

Department of  
**Health**  
North West Province  
REPUBLIC OF SOUTH AFRICA

3801 First Street  
New Office Park  
MAHIKENG, 2735

Enq: Nthabiseng Mapogo  
Tel: 018 391 4504  
[NMapogo@nwp.gov.za](mailto:NMapogo@nwp.gov.za)  
[www.nwhealth.gov.za](http://www.nwhealth.gov.za)

## POLICY, PLANNING, RESEARCH, MONITORING AND EVALUATION

Name of researcher : Ms. T.G. Zenzile  
North West University


Physical Address \_\_\_\_\_  
(Work/ Institution) \_\_\_\_\_  
\_\_\_\_\_

Subject : **Research Approval Letter- Community health workers' role in rendering Maternal, Child and Women's Health Services.**

This letter serves to inform the Researcher that permission to undertake the above mentioned study has been granted by the North West Department of Health. The Researcher is expected to arrange in advance with the chosen facilities, and issue this letter as proof that permission has been granted by the Provincial office.

This letter of permission should be signed and a copy returned to the department. By signing, the Researcher agrees, binds him/herself and undertakes to furnish the Department with an electronic copy of the final research report. Alternatively, the Researcher can also provide the Department with electronic summary highlighting recommendations that will assist the department in its planning to improve some of its services where possible. Through this the Researcher will not only contribute to the academic body of knowledge but also contributes towards the bettering of health care services and thus the overall health of citizens in the North West Province.

Kindest regards

  
Mr. L.P. Moasi  
Acting Director: PPRM&E



22/09/2017  
Date

Researcher

\_\_\_\_\_ Date



Healthy Living for All

## ADDENDUM D: Example of research permission request



Private Bag X6001, Potchefstroom  
South Africa 2520

Tel: 018 299-1111/2222

**INSINQ Focus Area**

Tel: 018 2991832

Fax: 086 2707077

Email: Rina.Muller@nwu.ac.za

29 May 2017

The Acting District Director: DHS  
Dr Kenneth Kaunda District

Dear Ms A. Mohutsioa

### **Application for permission to conduct research in Dr Kenneth Kaunda District**

I the undersigned a Master's student of Nursing Science in Community Health at the North-West University Potchefstroom Campus, hereby kindly request your permission to conduct research with Community Health Workers (CHWs) within Ward Based Outreach Teams, as participants. The practical research is a module that ensures partial fulfilment of the requirement for the abovementioned Master's degree. Permission to conduct research in the Dr Kenneth Kaunda District is already obtained from the Provincial Department of Health (PDoH) and the Ethics committee of the North West University.

The title of the proposed study I am requesting permission for is: Community Health Workers' understanding of their role in rendering Maternal, Child and Womens Health services.

The researcher will need a gatekeeper, whose role will later convert to a mediator; preferably the Outreach Team Leaders in the facilities to identify potential participants and introduce the research topic to them (gatekeeper role). The researcher will share information with potential participants who have already shown interest when the Outreach Team Leader introduced the research to them. This is to ensure that the participants are not unduly influenced by "power relationship" between the researcher and potential participants. The training needed to assist with recruitment, provision of information about the

study and to obtain informed consent will be given by the researcher. The researcher will schedule a time which suits participants, as guided by the Outreach Team Leaders to provide this essential training during their own time, therefore services will not be disrupted.

The focus group method of data collection will be applied. All information collected will be kept confidential and anonymous. No names of mediators or participants will be revealed or identified. Research findings will be made available after the study is completed to the participants and relevant management structures through presentations at appropriate forums e.g. PHC Forum and District Research Day. Additionally a report of the study will be provided to the Provincial Department of Health (North West) and will be available to the District Clinical Specialist Team of Dr Kenneth Kaunda District. A copy of the ethics committee and the PDoH permission to conduct the study is attached for your assurance.

I will be grateful if I am granted the privileged permission to collect data at this facility.

Warm regards

---

Ms. TG Zenzile

Master's degree candidate and researcher

# ADDENDUM E : Permission granted to conduct research by Dr KK District



**health**

Department of  
Health  
North West Province  
REPUBLIC OF SOUTH AFRICA

Westland Building  
51 Beak Street  
KLERKSDORP  
2570

Tel: 018-462-5744  
Email: amohutsioa@nwpg.gov.za



**DR KENNETH KAUNDA DISTRICT: OFFICE OF THE DISTRICT DIRECTOR**

**To: Mrs. TG Zenzile**  
Masters degree candidate and researcher

**Subject: Permission to conduct the research study in Dr Kenneth Kaunda District**

You are hereby granted permission to conduct a research study titled "Community Health Workers' understanding of their role in rendering Maternal, Child and Women's Health services". You are further granted to permission have Community Health Workers (CHWs) within Ward-Based Outreach Teams, of identified facilities within the district participate in your study as per your request.

