EVALUATION OF THE IMPLEMENTATION OF THE WARD BASED OUTREACH TEAMS (WBOT) PROGRAMME IN A RURAL AREA: THE CASE OF THE KGETLENG SUB-DISTRICT, NORTH WEST PROVINCE.

By

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DECLARATION

I, Rodney Azwinndini Mulelu ([redacted] declare that **Evaluation of the implementation of the Ward Based Outreach Teams (WBOT) Programme in a rural area: the case of the Kgetleng Sub-district, North West Province** is my work and that all the sources used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

26 February 2016

RA Mulelu **Date:**

DEDICATION

This mini dissertation is dedicated to my God the creator of the universe
who has given me the opportunity to complete this study
and to
my fiancé Ms. Manaha Melina Moloto for her support.

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ABSTRACT

The Ward Based Outreach Teams (WBOT) Programme is established in South Africa as part of a series of strategies to strengthen Primary Health Care (PHC) and to improve service delivery in the country. The purpose of the study was to gain an understanding of the experiences of Community Health Workers (CHW) in the implementation of the WBOT programme. The objectives of the study were to evaluate the experiences of CHWs in the WBOT, to evaluate factors that facilitate the implementation and to make recommendations and strategies on what can be done to improve the WBOT programme. A quantitative research design was used where self-administered questionnaires were provided to respondents for data collection. Respondents were asked to complete the questionnaires; completed questionnaires were returned by only 12 of the 27 respondents, resulting in a 44% response rate. The study's findings indicate that the Community Health Workers (CHWs) regarded the WBOT as helping the community in many ways such reducing the long queues at the clinic and providing the care of the patients in their own homes, although concerns about poor participation by the community structures and nurses in the health facilities were expressed.

CHWs expressed experiences that were positive and negative when conducting their work in the community. The results from the study have shown that there are successes, challenges and lesson learned. The results of the study further indicated that the programme is being implemented well even though it is still in a pilot phase in the sub-district. The programme has managed to improve and save many lives in the communities of Kgetleng Sub-district. Despite the level of depth in this study, there is a crucial need for more for more in-depth research regarding the experiences of users of the WBOT services and to conduct similar studies looking into urban areas and to compare and contrast the rural and urban findings.

KEYWORDS: Ward Based Outreach Teams, Community Health Workers, Community Participation, Health, District Health System

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LIST OF ACCRONYMS AND ABBREVIATIONS

WBOT	Ward Base Outreach Team
CHW	Community Health Workers
PHC	Primary Health Care
DMT	District Management Team
HST	Health System Trust
NDOH	National Department of Health
NHI	National Health Insurance
COPC	Community Oriented Primary Care
DHIS	District Health Information System
WHO	World Health Organisation
MDG	Millennium Development Goals
NGO	Non-Governmental Organisation
CEO	Chief Executive Officer
SASSA	South African Social Security Agency
ARV	Antiretroviral
UL	University of Limpopo
NWPG	North West Provincial Government

CHAPTER 1

SITUATING THE RESEARCH PROBLEM

1.1. INTRODUCTION

According to Bam, Marcus and Hugo (2013:3) South Africa has established ward-based Community Health Workers (CHW) outreach teams, as part of a series of strategies to strengthen primary health care. Nxumalo and Choonara (2014) have conducted a study in the Sedibeng District in the southern part of the Gauteng province; they indicate that Sedibeng has pioneered a complementary 'health post' approach in the Emfuleni sub-district. They further indicate that physical structures called '*health posts'* have been established in six communities of Ward 25 in Boipatong. Furthermore, these health posts are led by a nurse team leader who supervises an outreach team of up to 10(ten) CHWs and health promoters who visit households daily.

The structures range from converted containers to portable huts, where CHWs can meet each day, the nurse team leader can provide support and training to the CHWs, as well as conduct basic health screening, attend to minor ailments, controlled chronic diseases, family planning, mother and child care, and refer to the main clinic where necessary. The present research summarises the successes and challenges of the Kgetleng Sub-district *Ward Based Outreach Teams (WBOT*) approach. In the following section, the researcher shall present an overview of WBOT in South Africa.

1.2. BACKGROUND TO THE STUDY

The National Department of Health (NDOH) has set a long-term goal of establishing a National Health Insurance (NHI) in the country, which would provide equitable and universal coverage for a defined package of healthcare.

One of the key pillars of NHI is the re-engineering of Primary Health Care (PHC), which has at its heart in the development of Ward-Based Outreach Teams (WBOTs) who will take the responsibility for specific groups of households (NDOH, 2011). WBOTs will contribute towards a better understanding of local health care needs, inform service priorities and build stronger relationships between service providers and users in the communities.

The key elements to practise this service are person-centred comprehensive care, collaboration between people and practitioners, and continuity of health care. This will be community-orientated primary healthcare (COPC) on a massive scale, and it is estimated that 7 000 such teams all over the country (Community Health Workers and a nurse, supported by a doctor) are need to be established. They would provide basic preventive care and health promotion, identify people at risk, support adherence in chronic care, offer home-based care and help integrate care at the community level (Mash and Blitz, 2015:274).

WBOTs in the local areas are supported by a PHC clinic that would be largely nurse-driven, with part-time support from a doctor. In overall support of these WBOTs and clinics, a family physician is required to ensure evidence-based best practice, integrate care, help evaluate and reflect on what is happening, as well as mentor and capacitate team members. This research will be an important contributor to achieving these goals (Beasley, Starfield, van Weel, Rosser and Haq, 2007:516). The delivery of the health system in South Africa and other developing countries is an important measure that affects a country's health status (Marmot, Ryff, Bumpass, Shipley and Marks, 1997:901). The healthcare service delivery system is the mode to combine inputs and to allow the delivery of a series of interventions or serviced actions in order to improve the health condition of people (Bhattacharyya, McGahan, Dunne, Singer and Daar, 2008). This research will investigate the implementation of the Ward Based Outreach Teams (WBOT) in a rural area in the Kgetleng Sub-district, North West Province.

Dr. Masike (2012), the MEC for the Department of Health in the North West Province has indicated that in the 2012/2013 financial year, the WBOT programme will make

the financial year a defining moment in the history of the health service delivery in the North West Province. He furthermore has indicated that Outreach Teams (WBOT) will soon be on the ground visiting patients in their homes and providing the much needed health care services. “The WBOT approach will require all of us as health professionals, tribal authorities, the community, various families and patients themselves to work together to fight diseases from inside of our homes and out in broader communities”, said Dr. Masike (2012). However, in light of all discussed above, the health sector in the province, in South Africa and in developing countries are still faced with so many challenges. These challenges are the huge health status gap between urban and rural areas, low level of health awareness, cost of healthcare, scarcity of specialty care and under-resourced infrastructure (Schneider & Barron, 2008).

In recent years, these health sector problems have become more serious and higher priority has been given to delivering health service and meeting the needs of the poor in rural areas in many countries (Reddy, Patel and Jha, 2011:760). It is recognized and indicated that strengthening health delivery system as a priority for countries and governments to be able to meet the basic health needs of their people, especially for poor and vulnerable populations (Marmot, Allen and Bell, 2012:1011).

Challenges in the province and developing countries, including South Africa, are to find ways which will enable to address this basic health needs more effectively (David, Sameh, Banafsheh, Katja and Marko, 2009). In this regard, the South African National Department of Health (NDOH) has implemented re-engineering of the PHC model in the country in making sure health resources and technology are available, accessible, and affordable and that quality health services are delivered to all communities. The North-West Province is currently piloting the PHC reengineering, which includes the WBOT programme in all four districts (which are Bojanala, Ngaka Modiri Molema, Dr. Kenneth Kaunda and Dr Ruth Segomotsi Mompati). In the Bojanala District, the pilot site is in Ward 5 in the Kgetleng Sub-district where the current study has been undertaken.

The researcher will only cover Ward Based Outreach Team (WBOT) and leave out school health services and district specialist teams because not much has happened in this regard since the programme started in 2011. This study intends to evaluate the implementation of the WBOTs programme in the sub-district and to come up with conclusions and recommendations to improve the existing situation.

1.3. RESEARCH PROBLEM

The Kgetleng Sub-district is one of the pilot projects since the Ward Based Outreach Teams (WBOTs) programme was first established in the Bojanala District in North West Province in 2011. This is one of the three areas of the PHC reengineering strategy being implemented in the Province of the North-West and the rest of the country. Bojanala Operational Reports (2015) indicates there are high rates of maternal death, defaulters and lost to follow-up of patients on HIV and TB medication.

These are challenges that face the sub-district in the optimal implementation of the WBOT programme in the district. The problem the study is focused on, therefore, was to gain insight into the understanding of the key role players' experiences in the implementation of the Ward Based Outreach Teams (WBOT) programme in the Kgetleng Sub-district, Bojanala District in the North-West Province.

1.4. PURPOSE OF THE STUDY

The purpose of the study were to gain insight into

- The understanding of the key role players' experiences in the implementation of the WBOT programme.

1.5. AIMS OF THE STUDY

The aim of the study is the following:

- To evaluate, describe and explore the experiences of CHWs in the implementation of WBOT programme.

1.6. RESEARCH OBJECTIVES

- To evaluate the experiences of CHWs in the Ward Based Outreach Teams (WBOT) programme.
- To determine the factors that facilitates the implementation of the Ward Based Outreach Teams (WBOT) programme.
- To make recommendations and strategies on what can be done to improve the WBOT programme.

1.7. RESEARCH QUESTIONS

The research questions are:

- What are the experiences of CHWs in the Ward Based Outreach Teams (WBOT) programme?
- What are the factors that facilitate the implementation of the Ward Based Outreach Teams (WBOT) programme?
- What are the recommendations and strategies to improve the WBOT programme in the Sub-district?

1.8. SIGNIFICANCE OF THE RESEARCH

The researcher wanted to gain an understanding of the implementation of the WBOT Programme and the experiences of Community Health Workers in the programme. Furthermore, describing the roles of this workforce (CHWs) and their experiences in the programme will assist to strengthen Community Health Workers' contribution to

comprehensive approaches to Primary Health Care (PHC), especially Ward Based Outreach Teams (WBOTs). It is, therefore, crucial to gain an understanding of circumstances that either promote or hinder WBOT implementation so as to develop programmes aimed at addressing this challenge. This study is intended to contribute to that body of knowledge. The findings of the study will contribute towards enhancing understanding of the phenomenon WBOT implementation and also inform policy and programme development and implementation thereof. The study will be of benefit to academic scholars in the sense that it will contribute to the new knowledge, allowing future researchers pursuing research in related fields to use the study as their sense of inspiration.

This study will also benefit the policy makers in the Department of Health to make sure that there are relevant and appropriate changes and that they are entrenched and endorsed in light of the recommendations of this study. Furthermore, the results of this study will benefit the community and participants in this regard in a sense that the challenges they experienced will be taken to higher authorities in the department for consideration.

1.9. KEY CONCEPTS OF THE STUDY

1.9.1. Primary Health Care (PHC)

“PHC (Primary Health Care) is defined as an essential care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation, and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country’s health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and the community with the national health system, bringing health care as close as possible to where

people live and work, and constitutes the first element of a continuing health care service" (Petersen, 2014:3).

1.9.2. Community Health Worker (CHW)

Community Health Workers are defined as members of a community who are chosen by community members or organizations to provide basic health and medical care to their community (NDOH, 2012).

1.9.3. District Health System (DHS)

The District Health System (DHS) is the means to achieve the end of an equitable, efficient and effective health system based on the principles of the primary health care (PHC) approach. This means that the DHS is more than just a structure or form of organization. It is the manifestation of a set of activities that includes community involvement, integrated and comprehensive health care delivery, inter-sectoral collaboration and a strong bottom-up approach to planning, policy development, and management (NDOH, 2011).

1.9.4. Ward Based Outreach Team (WBOT)

WBOT is defined as a team of Community Health Workers dedicated to a community in a defined geographic area, providing door to door visits, building relationships with the community, providing lifelong health services, providing the entire spectrum from promotion to palliation, engaging with organisations and collecting and utilizing local information to act appropriately (NDOH, 2011).

1.9.5. Health

According to WHO (2009), health is defined as "A state of optimal well-being, not merely the absence of disease and infirmity." Wellness practitioners believe that optimal health or wellbeing requires a balance between wellness dimensions that

comprises the whole person. These dimensions of wellbeing include: physical, mental, emotional, environmental, spiritual and social components (WHO, 2006).

1.10. RESEARCH METHODOLOGY

1.10.1. Research design

Research design is basically a set of guidelines and instructions on how to reach a goal a researcher has set for him/herself (Auriacombe, 2006). The research design that is applicable for this study will be descriptive. A quantitative research method will be used for this study. Quantitative methodology is associated with analytical research and its purpose is to arrive at a universal statement. Terre Blanche, Durrheim and Painter (2006) point out that a quantitative method begins with a series of predetermined categories, usually embodied in standardised measures and uses these data to make broad and general comparisons. The quantitative method was based primarily on confidentially structured questionnaire provided to 27 Community Health Workers.

1.10.2. Study area

The study area for this research is the Kgetleng Sub-district in the Bojanala District, North West Province.

1.10.3. Population

According to Babbie (2005), the population for a study is that group (usually of people) about whom we want to draw conclusions. Sometimes it is not possible to study all the members of the population that interest us, and we cannot make every possible observation of them. With any survey, it is necessary to clearly define the target population, which can be defined as, ‘that group which constitutes the defined population from a statistical viewpoint’. The Kgetleng Sub-district has 41 CHWs (Bojanala Report, 2015). The target population for this study will be CHWs working

at the WBOT in the rural area of the Kgetleng Sub-district. In this study, the population consists of Kgetleng Community Health Workers (27), Outreach Team Leaders (2), and Professional nurse (1) of the feeder clinic. Twenty seven (27) respondents make up the study population. These respondents must reside within the catchment area of the Kgetleng Sub-district.

1.10.4. Sample, sampling methods and sample size

The sampling strategy involved in this study is purposive. The respondents will be selected purposively. Leedy and Ormrod, (2013) show that people or other units are chosen for a particular purpose. In this case, the purpose is to investigate the implementation of WBOT programme in the rural areas of Kgetkleng Sub-district, in the Bojanala District. In this study, twenty seven (27) respondents make up the study sample size. These respondents reside within the catchment area of the Kgetleng Sub-District.

1.10.5. Data collection

The researcher first requested for a permission from the District Chief Director to conduct the research in the sub-district and later made appointments with the participants to provide them with the self-administered questionnaires.

1.10.5.1. Self-administered questionnaire

Self-administered questionnaire have been used for the purpose of this study. The development of a questionnaire was informed by reading and reviewing of the literature during proposal writing. A total number of twenty seven (27) questionnaires were distributed to the targeted respondents. The use of self-administered questionnaires in the data collection process is critical, since it makes large samples feasible and has an important strength with regard to measurement generally (Leedy and Ormrod, 2013).

1.10.6. Data analysis

Leedy and Ormrod (2014) state that data analysis in a case study involves the steps listed below:

- Organisation of detail about the case – the specific facts about the case is arranged in a logical order.
- Categorisations of data – categories are identified to help cluster the data into meaningful groups.
- Interpretation of patterns – specific documents, occurrences, and other bits of data are examined for the specific meaning that they might have in relation to the case.
- Identification of patterns – the data and their interpretations are scrutinized for underlying themes and other patterns that characterize the case more broadly than a single piece of information can reveal.
- Synthesis and generalization – conclusions are drawn that may have implication beyond the specific case that has been studied.

In this particular study, data analysis followed a quantitative research analysis approach and steps mentioned above for data obtained through the questionnaires.

1.10.7. Validity and reliability of the study

Validity is the extent to which the instrument measures the attributes of a concept accurately. Reliability is the ability of the instrument (questionnaire) to measure the attributes of a concept or construct consistently (LoBiondo-Woods and Harber 2010:286). Before adopting the final version of the questionnaires to collect data, they have been piloted with colleagues to enable the researcher to review and make the necessary amendments to such questionnaires. Through pilot testing, the researcher had an opportunity to assess the validity of the questions and reliability of the data that has been collected through them subsequently.

1.11. ETHICAL CONSIDERATIONS

The basic considerations when conducting social research involve recognising and making ethical choices, making principled decisions, ensuring confidentiality and obtaining informed consent from participants while maintaining research integrity (Babbie and Mutton 2001:520-528). Ethical considerations in this study included gaining permission to access research participants from the Bojanala District Research Committee, from the Higher Degrees Committee of the Turfloop Graduate School of Leadership, University of Limpopo and obtaining consent from the participants.

1.11.1. Permission to access the study population

It is crucial and important for a researcher to obtain permission to access any study population. In many cases the researcher will have to negotiate access to the facility or the participants with a number of gatekeepers (Henn, Weinstein and Foard 2006:178). Prior to conducting this research, the researcher applied ethical clearance from the Turfloop Graduate School of Leadership (TGSL), University of Limpopo. The researcher then proceeded to request permission from the Bojanala District Research Committee where the study was undertaken.

1.11.2. Informed consent

Informed consent implies that the researcher makes participants aware of what the research study is all about and the processes that will be followed so that they are in the best position possible to make informed decisions regarding participation (Curtis & Curtis 2011:16). In this study informed consent has been obtained from each participant prior to conducting the focus group discussions and the individual interviews with the key informants. The process involved the researcher explaining verbally to each respondent and participant the objectives of the study and assuring them of anonymity and confidentiality, emphasizing that participation was voluntary.

Consent forms have been signed for this study by both the participants and the researcher.