It will be expected of the researcher to utilize available platforms to share the findings of the above-mentioned study and recommendations thereof with the management of Dr Kenneth Kaunda District.

Thank you,

**Mrs MAIN Mohutsioa**  
Acting District Director  
Dr Kenneth Kaunda District

NW DEPT. OF HEALTH
DR. KENNETH KAUNDA PRIVATE BAG/PRIVAATSAK A2
2017 -06- 05
KLERKSDORP 2570
NW DEPT. VAN GESONDHEID



Healthy Living for All

1

## ADDENDUM F: Example of focus group transcription

Focus group 1\_Zenzile TG\_NWU-00022-17-S1

<b>Sub-district code</b>	<b>1</b>
<b>PHC Facility</b>	<b>1</b>
<b>Date of focus group</b>	<b>6 Oct 2017</b>

1

### 2 **FOCUS GROUP 1**

3 I: Oraait colleagues. Good afternoon. My name is Thembeke Zenzile, I am a member  
4 of the district clinical specialist team in Dr Kenneth Kaunda District. My primary  
5 responsibility is to make sure that the issues around mother and child health issues  
6 are actually taken care of, nè. It is to make sure basically to say that our mothers  
7 when they leave our facilities, they leave our facilities alive and they leave our  
8 facilities healthy, nè. OK, firstly I am going to ask you guys to introduce yourselves  
9 before we even get into anything. OK, participant number 7 can you please introduce  
10 yourself?

11 P7: I'm female, I work at ward 16. I'm not married and I have two little boys

12 I: (laugh) OK

13 P8: I'm male. My age is 26, I working at ward 7. I am single. I have one daughter.

14 I: OK. Participant number 1?

15 P1: I'm female. I'm 36 years old, I work at ward 7. I am single. I have one little boy of  
16 two years.

17 P2: I am female I'm 28 years old. I work at ward 16. I'm single and I have one  
18 daughter.

19 I: And today we call you participant number?

20 P2: Two

21 I: Thank you.

22 P6: I am a female, 42 years. I work at ward 7. I am single. I don't have a child.

23 I: Good. OK participant number 5?

24 P5: I am a male. I am 32 years old. Working at ward 6. I'm single and I have got  
25 three children.

26 I: Participant number 3?

27 P3: I'm a female, 42 years old. I work at ward 7. I am single, no children.

28 I: OK. Participant number 4?

29 P4: I'm a male, 33 years old. Working at ward 6. I am single. Three children.

30 I: Thank you, colleagues. It is good now that we know each other. raait. OK, let's  
31 also introduce our field worker.

32 F: I'm a female at the age of 37 years old. I have two boys. I work as a CHW mentor  
33 mother,

34 I: Thank you very much. OK colleagues like I said to you, this, I want this to be on  
35 record, please like this is not a quite conversation as we agreed. I want this to be on  
36 record colleagues, that this interview that I am having with you today is got nothing to  
37 do with extension or termination of your contracts. It solely wants to identify issues  
38 around maternal child and women's health. That is it, colleagues. Nothing more than  
39 that. OK, Raait, and this information it will not be accessed by anyone that is not  
40 warranted to actually access it. OK. Raait. My first question for you guys. The way I  
41 am going to ask the questions nè, I am not going to ask and then you answer the  
42 same question like that you know. Anyone who feels like answering can just raise a  
43 hand and then I will give her chance to speak and then she can answer the question  
44 or he can answer the question. OK, all right colleagues. The first question, nè,  
45 describe your role as a health worker in providing services to mothers and children.

46 (silence)

47 I: Participant no 1?

48 P1: My role is to make sure that the mother comes to full term before, he...she must  
49 come to a clinic before six weeks when she is pregnant.

50 I: OK

51 P1: And then my role is again to make sure again that the mother continue again to  
52 attend the clinic through the pregnancy term and then my role is again to make sure  
53 that when the child is born it comes to the clinic for other immunisations and vitamins  
54 and other things that previously that clinics are providing for the children.

55 I: You are saying that the mother. You want the mother to come as early as possible  
56 for bookings when she is pregnant at about six weeks. Is there a reason why you  
57 want the mother to come that early?

58 P1: The reason is that the mother when she... the reason for the booking before six  
59 weeks is to make sure that she did not get any complications during the pregnancy  
60 or delivery.

61 I: OK, thank you very much. Any other respondents to that? Anything to say?  
62 Participant number 5, do you have anything to say on that? What you think your role  
63 is in relation to provide services to mothers and children. Remember colleagues  
64 there is no wrong or right question, nè

65 P5: As she has already speak participant number 1. I will only have to add there and  
66 there is my role as a CHW. (silence) I really pass. I'll come again.

67 I: OK. Any other one?

68 P6: Is my role....

69 I: Participant no 6?

70 P6: I my role. I teach the mother the danger signs and how to eat healthy food and to  
71 exercise. She must come on the visit on the clinic. I do four visits for the mother  
72 before she give birth and after the birth I do exactly four again and an extra one is

73 the first day after the birth. One day. If she not come to the clinic, I must go and  
74 check the mother and the baby and then after three days to check if she have bring  
75 the baby on the clinic. Then seven days and fourteen days and after that is six  
76 weeks to check the danger signs and all those things.

77 I: OK Participant number 6. You are saying that you visit the mother at least about  
78 four times during pregnancy.

79 P6: Yes, they must do four visits.

80 I: Four visits. What is it that you are doing for the mother in that, actually in those four  
81 visits?

82 P6: On this three visits I do this visit, is the danger signs, I teach her high and how to  
83 birth the baby and to eat healthy food. On the fourth visit we prepare for when she go  
84 to deliver at the hospital to pack her bag and all her medication. If she is HIV Positive  
85 she must disclose to one person at least.

86 I: Where? At home or at the clinic?

87 P6: At home.

88 I: OK.

89 P6: And prepare the transport.

90 I: OK, thank you. Any other input in terms of that question?

91 (Silence)

92 I: Are you OK? OK. My next question, colleagues. What makes it easy for you to  
93 provide these services as you go to the communities? What do you think makes it  
94 easy for you to be able to work in the communities or to provide the service that you  
95 are supposed to provide at the communities?

96 (Silence)

97 I: Participant number 7 do you have anything to say? Just think of something that  
98 makes it easy for you. You know there are those things that might be assisting you to  
99 be able to do your work or something like that, you know. What makes it easy for  
100 you?

101 P7: The thing that makes easiest is when you communicate with the mother, when  
102 you do the visit, you do pregnancy screen, if you communicate a lot when you do a  
103 visit.

104 I: OK. Any other input? (Silence) Participant number 1?

105 P1: The thing that makes it easy again is the timetable of your work. Like this week I  
106 went to see the number 3, this week I went to see a number 4.

107 I: OK are you saying, participant number 1, that before you go out you normally  
108 make like a schedule?

109 P1: A schedule.

110 I: To say where you are going, when and the like? How does that make it easy for  
111 you?

112 P1: Like every month you are having your schedules and you see and you know the  
113 visit at the patient number 3 you know the month of that particular person is this one  
114 and that one and that one.

115 I: OK. Any other input on that particular issue?

116 (Silence)

117 I: Participant number 8? Any input on that issue? What do you think makes it easy  
118 for you? Remember colleagues we said there is no wrong or right question and  
119 answer.

120 (Silence)

121 I: Participant number 2, do you have anything to say? What makes it easy for you to  
122 provide these services?

123 P2: What makes it easy to provide the services to the mother or the child. I think it is  
124 when you communicate with the mother about the danger signs of pregnancy, after  
125 PMC, the danger signs of PMC, after having the baby, to teach her about the  
126 immunisation and you go there to check the road to health card that the child is up to  
127 date with immunisations.

128 I: OK. Participant number 2, just to be clear in terms of what you are saying, just to  
129 make sure that I understand what you are saying. You are saying that what makes it  
130 easy for you is when you would go to the client and then you like give her information  
131 about the danger signs and all the relevant information that you are supposed to give  
132 to them. Is that what you are saying? OK. Thank you very much. Any input on this  
133 one? (Silence) Are we OK? Are you covered Participant number 4?