1.11.3. Voluntary participation

The researcher explained and emphasized that participation was voluntary and participants could choose to withdraw at any point with no penalty or even decide not to participate at all without any repercussions for them. During this study seven of the patients selected for the survey opted not to participate in the study.

1.11.4. Confidentiality

Confidentiality refers to protecting and not sharing any personal information of the respondents without their consent (Henn, Weinstein and Foard 2006:85). In this study the names and identity of all participants will be kept confidential. The notes and tape recorded data taken during the focus group interviews and the key informant interviews and all signed consent forms will be kept in a locked cupboard by the researcher. This material will be shredded five years after the degree has been conferred.

1.11.2. LIMITATIONS OF THE STUDY

The limitations in this study are that:

- Selection bias may occur as only those CHWs on WBOT at the time of data collection have been included.
- The research has been conducted only on CHWs on Ward Based Outreach Teams (WBOT). The CHWs on other programmes such HIV and TB has been excluded.
- This limits the generalization of the study findings to all CHW in the sub-district.
- The findings of this study are not representative of other locations in the Bojanala District.

- The use of open-ended questions in a qualitative study gives much discretion to researchers and participants.

The presence of the researcher can potentially influence the behavior and responses of participants.

1.12. CHAPTERS OF THE DISSERTATION

This section presents the general outline and organization of the study report

Chapter 1

The first chapter presents the overview and introduction of the study. Here the researcher also presents the overview of the WBOT Programme implementation in South Africa. The aims and objectives of the study are also stated in the first chapter.

Chapter 2

The second chapter discusses the literature review and explored on WBOT programme in South Africa. The chapter also describes factors that influence the success and lessons from international experiences of the implementation of the WBOT programme.

Chapter 3

The third chapter reports the outline of the methodology and design. The study respondents, sampling technique, the process of data collection and analysis, as well as the ethical consideration in the research are defined and discussed in the third chapter.

Chapter 4

The fourth chapter presents the results and discussion of the study results.

Chapter 5

The fifth chapter presents the summary of findings, recommendations and conclusions. The limitations of the study are also discussed in this final chapter.

1.13. CONCLUSION

In this chapter the background of the study on the WBOT Programme implementation is introduced. The research problem, aims and objectives of the study are also articulated. In the next chapter, a detailed review of the relevant literature will be presented so that the basis of explanation on WBOT Programme implementation can be well understood by the reader.

CHAPTER 2

LITERATURE REVIEW

2.1. INTRODUCTION

The purpose of a literature review is to enable the researcher to gain a better understanding of the complexity and extent of the research problem. The focus of this chapter is on an overview of WBOT in South Africa and the North West Province, on key aspects of comprehensive Primary Health Care (PHC) implementation in South Africa, on factors that influence and facilitates the successful implementation of comprehensive WBOT programme, on challenges that continue to impede progress in achieving comprehensive WBOT Programme and on these challenges and their relevance to the implementation of the programme. South Africa, as compared to other middle–income countries, has relatively poor maternal and child outcomes. (Gilbert, 2013:54). South Africa has reduced maternal deaths from 189 per 100 000 births in 2009 to 132 per 100 000 births in 2012/13. However, the country is still very far from meeting the international commitment to reduce maternal mortality to 38 deaths per 100 000 births by 2015 as part of the global Millennium Development Goals (MDGs) (Gilbert, 2013:54).

In order to improve the high levels of largely preventable maternal, new-born and child death's, South Africa recognizes that critical measures are needed to improve and strengthen its Primary Health Care (PHC) system (Taole, 2011). The National Department of Health (NDOH) has embarked on a strategy for re-modelling the implementation of the primary health care system (PHC Reengineering) using community and clinical health care worker teams to improve support and to strengthen the districts health services. PHC re-engineering has three streams: Ward Based Outreach Teams (WBOT), District Clinical Specialist Teams (DCST) and the School Health Programme. The integration and collaboration across all three streams is important to ensure the improvement and success of the primary health care across the district and the Province of the North West and to improve maternal and child health outcomes (NDOH, 2012:2).

2.2. WARD BASED OUTREACH TEAMS (WBOT) PROGRAMME IN SOUTH AFRICA

According to Sepulveda (2006:2017), observations from many developing countries suggest that provision of home and community based health services and their links with the fixed PHC facilities in particular are critical to good health outcomes, especially child health outcomes. The role of community health workers in many countries has contributed to better health outcomes (WHO, 2007). The South African National Department of Health has suggested that this is the result of a multiplicity of factors related to community based health workers.

The adverse factors include inadequate training, inadequate support and supervision, random distribution with poor coverage, no link between the communities based services and services offered by fixed health facilities, funding through NGOs with inadequate accountability, limited or no targets for either coverage or quality to be reached (NDOH, 2011). According to Friis-Hannsen and Cold-Ravnkilde (2013) the impact of HIV on key impact indicators has also contributed considerably to the relatively poor health indicators and is independent of interventions made by CHWs or other health workers and interventions. Many of these factors could be corrected if CHWs were part of a team, were well trained, supported and supervised with a clear mandate both in terms of what they are expected to do and of the catchment population that they are responsible for. The ward based PHC outreach team is designed to correct these limitations in the way community based health services are currently provided in the country (Gemma, 2015:57). Given the key role that CHWs will play, they should, over time, be directly managed by the Department of Health (as opposed to NGOs).

This move has already happened in all the provinces in the country. The strategies for direct management by the Department have already happened and all the districts in the country have done an audit on the number of CHWs, to be trained and employed by the Department of Health as CHWs.

The PHC reengineering toolkit for implementation of the WBOT in provinces indicates that each team is linked to a PHC facility with a nurse in each facility, who is the team leader. The team leader is responsible for ensuring that their work is targeted and linked to service delivery targets and that they are adequately supported and supervised – this approach has been adopted and provinces have been implementing this strategy as from 2011 (NDOH, 2011, Matsoso and Fryatt, 2012:21). The WBOT implementation tool kit also indicates that the re-engineered approach to providing PHC services proposes a population based approach for the delivery of services. In addition, the PHC outreach is a service to the uninsured population of South Africa.

It further indicates that the Department of Health in a sub-district or on local levels will deploy PHC outreach teams in rural areas, in informal urban settlements as well as townships. According to Matsoso and Fryatt (2012:2), the Ward Based PHC Outreach Teams (WBOT) which are one of the one streams of the re-engineered PHC model are the level of health service which provides services to communities, families and individuals at community –based institutions and at a household level in a ward. Furthermore, the ward based PHC outreach team is the cornerstone of community based PHC services, which encompass activities in communities, households and educational institutions, and referral networks with community based providers.

The researcher, however, will only concentrate on and conducts this research on the Ward Based Outreach Teams (WBOT) area of PHC reengineering. The National Department of Health (2011) states that a debate in the National Health Council, a three stream approach to PHC re-engineering has been adopted by the National Department of Health of South Africa. These three streams are as follows: ward based PHC outreach team for each electoral ward, strengthening of school health services and district based clinical specialist teams with an initial focus on improving maternal and child health. According to the National Department of Health (NDOH, 2011) policy on Re-engineering of Primary Health Care (PHC), a PHC outreach team should cover one ward, which constitutes on average 7 660 of the population (or

1 620 households). Each team will be composed of a PHC nurse and six community health workers (CHWs). Each CHW will be responsible for 250 households. The tabular form of PHC outreach teams is presented below in Table 2.1.

Ratio of CHW/PHC Outreach Team/Clinic to Households/Population		
	Households	Population
1 CHW	250	1080
1 PHC Team	1620	7660
1 Clinic	7660	30640
PHC outreach teams required for current uninsured population		
Number PHC Outreach Teams in South Africa		6907

Table 2.1: WBOT ratios: Adopted from WBOT tool kit, NDOH (2011)

The CHWs responsibilities will include the following: Knowing the demography of the catchment population, knowing the epidemiology, health promotion, prevention (household and community), screening and referral, palliative care, social mobilization and linking resources to community needs to improve health (NDOH,2011). The table below shows WBOT roles and responsibilities.