134 P4: I'm covered.

135 I: Thank you.

136 (Silence)

137 I: OK colleagues. Now the next question is what makes it difficult for you to provide  
138 these services?

139 I: Participant number 8, what makes it difficult for you to provide these services?

140 P8: What makes it difficult is that sometimes you do not get the mother at home.  
141 Sometime they go somewhere at the family so just to locate themselves. You don't  
142 find them.

143 I: OK. What you are saying participant number 8 is that at times, when you leave the  
144 clinic and go to visit the mothers, you don't find them at home.

145 P8: Ja. Some are... When you go to their home they are not there. You just make  
146 the visit there.

147 I: OK. But now if you don't find them, what does that create? You know, what does  
148 that result in if you don't find the mother?

149 P8: You just make the follow-up after that date.

150 I: Until you find the mother.

151 P8: Until you find the mother.

152 I: So you are saying that if you go to a household and you then don't find the mother  
153 there, you make a follow-up until you get hold of that mother.

154 P8: Ja.

155 I: OK. I don't know, maybe I should also ask as a follow-up question to say if it  
156 happens that you keep on going to this house and then you did not find the mother  
157 there, then what happens eventually?

158 P8: I will still make a follow-ups and just tell the sister at the clinic.

159 I: OK. Thank you. Let us not get derailed, nè, colleagues. I'm still going back to the  
160 question that says what makes it difficult for you to provide these services that we  
161 are supposed to provide?

162 P3: What makes it difficult that when the body's pregnant there is not big difficulty but  
163 once she give birth some of them... They tell you, no, you must come after a month  
164 or six weeks. That makes it difficult because when she's pregnant you must know  
165 every day you must come there. Weekday OTA. She will agree but when she come  
166 to the clinic she just says wait. What you must do? Nothing. She will tell you, you  
167 must come after six weeks and that six weeks is almost old to be a child. Because  
168 you know after eight weeks it is a child is not a baby.

169 I: OK. Participant number 3? Are you saying that when the woman is sort of like in  
170 labour, or maybe when she's coming for her anti natal classes you will tell the  
171 woman you are supposed to come and see her after that and then when you go to  
172 the household she change her mind now. She does not want you to come or when  
173 you are there already she does not want you to come in.

174 P3: She does not want me to come in.

175 I: When you are already at the household?

176 P3: Yes.

177 I: So how do you normally deal with this situation?

178 P3: With this situation you have to act if the mother does not want you to enter. You  
179 go to OTL. If she don't agree again we will wait for that month or six weeks and then  
180 we go back.

181 I: OK. Then what happens to the mother eventually?

182 P3: We don't do nothing because what you can do? She will tell us it is a tradition.  
183 We must not handle the baby.

184 I: OK. Participant number 7?

185 P7: Sometimes you will do the visit, at the ANC mom, when she is in labour she will  
186 be working. Maybe my house won't even be send me my money. When you go  
187 there, she's not home. Maybe she is at the extension because she will need the  
188 money.

189 I: Then is there an easy way maybe for you to find her. Maybe. You know, let's say  
190 for instance you are supposed to be visiting her at this particular number house  
191 number, that you normally visit her. You get there, she's not there. What you do  
192 about this situation?

193 P7: I do the follow-ups.

194 I: Until when?

195 (Silence)

196 P3: To add to that, If she relocate at the extension four maybe I give the sister who  
197 work there on that side, you must check for me that person, please.

198 I: OK colleagues, please wait for me to say participant number 3 otherwise it is going  
199 to be you know there is going to be a mix-up. OK. Participant number 3, can you just  
200 repeat what you said now?

201 P3: If she relocated at the extension four maybe, we give the sister who works there  
202 on that side to check her.

203 I: OK.

204 P3: But it is difficult when she is at the farm.

205 I: Are you saying that... Why is it difficult when she is at the farm?

206 P3: We don't have transport to go there to the farm. Maybe at Haasbrook. We don't  
207 work there.

208 I: Are there no community health workers at Haasbrook?

209 P3: No.

210 I: (laugh) OK. Thank you. Is there anyone else wants to say something on what  
211 makes is difficult for you to provide these services? (Silence) Are we covered in  
212 terms of that one? OK participant number 5?

213 P5: Like they are all our patients. Sometimes it is... actually it is difficult for us, like  
214 they would say the mother would be there with her child, you see. Those CHW's who  
215 they work at other ward, maybe, for instance they may give you a visit there. They  
216 just like we communicate with our phones. So it is much....aa...