THE PHC OUTREACH TEAM AND ROLES/FUNCTIONS	
WHO	**ROLE/FUNCTIONS**
1 Professional Nurse	Clinic-Based Services Support/Supervision of Community-based Services Clinical Support: Early Learning Centres (ELC), Crèches, Old Age Homes, schools
2 Staff Nurses	Clinic based services IMCI basic Ante-natal / Post-natal care (normal pregnancies) Immunization Repeats stable chronic patients Treatment of minor ailments

1 Staff Nurse	Support & supervise CHW services in the community School health services Community based programmes (e.g. ante-natal, post-natal care, immunization campaigns) Screening & support services to schools, ELC, Crèches, Old Age Homes
6 CHWs	Screening, assessment & referral, Information & education, psychosocial support, basic home Rx, support community campaigns, schools

Table 2.2. The PHC outreach team (WBOT): Roles and Functions adopted from NDOH tool kit (2011)

Although the Bojanala Health District already has around 1179 CHWs under PHC re-engineering, health outcomes are generally accepted to be sub-optimal especially in the areas of maternal and child health (Bojanala Annual Reports, 2014/15). Reasons for this include a number of 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 fixed health facilities, funding or stipend not sufficient, no targets for either coverage or quality to be reached and poor reporting. These factors have been expanded in a number of reports (Health System Trust, HST, 2011, Lehmann and Sanders, 2007). Lehman and Sanders (2007) state that the impact of HIV on key impact indicators has also contributed considerably to the relatively poor health indicators and is independent of interventions made by CHWs or other health workers and interventions. In addition many of these factors and challenges could be corrected if CHWs were part of a team, were well trained, supported and supervised with a clear mandate both in terms of what they are expected to do and of the catchment population for whom they are responsible. According to NDOH (2011) a PHC outreach team is designed to correct these limitations in the way community based health services are currently provided in the country. Each ward should have one or more PHC outreach teams. These teams are composed of a professional nurse, environmental health and health promotion practitioners as well as six CHWs.

According to NDOH (2012), the main functions of these teams is to promote good health and prevent ill health through a variety of interventions based on the concept of a healthy community, a healthy family, a healthy individual and a healthy environment. Each team should also be linked to a PHC facility through the professional nurse who is the team leader. The team leader is responsible for ensuring that their work is targeted and linked to service delivery targets and that they are adequately supported and supervised (NDOH, 2011, Friis-Hansen and Cold-Ravnkilde, 2013).

The diagrammatic PHC Outreach Teams (WBOT) model is presented in figure 2.1 below.

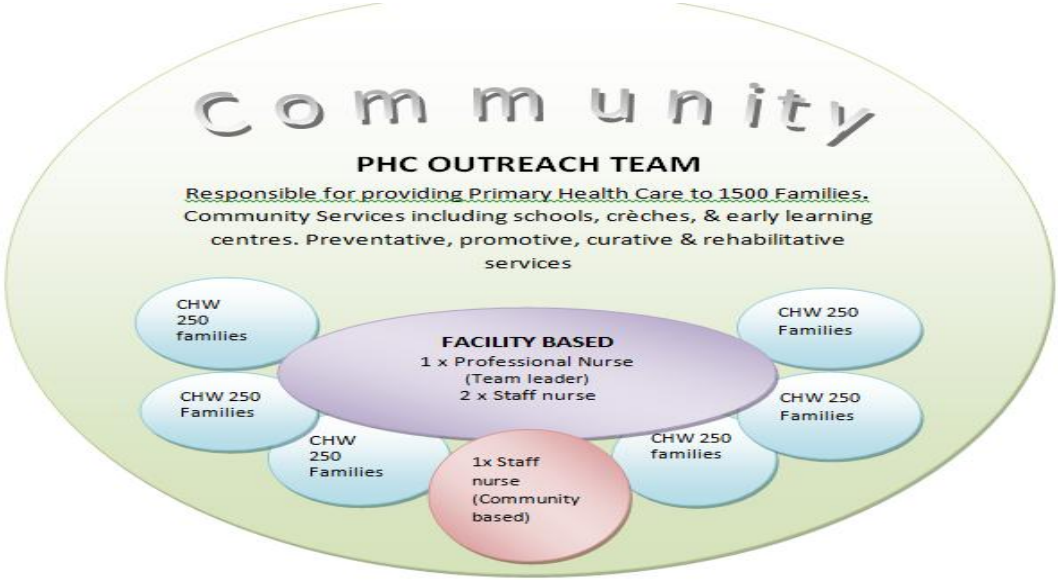


Figure 2.1. The Ward Based Primary Health Care Outreach Team (WBOT) adopted from NDOH (2011)

2.3. THE DISTRICT HEALTH SYSTEM (DHS)

Dr. Motsoaledi, Minister for the Department of Health in South Africa, during his Budget Speech in March (2015) indicated that the PHC re-engineering process does not detract from the need to strengthen the district health system – which continues to be the institutional vehicle for the delivery of PHC and district hospital services.

He further said that district management, sub-district management as well as management of all facilities within the district must continue to be strengthened; and that the district health plans are developed (and strengthened) and that the existing information systems are used to monitor and strengthen service delivery. He also said this means that quality of care must be improved through better supervision and clinical governance and paying attention to the basics, amongst other systemic interventions. According to Naledi, Baron and Schneider (2011:17), District Management Teams (DMTs), Sub-DMTs and district hospital Chief Executive Officers (CEO) must be responsible and accountable for all the services that take place in all the facilities and communities in the district. It is further highlighted that district, sub-district and hospital plans must take into account the key ministerial priorities and focus on these, including improving the systems for PHC as well as the three focused streams. It further means regular monitoring of all key performance indicators related to these and taking remedial action swiftly when these do not improve as planned.

The diagrammatic presentation of the district model is shown in Figure 2.2.

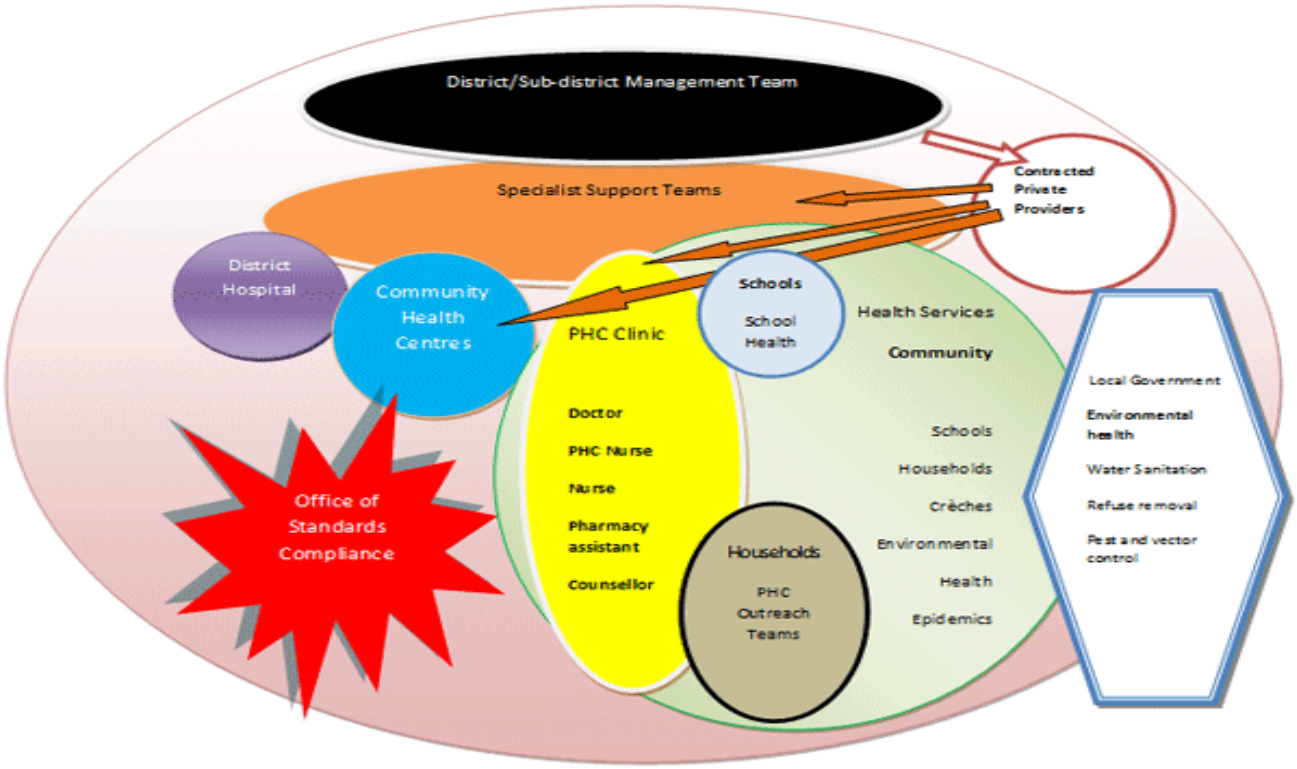


Figure: 2.2. District PHC Model: Adopted from NDOH (2011).

Minister Motsoaledi and the National Health Council Debate (March 2015), indicate and agree that a three stream approach to PHC re-engineering has been adopted by the Department of Health (NDOH) as mentioned above. This model was also discussed during a parliamentary session on Health in the National Assembly in 2015. These three streams are a ward based PHC outreach team for each electoral ward, strengthening of school health services and district based clinical specialist teams with an initial focus on improving maternal and child health which is a big challenge in the province and country as a whole.

2.4. KEY ASPECTS OF COMPREHENSIVE PHC IMPLEMENTATION

The WHO (2014) indicates eight elements that form the basis of comprehensive PHC programme interventions in order to achieve the goal of health improvement. These elements include the following: “education on prevailing health problems and methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care including family planning, immunization against major infectious diseases; appropriate treatment of common diseases and injuries; and the provision of essential drugs.” (Lehmann and Sanders, 2007).