217 (Silence)

218 I: Remember I said colleagues; there is no right or wrong, nè. And like I said, I don't  
219 want perfect English. All that I want from you is just to be able to put your matter  
220 across the table.

- 221 P5: Ja. So is...(Silence)
- 222 I: Shall we leave it for now? OK. Participant number 6?
- 223 P3: To be more difficult again is if the mother does not have disclose on me if she is  
224 HIV+ and then it would be more difficult to come and check her because she know I  
225 must go through that road to health card. And I must check it. And check the PCR  
226 and it make it more difficult.
- 227 I: OK. Are you saying now participant number 3 that when the mother is HIV+ and  
228 has not disclosed to you, when you must access the road to health card it becomes  
229 a problem.
- 230 P3: Yes.
- 231 I: Why do you think it becomes a problem?
- 232 P3: It becomes a problem even if I would give her maternity book I see maybe she is  
233 HIV+. I will not say: You are HIV+. Why you not tell me. I must go and just keep  
234 quiet. Because I know they don't know...
- 235 I: And how do you deal with that situation?
- 236 P3: I encourage her to bring the baby on the clinic and I am not going to talk about  
237 the PCR. Because if you talk about the PCR you will not get that card again.
- 238 I: Let me maybe just come up with a follow-up question on this one. That if you  
239 identify that the woman is HIV+ and she has not disclosed to you, like you say and  
240 then you happened to get hold of her file or the baby's road to health card. You open  
241 it and you identify that there is issues of PCR there. And like, are you just going to  
242 leave it like that?
- 243 P3: No.
- 244 I: How are you going to deal with it?
- 245 P3: I am going to deal with it. You must take this baby to do PCR. Even if you talking  
246 you said: you must take this baby to clinic to do PCR that day. When you go to do  
247 follow-up you ask for the card. You will never ever get that card. She will tell you the  
248 baby's card is there at mother. You will never ever... (Silence)
- 249 I: OK, Thank you very much. Is there any other comments or can we pass this  
250 question? (Silence) Are you comfortable?
- 251 (Silence)
- 252 I: OK colleagues. My next question to you...; this is now question number four, nè.  
253 What challenges do you face every day while providing these services? (Silence)  
254 Can I repeat the question? What challenges do you face every day while providing  
255 these services?
- 256 I: Participant number 8?

257 P8: The challenges that you are facing is that the mother will go somewhere and  
258 sometimes you look there and there is no someone there. When you go and look  
259 there, there is no someone. And sometimes when we find the booklet, they say that  
260 they don't have a booklet.

261 I: Are you saying participant number 8, that sometimes when you go to a household  
262 you don't find someone or you find somebody, you don't get hold of the card of the  
263 patient.

264 P8: Ja.

265 I: When you are saying the booklet, are you referring... actually hat are you referring  
266 to?

267 (Silence)

268 I: When you are talking about the booklet. Which booklet are you referring to? Are  
269 you talking about?

270 P8 : The booklet ANC for booking.

271 I: O. For ANC booking. Thank you participant number 8. Other participant?  
272 Participant number 2? What challenges do you face every day while providing these  
273 services?

274 P2: The other challenge that we are facing is when you go to the household you find  
275 this under 5 there. Sometimes when you ask them for the road card, child book, they  
276 don't want to give it to you because they said.... Sometimes the book is not up to  
277 date with the immunisation of the baby. So they hide it. She will tell you: No the book  
278 of the child it's somewhere there at the farm. I forget it at mother's house. She tells  
279 you two plain stories. That is the challenge that we get at the household.

280 I: OK. Participant number 2, if I may ask, nè? Why do you think they hide the books?

281 P2: Because they have a fear of when they come to the clinic for the baby, they say  
282 that the sisters they just shouting at them. Why you didn't come to bring the child to  
283 the clinic. So that is why they don't want to bring the child because their  
284 immunisations are not up to date.

285 I: OK Participant number 2. If I understood you well. Correct me if I did not  
286 understand properly. You are saying that if the mothers skipped bringing the baby to  
287 the clinic, then when they come, they do not come with the book of the child.

288 P2: No, They come with it. When I said, I refer to her to come to the clinic.

289 I: When is it that they don't show it?

290 P2: When the book of the child is not up to date.

291 I: Are you saying that when you visit them at home and then you ask them for the  
292 book, then they say they left it somewhere else. Only when they come to the clinic  
293 now, when you refer them, it's only then that they produce the book.