Denhill, King and Swanepoel (1998) indicate that, overall, in any health care programme or strategy, the successful implementation of PHC must be guided by the following principles:

- Political will: The presence of progressive political will is central to the success of a health system.
- Integration of promotive, curative, preventive and rehabilitative health care services.
- Equity: Communities must have equal access to basic health care and social services without segregation of sub-groups and provision of care.
- Accessibility: Health services must reach all people in the country in terms of geographical, financial and functional accessibility.

- Affordability: The level of health care services must be in line with what the community and country can afford. Not being able to afford should not be a limiting factor to receiving health care.
- Availability: An adequate and appropriate health services to meet particular health needs of each community.
- Effectiveness: Health services provided must meet the objectives for which they were intended and should be justifiable in terms of funding.
- Efficiency: Objectives and goals accomplished should be balanced to resources used.

These principles mentioned above determine the success or failure of any WBOT and PHC programme worldwide.

2.5. FACTORS THAT FACILITATE SUCCESS OF WBOT IMPLEMENTATION

According to Lewin and Lehman (2013:3) most comprehensive PHC programmes that are successful come as a result of good government policies and legislature for equitable implementation of efficient and cost-effective health care interventions; they also emphasize the need for community and individual participation (Lewin and Lehmann, 2013:3).

2.5.1. Government commitment and will

According to WHO (2008), government will and commitment has proved to be crucial in the decentralization of health services to improve access to PHC services especially in rural areas. In other countries such Brazil, for example, health care facilities were set up in areas that previously had no health services and this contributed to the prevention and control of minor communicable diseases as well as a fall in infant and maternal mortality rates (WHO, 2008). Similarly, following the endorsement of comprehensive PHC in 1978, the Tanzania Government also embarked on a health strategy that led to the doubling of health facilities and an increase in the number of trained community health workers. In addition, the government prioritized expansion of health facilities to rural areas with emphasis on

preventive health services. As a result of such key community policies from the government, infant mortality rates reduced significantly (Oboimbo, 2003:7).

NDOH (2011) indicate that inadequate political and government will and commitment have also contributed to the failure of PHC in developing countries. For example, South African government was a worldwide leader in the conceptualization and development of the PHC concept. However, despite going through years of structural reform and sincere commitment to achieving health for all, the slow response by the government to provide equitable and quality health services to all individuals has hampered progress in achieving the desired health outcomes (NDOH, 2011). This was aggravated by the intimidating state interventions during the apartheid era and weak leadership in the health sector after independence, particularly related to the decentralization of health services, poor infrastructure and services - especially in the public sector - inequities in resource allocation and distribution and poor leadership in the management of Human Immune Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), Sexual Transmitted Infections (STI) and Tuberculosis (TB).

South Africa is faced with a quadruple burden of disease, such as increased cases of HIV & AIDS and Tuberculosis (TB), non-communicable diseases, violence and injuries as well as high maternal and child death according to NDOH (2011). The South African government is currently experiencing an increased burden on health care services largely as a result of HIV & AIDS. Kautzky and Tollman(2009) states that South Africa has one of the highest prevalence rates of HIV & AIDS in the world at 17% of the population infected, and 73% of all those infected by the HIV are co-infected with TB. Due to the increase in disease burden, efforts to improve PHC have proved to be challenging, as there are shortages of health workers and health infrastructure, all of which have contributed to the current poor health indicators (Kautzky et al, 2009). However, despite these challenges, South Africa and most developing countries continue to strive to abide by the guiding principles of the Alma Ata declaration (1978) in their aim to provide comprehensive health care services as close to all individuals in the local communities as possible. For example, the South

African government is implementing the re-engineering of PHC in order to achieve health for all (NDOH, 2011).

2.5.2. Community participation by stakeholders

According to Dennill et al (1998), community participation is a critical support activity for the PHC system to achieve the goal of health for all. There are three basic characteristics to the concept of community participation: “Participation must be active, people have the right and responsibility to exercise power over decisions that affect their lives, and there must be mechanisms to allow for the implementation of the decisions by the community.”(Dennill et al., 1998).

This is not a theoretical idea but it is a key principle and if put into action in an organized manner, it will significantly contribute to the attainment of optimal health of a community or population. The involvement of the community encourages participatory approaches in health care planning and subsequent implementation, leading to improved health outcomes.

For example, in the 1980s, countries like Mozambique and Cuba expanded their PHC coverage and significantly improved their health indicators. These accomplishments were largely driven by active community involvement, political will to meet basic health needs of citizens, and increased economic and social equity. However, the implementation of PHC in Mozambique was fleeting due to political instability that deterred its advancement. In addition, Cuba has sustained steady progress attributed to its commitment in adopting the comprehensive PHC approach. Cuba’s population indicators are similar to those of developed nations that have comparatively larger budgets (Magnussen 2004:167).

According to Magnussen (2004:167), life expectancy is 77 years and infant mortality is 7.7 per 1 000 live births, which puts Cuba among the 25 countries worldwide with the lowest infant mortality rates. In addition, the unique feature of Cuba’s PHC system is that in Cuba PHC is law (policy) and the foundation upon which the health system is built. It is not just one of the many integrated approaches in the delivery of health services, as is the case in other countries but rather, it is the vehicle through

which all health systems are run. Furthermore, the Cuban PHC system is also driven by community initiatives, where the communities are involved in the diagnosis of their health problems and identify their health priorities. Lastly, together with government representatives, they develop strategies and action plans to address the community health diagnosis priorities (Magnussen 2004:167)

2.5.3. Cost-effectiveness, efficiencies and equity

Loggie (2010:1) state that cost-effectiveness and equity also form an integral part of primary health care provision. Furthermore, it has been shown that countries with a well-functioning PHC system (such as Cuba, Brazil and Zambia) have better health outcomes at low costs (Loggie 2010:1). In addition, developing countries recognize that more cost-effective measures are desirable if better health outcomes are to be attained. For instance Ghana, South Africa, Uganda and Zambia abolished user fees at the primary care level in the public sector, thereby promoting equity and increasing access to basic health care services for the poor. As a result of the increase in the number of people accessing basic health services (particularly women) in the named countries, there was reduced infant and child mortality through immunization (though not to desirable levels).

In addition, through the health facilities, women also received basic health education which saw to improved clean water and sanitation efforts – as evidenced by the falling number of reported cases of water borne diseases – breastfeeding, household involvement in treatment of diarrhea, and monitoring child growth and nutrition (Lewin and Lehmann, 2013:3). Therefore, it is clear that political commitment, community participation as well as cost effectiveness, efficiency and equity in the delivery of health services are key factors crucial to the success of PHC, without which, the goal of health for all remains unattainable.

2.6. LESSONS LEARNED FROM INTERNATIONAL EXPERIENCES

Loggie (2010:1) indicates that despite the evidence of the benefits of PHC services, countries have not been able to commit to fully incorporating all the essential

elements and principles of PHC re-engineering in their implementation model. In many developing countries, health care systems are seriously under-funded and overwhelmed by multiple, disease-orientated programmes. Currently, 70% of health costs in poor countries are spent on 30% of the population, mainly on hospital and specialist care (Loggie, 2010:1). Furthermore, the health systems in many developing countries, particularly in Africa, developed from colonial health services that put an emphasis on overpriced, high-tech, urban concentrated and curative health care. In addition, when most of these developing countries gained independence in the 1950s and 1960s, and in 1994, they inherited health care systems of developed nations (Magnussen 2004:167).

In an effort to improve health outcomes following the Alma Ata Declaration (1978), most developing countries developed PHC implementation strategies. However, the implementation of these strategies has been met with serious challenges which include falling gross domestic product (GDP) and shrinking health budgets, inadequate political will and increased burden on health care services as a result of HIV & AIDS (Oboimbo, 2003:7). Comprehensive PHC re-engineering services are expensive to implement as it requires a multi-sectoral, multi-disciplinary and holistic approach. It calls for an increased number of health staff in all disciplines, proper supply chain system for drugs and laboratory services, improved transport services and infrastructure, as well as sufficient water and sanitation. With falling GDP and shrinking health budgets, comprehensive PHC services remains indescribable. The successful lessons from international experiences are discussed below.

2.6.1. LESSONS LEARNED FROM CUBA

According to Gorry and Keck (2014:407), Cuba is an example of the successful implementation of community participation. It involved the integration of the mass democratic movement into formal governance structures, including health. Institutional structures were developed to allow for the participation of communities in decision making and policy processes. Furthermore, public officials were elected to People Power Assemblies at the provincial and national level to represent

community interests. In addition, all authority comes from the people and all accountability comes from the state to the people (Birkland, 2014).