294 P2: Yes.

295 I: OK thank you very much. OK, colleagues, Are you paying attention to the  
296 challenges that we face every day? OK, Participant number 1?

297 P1: That challenge of patient. Other peoples are saying that there are cultural  
298 beliefs, they don't belief to take the child to the clinic for other services like  
299 immunisations and other....

300 I: So,

301 P1: They only bring the child when they even cough or something.

302 I: Are you saying that the other people, they are saying that their cultural beliefs do  
303 not allow them to bring baby to the clinic for like routine things like immunisation and  
304 the like. They only bring them when they cough or they are sick or something like  
305 that. Is it something that you see often? Or is it....

306 P1: I come across, it was the first time I come across it.

307 I: And then how did you deal with it, if I may ask?

308 P1: At the training they said that other people's beliefs we must respect those  
309 beliefs. So I didn't follow up or do anything.

310 I: OK. Is there any other participant who thinks maybe when we come across a  
311 challenge like that we should deal with it actually in a particular way?

312 (Silence)

313 P3: On the things we must obey the tradition of the people. We must not force  
314 inward.

315 I: Participant number 3. Are you saying to me that when you come across people  
316 with cultural beliefs that do not allow them to take the child to the clinic for routine  
317 issues like immunisations you must just leave them like that? Because you will be  
318 respecting their culture.

319 P3: Yes, but I will explain what is important to take the child today for a warding. If  
320 they do not agree I must respect them.

321 I: Thank you participant number 3. (laugh) OK. Any other input on this issue?

322 (Silence)

323 I: Colleagues before we even pass this last question that we asked now, nè. What do  
324 you think this can result in. The issue of you come across a people that have got this  
325 cultural belief of saying that you cannot bring the child to the clinic for routine issues  
326 like immunisation. What do you think that can create?

327 P3: The child she can be disabled, have polio have, muscle, when she come and  
328 walk.

329 I: OK. Thank you participant number 3. OK. I'm going to move to question five.  
330 Participant number 8 and participant number 7, I need your inputs also, please.  
331 Participants number 5, number 4. I need you inputs, guys, nè. OK. Our next

332 question. It says: How do you cope with these challenges that you come across  
333 every day? You have just mentioned challenges that you come across like this and  
334 this and this. But how do you cope with them? Let me take you to participant number  
335 7. How do you deal with this challenges?

336 P7: Firstly I talk with my team leader and address it to him. And secondly, I go there  
337 again and explain how important immunisation it is. Then after that I will do the  
338 follow-up again until they allow me to attend to the immunisation.

339 I: Thank you participant number 7. Participant number 8?

340 P 8: Firstly I will tell the team leader. And secondly I will just go with my team leader  
341 and then he supervise me to household and just tell the person to bring the children  
342 at the clinic.

343 I: OK. How do you cope with this challenges every day? Participant number 3?

344 P3: Sometimes when I come across that challenge maybe I refer that child today, the  
345 mother does not come, then tomorrow I do the follow-up and I will take the mother  
346 with the child. I will come with them here at the clinic and I go to the sister and  
347 explain to her. And when she go back the sister have already dealt. That is how I do.

348 I: OK.

349 P3: If you don't force them, they will not do anything.

350 I: OK, participant number 3, are you saying that when the patient does not want to  
351 come, actually, when the mother does not want to bring the baby due to this cultural  
352 belief or this challenges, you force the mother to come to the clinic.

353 P3: I will explain the way I know myself. I will explain to her, and I am going to tell her  
354 I will come in again. At last she must agree. Because if I come back to the clinic I will  
355 go to the sister to give me some advice how to enter that person.

356 I: uh-uh

357 P3: Yes.

358 I: Thank you. Participant number 2? Do you have anything to say?

359 P2: I will also do that. I will take my OTL to go at that household to talk to that  
360 mother. We know exactly that it is the cultural belief but at the end of the day they  
361 have to bring the child to the clinic because the child, he or she is going to have  
362 complications when he or she grow up.

363 I: Thank you very much, participant number 2. OK colleagues, I am going to go to  
364 the last question. I really want you to talk to this. I really want you to talk to this and I  
365 really would appreciate the input from all of you guys. What suggestions do you have  
366 to better these services? What suggestions do you have to better these services?

367 I: This time I am going to say participant number 1, nè? It's number 1. Yes.

368 P1: I will only give my team leader, my department of health, to make this easier is to  
369 take the immunisations with team leader and other vitamins to give to the child at  
370 home. Is only the best I know.

371 I: OK. Are you suggesting participant number 1 that in a case where the mother does  
372 not want to bring the child maybe for immunisation to clinic due to cultural beliefs you  
373 suggest to your team leader that you must take the immunisation to the child at  
374 home. Is that what you are saying?

375 P1: Yes.

376 I: OK. Any other? Participant number 3?

377 P3: I will suggest that there must be more pamphlet to distribute for the mother. We  
378 speak about if the mother do not have HIV and what will happen at birth. How long  
379 and what will happen. Maybe if they can read for themselves they will understand.  
380 We do not speak. I don't know what to say.

381 I: (laugh) OK participant number 3. Are you saying that, just to clarify, are you saying  
382 that in a case where the mother does not want to bring the baby to the clinic due to  
383 the immunisation issues and the like. What you are going to suggest is that there  
384 should be pamphlets that will reach them.

385 P3: Yes. Just like on the ANC. The ANC they have proof. They have pamphlet. That  
386 pamphlet they must write with Twana, English. You give them, they will read the  
387 danger sign. Once she know that this thing is the babies does not play she will come  
388 to the clinic. When we are on the field we will give them the pamphlet to read for  
389 themselves. I will agreed and say take that pamphlet and you shall read that.  
390 (laughter)

391 I: (laugh) OK thank you. Colleagues, we must remember now that when we are  
392 talking about the suggestions, nè. We must not only talk about the suggestion  
393 around the issues of immunisations. We must talk about the suggestions that will  
394 better all the services to mother and child. So what is it we think can be done in order  
395 to better this services. Sorry.(cough) participant number 2 do you have anything to  
396 say?

397 (Silence)

398 I: Sorry. Sure fine, OK. sorry (cough) participant number 7?

399 P7: The issue I think is the health department calling every Friday at the crèche and  
400 address the mother of children how important is immunisation. (mumble - cough) we  
401 are going to tell them how important it is so they will know.

402 I: OK. Now. A follow-up question to you participant number 7... at least can I have a  
403 second (cough) Sorry, A follow-up question to you, nè. How do you think this holding  
404 a meeting every Friday. How do you think you are going to get the client?

405 P7: At the crèche we have lots of babies and they have mothers. If you call them  
406 every Friday and tell them about the immunisation how it is important and how  
407 importance it is going to the clinic every month when they are pregnant it will be

408 much easier because they take their children every day to the crèche and most of  
409 the children are there at the crèche.

410 I: OK. I want us to unpack this a little bit number 7, nè. This suggestion that we, I  
411 mean the department of health meets every Friday with the crèches and issues like  
412 that. How do you think this is going to work? For in the sense of are you saying every  
413 Friday you must be at the crèches? Or maybe one crèche this Friday and another  
414 crèche the following Friday. I want it to be clear in terms of what do you mean in  
415 terms of that.

416 P7: This week another crèche. Like that.

417 I: What time of the day do you think will be feasible? In the morning?

418 P7: Half past eight because we clock in at eight o'clock and even if you go to the  
419 household you have to tell them about the crèche you do that morning.

420 (Silence)

421 I: Colleagues is there any other way that we can try to better the services? (Silence)  
422 Just think of any way that you think that this services could be bettered. What is it  
423 that can be done to better the services for MCWH? participant number 1?

424 P1: I think as a CHW there must be again...The department must bring other users  
425 every team of CHW's must have two nurses.

426 I: Nurses? Are you referring to..?

427 P1: Team leaders.

428 I: Outreach team leaders.

429 (Silence)

430 I: Participant number 4 you are being very quiet. (Silence) What you think can be  
431 done to better the services? (Silence) Remember colleagues we are talking like you  
432 know in your own opinion you think this can be done. (Silence) Is your hand up  
433 participant number 8? OK.

434 P8: I think that the mother should be visited in the home giving their ABC's in the  
435 home. Just to do the campaigns at the location and then the just to call the people to  
436 come and just to give the people the services.

437 I: OK. Participant number 8 are you suggesting that the department must go out  
438 there and give the services to the people at home and at the community.

439 P8: Ja.

440 I: Is that what you are saying? If I may have a follow-up question, Is that not what is  
441 happening already? Now?

442 P8: Ja it is already happening now.

443 I: Are you suggesting that they should continue? Or that it should be bettered in  
444 maybe in any way or something like that. What exactly do you mean because now.  
445 As you are saying it is something that is already happening.