Oviedo (2011) state that, In Cuba, Each People Power Assembly at each level of government appoints the personnel of the administrative agencies assigned to it. Each health facility had an advisory committee consisting of representatives; management consults with the advisory committee on issues that affect or require participation from the community. Though rarely done, the community has the power to request the removal of health workers. According to Oviedo (2011) Cuba developed a unique Family Doctor Programme that attaches a family doctor and a nurse to every 120-140 families. These health workers are responsible for all the health needs of that community (including health education, promotion and curative services). Furthermore, this has strengthened communities' understanding of health matters, and promoted the collective discussion and solution of health problems, thereby improving the families and communities' participatory skills. However, a criticism of this approach is that it fostered dependence on medical interventions of the communities.

2.6.2. LESSONS LEARNED FROM BRAZIL

According to Spink (2011:50), the example of the Unified Health System in Brazil has been the guiding vision behind the South African Re-engineering Policy. Furthermore, social participation in health is mandated by the constitution to be included in all levels of government (Health councils – 1 national, 27 state and 5500 municipal). According to Crisp (2014:249) the health councils are permanent bodies in charge of formulating health strategies, controlling implementation of policies, and analysing health plans and management reports submitted by their respective level of government. Furthermore, strong interactions exist between councils, managers, and policy makers, forming a complex and innovative decision-making process. All councils are made up of health care users (50% of members), health workers (25%), and health managers and service providers (25%).

In addition, health conferences are held every four years at the three levels. The mandate of these conferences is to assess the health situation and propose directives for health policies, thus contributing to inclusion of themes in the public agenda. Among other democratic mechanisms, the participatory budget adopted by several states and municipalities is also innovative. A proportion of the health budget for a city (municipality) or state is defined on the basis of popular vote; the population of a given city can vote, for example, on whether a new intensive-care unit or more health posts should be built (Crisp, 2014:249).

2.6.3. LESSON LEARNED FROM ZAMBIA

According to Resnick (2014), declining Gross Domestic Product (GDP) and decreasing health budgets have impacted negatively on many countries in Africa. In Zambia, for instance, PHC implementation began in August 1981, with steady progress and interventions that included the training of community health workers, construction and upgrading of rural health centers, improved distribution of medicine, a strengthened transport system, as well as improved health planning and management. Furthermore, these interventions were largely driven by the economic boost that Zambia experienced due to the increase in the global demand for copper - Zambia's main export product and the country's major source of income at the time (Resnick, 2014). Furthermore, the current public health system is two-tiered as well as inequitable and unsustainable in terms of poor financial resources allocation, inadequate human resource, staff turnover and unequal access to health care services. The two-tiered system is characterized by poor management, supervision and poor quality of health care services and deteriorating infrastructure in the public sector, whilst the private sector is characterized by over-pricing of services (Kautzky et al, 2009).

2.7. CONCLUSION

The comprehensive and successful WBOT programme is costly to implement. It does, however, provide a more holistic approach to addressing the health needs of all individuals promotes the development of health infrastructure and the provision of

staff and is critical for sustained improvements in the health of communities (NDOH, 2011). Since the Declaration of Alma Ata, lessons learned from developing countries, that are also applicable to developed countries regarding WBOT implementation, include the recognition that better cost-effectiveness and efficiently measures are necessary, that equity is an integral part of a health strategy and that disease prevention involves community participation and consequently, this needs to be encouraged.

PHC and WBOT services are indispensable to the success of national health systems. It is widely acknowledged, that many managers at district, sub-district and facility level (especially in rural areas) urgently need to be equipped with skills to enable them to successfully fulfill their roles and responsibilities. Management capacity is important at PHC facility level and requires intervention and strengthening through providing PHC facility managers with the necessary training and mentoring to support the effective and efficient management of their facilities and implementation of the PHC re-engineering priorities which also form part of WBOT (Alma Ata declaration, 1978).

In this chapter, an overview of the WBOT programme, key aspects of comprehensive PHC implementation in South Africa, successful lessons from international experiences, factors that influence the implementation of a comprehensive WBOT programme and relevance to optimal implementation of the program were discussed. In the next chapter, the research methodology and design utilized in this research were presented.

CHAPTER 3

RESEARCH METHODOLOGY

3.1. INTRODUCTION

This chapter is dedicated to the description of the research methodology used in the research starting from the research design and the approach used sampling, data collection, analysis and interpretation thereof. Ethical considerations and issues of rigour, trustworthiness in qualitative research are all outlined in detail. The process of gaining permission to access is also discussed.

3.2. RESEARCH DESIGN

According to Mouton (2001:55), research design can be defined as "a *plan or blue print of how one intends conduct research*". Babbie and Mouton (2001:80-81) identify the three most important purposes that different researchers may have when undertaking research and these are exploration, description and explanation. According to Collins English Dictionary for Advanced Learners (2001:540), "exploratory actions are done in order to discover something or to learn the truth about something." Burns and Grove (1998:38) define exploratory research as research conducted to gain new insights, discover new ideas and/or increase knowledge of a phenomenon. The approach adopted in this study was the use of explorative and descriptive research design.

The main objective of the design is to improve a researcher's knowledge of a topic. The disadvantage is that does not draw definite conclusions, because of its lack of statistical strength, however it can help an investigator begin to determine why and how things happen.

3.3. RESEARCH APPROACH

The researcher chose a quantitative approach because he wanted to generate explanations and predictions that would generalize to other persons and places according to Leedy and Ormrod (2013:96). Furthermore, the intent to use quantitative design is to establish, confirm, or validate relationships and to develop generalisations that contribute to existing theories. Quantitative research is aimed at determining the extent of something or detecting the relationship between variables within a particular population by managing and presenting data numerically. However, the weakness for this design is that knowledge produced might be too abstract and general for direct application to specific local situations, contexts, and individuals.

Taylor (2005:235) indicates that quantitative research is designed to provide objective descriptions of phenomena and how these can be controlled. Leedy and Ormrod (2013:97) state that quantitative studies seek to answer research questions about quantity. In this study the researcher utilised questionnaires provided to respondents and this provided a clear profile of the respondents and was descriptive in nature.

3.4. RESEARCH POPULATION

According to Fellow and Liu (2015) the population is the entire set of individuals (or objects) having some common characteristics as defined by the sampling criteria established for the study. In this study, the population consists of the Kgetleng Community Health Workers (27), Outreach Team Leaders (2), and Professional nurse (1) of the feeder clinic. Twenty seven (27) respondents make up the whole population of the study and were provided with questionnaires. These respondents must reside within the catchment area of Kgetleng Sub-district.

3.5. SAMPLE, SAMPLING METHODS AND SMPLE SIZE

According to Grinnell (2001:207), sampling is defined as the selection of some units to represent the entire population from which the units were drawn. There is very little or no assumption that the sample will be representative of the larger population and as a result the findings cannot be generalized. The researcher provided twenty seven questionnaires to the respondents.

3.5.1. Sampling methodology

Sampling is the process of selecting the people with whom to conduct research. In qualitative research, individuals are selected to participate based on their firsthand experience of a phenomenon of interest (Streubert & Carpenter 1999:22). Purposive sampling refers to judgmental sampling that involves the conscious selection by the researcher of certain participants to include in the study (Burns & Grove 1998:750).

With non-probability sampling, the probability for the participant to be selected cannot be estimated and is therefore not known (Grinnell 2001:215). In purposive sampling, the researcher uses his/her own judgments when selecting possible participants for the study (Grinnell 2001:216). According to Denscombe (2007), the advantage of using purposive sampling is that it allows the researcher to home in on people or events which there are good grounds for believing will be critical for the research. In this sense it might not only be economical but might also be informative in a way that other sampling such as probability cannot be.

3.5.2. Sample size

The development of a rich and dense description of the experiences of WBOT in the implementation of the programme determined the sample size (Leedy and Ormrod (2013:215). The size of the sample was determined by the principle of saturation and Parahoo (2014) describe as the point at which data-collection themes are repeated. Twenty-seven (27) respondents participated in this study.

This is 63% in relation to the total sample of forty three (43) respondents working in the WBOT programme in Kgetleng. It is a representative sample.

3.6. DATA COLLECTION TECHNIQUES

Data collection is the precise, systematic gathering of information relevant to the research sub-problems, using methods such as interviews, participant observation, focus group discussions and case histories (Walliman, 2015). The advantages of questionnaires as a data collection tool is that administration is comparatively inexpensive and easy even when gathering data from large numbers of people spread over wide geographic area.

On the other hand, the disadvantage is that survey respondents may not complete the survey resulting in low response rates according to Walliman (2015). Self-administered questionnaire have been used for the purpose of this study. A total number of 27 questionnaires have been distributed to the target population. The use of self-administered questionnaires in the data collection process is critical, since it makes large samples feasible and has an important strength with regard to measurement generally (Leedy and Ormrod, 2013:61).

3.6.1. Self-administered questionnaires for the study

Self-administered questionnaires were provided to respondents in October 2015. The respondents were asked to complete the questionnaires and the researcher personally collected them from them. Each completed questionnaires and signed informed consent form received was put in a file for safe keeping. Completed questionnaires were returned by only 12 of the 27 respondents, resulting in a 44% response rate.