446 P8: Ja.

447 I: Yet now you are mentioning it for it must be done. What I want to understand from  
448 you is that what you mean is that that service must continue or are you saying that  
449 maybe the service must be improved.

450 P8: The service must improve.

451 I: The service must improve. In what way maybe do you think it must improve?

452 P8: By visiting the people at the houses and just to give them the services. It will be  
453 better that way because that people she be too sick to come to the clinic. I think that  
454 she will become better just for people to come at the clinic. That would be for people  
455 to also difficult to come to the clinic.

456 I: OK participant number 8. Just to summarize what you said now. As it is now  
457 people are seen at the community during outreaches. Like outreach campaigns.  
458 Those campaigns are done at the community at a central point. Now you are  
459 suggesting that maybe it need to be forwarded at home. This must be done at their  
460 homes.

461 P8: Ja.

462 I: OK. Thank you participant number 8. I saw your hand was up, participant number  
463 2?

464 P2: (laugh) My suggestion is the same as number 1, for the department to bring  
465 more nurses to the field to help with the OTL's, because the clients sometimes they  
466 don't want to come at the clinic to attend. So maybe it will be better when they bring  
467 the professional nurse to work in the field with the OTL's.

468 I: OK. Thank you participant number 2. That is clear. I think participant number 7  
469 your hand was up?

470 P7: I think department must bring one mother mentor and one counsellor because  
471 when you go to household, you will ask maybe you will screen for pregnancy. Then  
472 when you ask questions the person would say: no, no, no, no, no, no, no and you  
473 don't even know her term of pregnancy. Maybe if we have mother mentor and  
474 counsellor, mother mentor will see she is pregnant and maybe even at counsellor  
475 they would not go to clinic to book early because of you have to test to make sure  
476 that if you book in you will take your treatment and you will be everything.

477 I: Participant number 7, are you suggesting that in the team that is there now there  
478 has to be an addition with a mentor mother and with a counsellor in order for them to  
479 cover the areas that you are unable to cover. I mean in terms of talking to the  
480 patient, maybe they will be in a better position to give more information around why  
481 you should go to a clinic early and things like that. Is that what you are saying?

- 482 I: I want you to say it because if you are nodding it can be doubt.
- 483 P7: Yes, yes, yes. If you tell the person go to the clinic then check everything, test for  
484 HIV, she will look at you like anything. If she had a counsellor she will tell her the  
485 importance of going to test.
- 486 I: OK. Thank you very much. Participant number 6?
- 487 P6: I think we must re-see the rumours Do not talk. A serious one at the home visit  
488 for the mother to understand how this thing works. Because now there is not a cure  
489 on the clinic. Serious, talk and the department must help with the new information.  
490 Because we know old information.
- 491 I: OK. Are you suggesting then that the department must come up with the latest  
492 information and give you the latest information so that you when you go out there  
493 you have got the latest information because you still have got the old information.
- 494 P6: Yes and on the old one I know if the baby don't have polio she will be disabled.  
495 Where? They don't explain where? Only when people will not go. How? They only  
496 give us on top they don't get deep into the case.
- 497 (Silence)
- 498 I: OK. So then you are suggesting that the information that is given it must be more  
499 detailed it terms of .. Yes.
- 500 P6: The topic.
- 501 I: Which topic in particular?
- 502 P6: Mother and child.
- 503 I: More details information about mother and child.
- 504 (Silence - writing)
- 505 I: Colleagues, I don't know if anyone of you wants to have any more suggestions.  
506 Because now this is the question where we're saying what suggestion do you have  
507 to better this services. Remember as you are working on the day to day basis, nè,  
508 you always got this thing where if they can do this it will better this. If they can do this  
509 it will be better. So whatever you are thinking of it can better the service. Do not  
510 doubt it. Put it on the table. If it's not workable it's fine we leave it out. But if it is  
511 something that is workable it is something that can be used. So are we comfortable  
512 with what we put across today. What suggestions do we have to better this services.  
513 Are we comfortable with the information?
- 514 P's: Yes.
- 515 (Silence)
- 516 I: OK, colleagues I would really like to thank you for participating and to actually avail  
517 yourselves and be participating for SUV now. I appreciate it, colleagues. Thank you  
518 very much and I will stick to my promise, like I said to you, this information will only

519 be accessed by myself and the university. None of your names will be disclosed to  
520 anybody. OK colleagues, thank you very much.

521 END

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