3.6.2. Literature review

The purpose of a literature review is to enable the researcher to gain a better understanding of the complexity and extent of the research problem. According to LeCompte et al. (2003:123) conducting a literature review is a means of demonstrating an author's knowledge about a particular field of study, including vocabulary, theories, key variables and phenomena, and its methods and history. It is further indicated that conducting a literature review informs the student of the influential researchers and research groups in the field. In addition, with some modification, the literature review is a "legitimate and publishable scholarly document". The researcher consulted a number of international, national and online research materials for this study to gain more understanding on the topic under review.

3.7. DATA ANALYSIS

Data analysis is the process by which all data are arranged and reduced from their raw form to a point at which they are more manageable and can yield meaningful findings. The research approach adopted in this study in analysing data will be discussed hereunder.

3.7.1. Data analysis strategies

According to Leedy and Ormrod (2013:270), data analysis requires that researchers dwell with or become immersed in the data. Data analysis is done to preserve the uniqueness of each respondent's lived experience while permitting an understanding of the phenomenon under investigation. In this particular study, data analysis followed a quantitative research analysis approach for data obtained through the questionnaires. The Statistical Package for the Social Sciences (SPSS) was used to capture questionnaires that produced data distribution into tables, figures and frequencies. This made analysis of data collected through questionnaires to be easy to derive meanings and interpretations from.

The completed questionnaires were checked by the researcher. The completed questionnaires were captured and tabulated by the researcher for report writing.

3.8. VALIDITY AND RELIABILITY OF THE STUDY

Validity is the extent to which the instrument measures the attributes of a concept accurately. Reliability is the ability of the instrument (questionnaire) to measure the attributes of a concept or construct consistently (LoBiondo-Woods & Harber 2010:286). Before adopting the final version of the questionnaires to collect data, questionnaires have been piloted with colleagues to enable the researcher to review and make the necessary amendments to such questionnaires. Through pilot testing, the researcher did have an opportunity to assess the validity of the questions and the reliability of the data that would be collected. The respondents that were credible units of analysis were selected as they possessed the knowledge as working in the programme.

3.9. ETHICAL CONSIDERATIONS

The basic considerations when conducting social research involve recognising and making ethical choices, making principled decisions, ensuring confidentiality and obtaining informed consent from participants while maintaining research integrity (Babbie & Mutton 2001:520-528). This is done in order to minimize any possible harm and distress that may be caused through participating in the research (Curtis & Curtis 2001:160). Ethical considerations in this study included gaining permission to access research participants from the Bojanala District Research Committee, The Higher Degrees Committee of the Turfloop Graduate School of Leadership, University of Limpopo and obtaining consent from the participants.

3.9.1. Permission to access the study population

It is crucial and important for a researcher to obtain permission to access any study population. In many cases the researcher will have to negotiate access to the facility

or the participants with a number of gatekeepers (Henn, Weinstein & Foard 2006:178). Prior to conducting this research, the researcher applied ethical clearance from the Turfloop Graduate School of Leadership, University of Limpopo and it was obtained on the 26 May 2015 (Annexure C). The researcher then proceeded to request permission from the Bojanala District Research committee where the study will be undertaken. The researcher was granted approval from the Northwest Province (Annexure D).

3.9.2. Informed consent

Informed consent implies that the researcher makes participants aware of what the research study is all about and the processes that will be followed so that they are in the best position possible to make informed decisions regarding participation (Curtis & Curtis 2011:16). In this study informed consent has been obtained from each participant prior to conducting the focus group discussions and the individual interviews with the key informants. The process involved the researcher explaining verbally to each respondent and participant the objectives of the study and assuring them of anonymity and confidentiality, emphasizing that participation was voluntary. Consent forms have been signed for this study by both the participants and the researcher (Annexure A).

3.9.3 Voluntary participation

The researcher explained and emphasized that participation was voluntary and participants could choose to withdraw at any point with no penalty or even decide not to participate at all without any repercussions for them.

3.9.4. Confidentiality

Confidentiality refers to protecting and not sharing any personal information of the respondents without their consent (Henn, Weinstein & Foard 2006:85).

In this study the names and identity of all participants have been kept confidential. The notes and tape recorded data taken during the focus group interviews and the key informant interviews and all signed consent forms are kept in a locked cupboard by the researcher. This material will be shredded five years after the degree has been conferred.

3.10. LIMITATIONS OF THE STUDY

The limitations in this study are that:

- Selection bias may have occurred as only those CHWs on WBOT at the time of data collection were included.
- The research was conducted only on CHWs on Ward Based Outreach Teams (WBOT). The CHWs on other programmes such HIV and TB was excluded.
- This limits the generalization of the study findings to all CHWs in the sub-district.
- The findings of this study were not representative of other locations in the Bojanala District.
- The use of open-ended questions in a quantitative study gives not much discretion to researchers and participants.

3.11. CONCLUSIONS

This chapter was dedicated to the review of the research methodology and design which were used in this research study. The study was both descriptive and exploratory in nature in that it is aimed at describing and exploring factors in implementation of the WBOT programme in the sub-district. The measures taken to ensure reliability and validity in the quantitative research study were also outlined. The ethical considerations taken during this research were also explained.

CHAPTER FOUR

PRESENTATION OF THE FINDINGS

4.1. INTRODUCTION

The chapter focuses on the presentation of the findings from the research study. The quantitative research design used is inspired by readings underpinning of the study. The data for the quantitative study were generated via the structured questionnaires distributed to the respondents. The findings are discussed in the following sequence: First, the demographic characteristics of the twelve respondents are presented in terms of gender, age, highest qualifications, current position and lastly the number of years of the respondents in the current.

Second, responses to experiences of the respondent's questions are given in a tabular form. These include among other things, what the experiences of the respondents working in the community are, challenges and successes that the respondents have experienced when conducting their work in the community, challenges of referral processes, challenges of any interaction with the community structures, whether the respondents been trained or informed about the WBOT programme, and finally what are the benefits of WBOT to patients and the respondents.

Third, the factors that facilitate the success and failure of the WBOT programme. These include questions about, among other things, whether there are any difficulties and the benefits of the respondents of working with Nurses in the health facilities, views of community structures that allow community involvement in the health issues including WBOT and decisions, any challenges that the respondents think that the community structures face to encourage and support the community to participate in the WBOT programme and finally any recommendations that the respondents could make to improve community participation.

4.2. BACKGROUND CHARACTERISTICS OF THE RESPONDENTS

The purpose of the research was to provide answers to questions pertaining to the research conducted. The target group of this study consisted of 27 respondents comprising 24 female and 3 male CHWs from the Kgetleng Sub-district in the Bojanala District. The target population was specifically chosen in order to gain knowledge about the WBOT implementation programme in a rural area of Northwest Province and to ensure that opinions were solicited from respondents who were affected by the WBOT programme implementation. The data were collected through structured questionnaires.

In the structured questionnaire carried out on the respective respondents at the Kgetleng Sub-district, the respondents were asked questions concerning three core objectives of the study. Firstly, to investigate the experiences of CHWs in the WBOT implementation programme which affect optimal implementation at the Kgetleng Sub-district. Secondly, to identify factors that facilitate the implementation of the WBOT programme and how these, in turn, affect the optimal implementation of the WBOT programme in the rural area of Kgetleng sub district. The third objective was to recommend possible strategies and mechanisms to overcome challenges in the implementation of the WBOT programme at the Kgetleng Sub-district. Statements were formulated to allow the respondents to respond on equal terms on the WBOT implementation.

4.3. PRESENTATION OF RESULTS

Questionnaires for the Kgetleng Sub-district WBOT programme survey were provided to 27 respondents who were given seven days to complete them, including 22 CHWs, 3 OTLs, 1 Community Ward Counsellor and 1 Nurse in the Clinic. Of the 27 questionnaires provided, 15 were incomplete and 12 were completed. The reason for incomplete questionnaires was that the respondents cited time and busy schedules and therefore were unable to complete them in full.

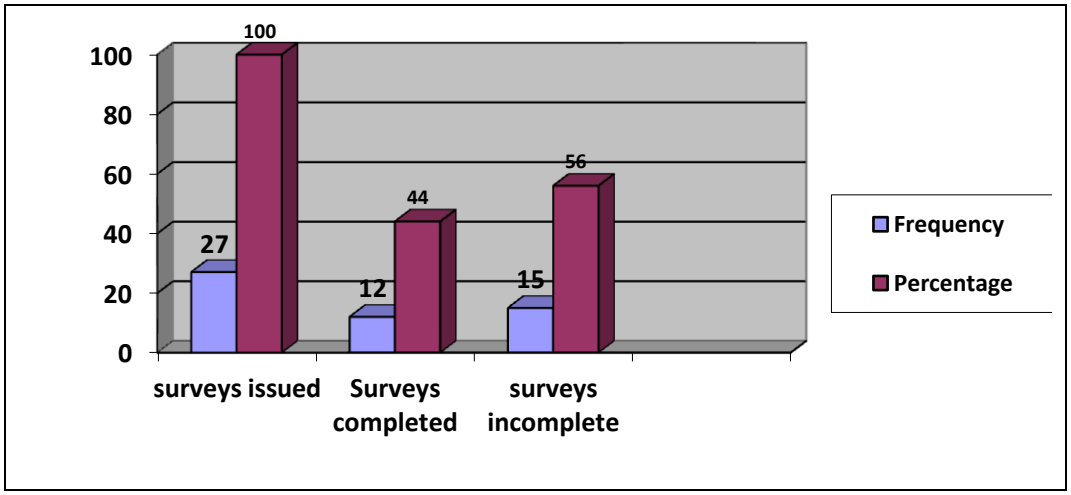
4.4. RESULTS AND DISCUSSIONS

The data obtained from the questionnaires were analyzed and interpreted. The results are illustrated, using tables, graphs and charts. This chapter presents the responses on a question-by-question basis. Results from all sections of the questionnaire are also compared to existing empirical evidence to assess consistency.

4.4.1 Response rate for the respondents (N=27)

Figure 4.1 below shows the total number and percentage of questionnaires that were sent out, questionnaires that were not answered in full, and the questionnaires that were completed in full. CHWs, Ward Counsellors, OTL and Nurse at the Kgetleng sub-district were available to responds to the questionnaire.

Figure 4.1: Response rate for the respondents (N=27)



From figure 4.1 (above), it can be seen that a total of 27 (100%) questionnaires were sent out to respondents. 12 (44%) questionnaires were returned fully completed and 15 (56%) were uncompleted. This means that only 12 (44%) questionnaires were analysed. Denscombe (2008:22) states that when surveys are based on responses from people or organisations, there is likelihood that some of those who are contacted with requests for information will not co-operate. In this study, the

response rate was 44%, which is high enough to guarantee accurate results and in line with comparable surveys according to Denscombe (2008:23).

4.4.2 Demographic information for the respondents

Demographic information of the respondents is significant in research. It gives a clear picture of the type of respondents the researcher is dealing with. In addition, it helps in determining the reasons for a variety of responses which are influenced by demographic factors. In establishing the demographic information of respondents in this regard, the researcher asked the following demographic information: gender, age group, highest qualifications, current position and number of years in the post. The responses with regard to demographic information are demonstrated as follows.

4.4.2.1 Age group for the respondents (N=12)

The age group of the respondents often determines the response they will provide to the interviewer. Again, the age group of the respondents is significant depending on the information required by the researcher. The results of the investigation regarding the age group of the 12 respondents in the study are provided in tabular format below. Of these 12 participants, five (42%) fell between 20 and 29 age range, while five (42%) fell between 30-39 years range. The other two (17%) fell between the age range of above 60 years. These results are depicted below in table 4.1.

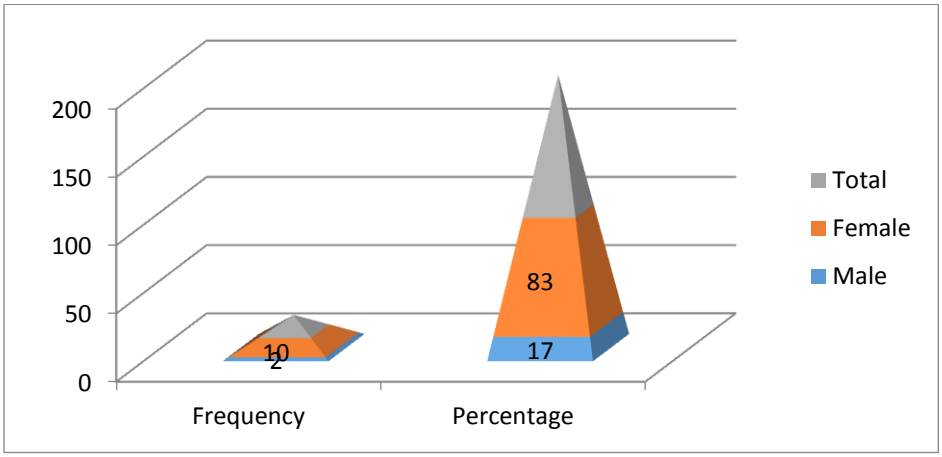
Table 4.1: Age group of respondents (N=12)

Age group	Frequency	Percentages (%)
20-29 years	5	42
30-39 years	5	42
40-49 years	0	0
60+ years	2	17
TOTAL	12	**100**

4.2.2.2 Gender of the respondents (N=12)

Figure 4.2 (below) indicates that for this particular group, there were more female (10 or 83%) than male (2 or 17%) respondents. This corresponds with the gender breakdown of the community health workers appointed for this WBOT programme in the Northwest Province. However, one cannot deduce that the WBOT programme and the type of roles in the community are more favoured by women than men. The Bojanala Quarterly Report (2015) indicates that in a class of 2015 for CHW qualification training, 50 learners were enrolled and the actual breakdown of the group was 3 males and 47 females. In addition, Anderson and Haddad (2005) indicate that female students in a group tend to develop greater social interdependence that their male counterparts. These results are depicted below in figure 4.2.

Figure 4.2: Gender of the respondents (N=12)



4.2.2.3. Highest qualification of the respondents (N=12)

Table 4.2 (below) shows the level of highest qualifications amongst the study respondents. It depicts that of the twelve respondents, ten (83%) fall between the grade 8-12 range, while two (17%) have got a bachelor's degree. The fact that the majority of the respondents had range of grade 8-12, might be an indicative of the respondents ability to know their WBOT programme well, understand and recognize and possible factors that facilitates the implementation of this programme.

Table 4.2. Highest qualification of the participants (N=12)

Highest Qualification	Frequency	Percentage (%)
Grade 0-7	0	0
Grade 8-12	10	83
National Diploma	0	0
Bachelor Degree	2	17
Total	**12**	**100**

4.2.2.4. Current positions of the respondents (N=12)

Table 4.3 (below) shows that 10 (or 83%) of the respondents current position is Community Health Worker (CHW) whilst 2 (or 17%) were working as Outreach Team Leaders (OTL) supervising the CHW.

Table 4.3: Current positions of the respondents (N=12)

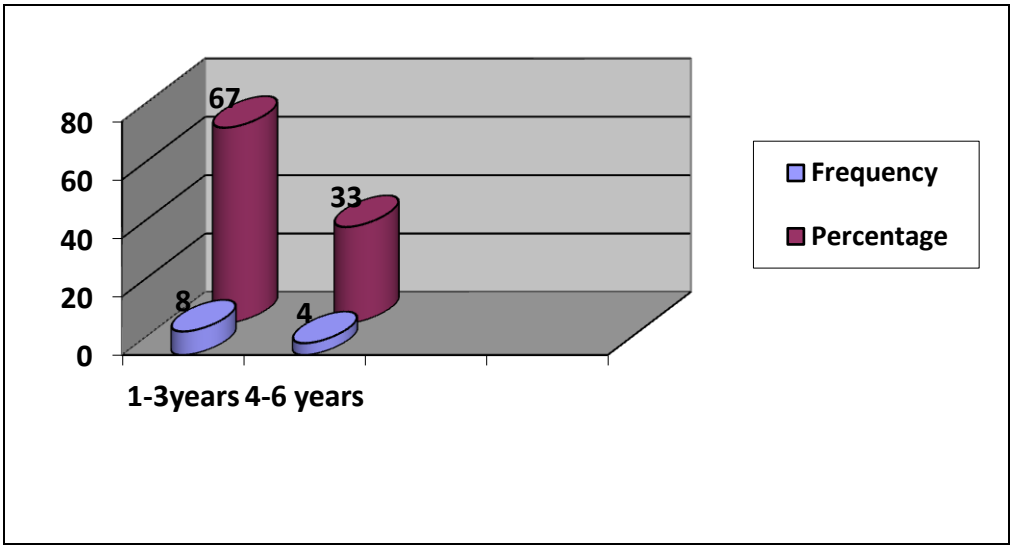
Current position	Frequency	Percentage (%)
CHW	10	83
OTL	2	17
Nurse	0	0
Community leader	0	0
Total	**12**	**100**

4.2.2.5. Number of years of respondents in the post (N=12)

Figure 4.3 (below) shows the total numbers of year's respondents were in the post. The graph below indicates that of the twelve respondents, eight (67%) have been in the post between 1-3 years, whilst four (33%) respondents are in the post for the period between 4 and 6 years. This is an indicative of a programme that has been in existence since 2011, because more people were in the post for 1-3 years and less

for your years or more. The WBOT programme has been piloted in the Kgetleng Sub-district since 2012. This indicates that the programme is less than five years old since inception.

Figure 4.3. Number of years of respondents in the post (N=12)



4.5. Respondents experiences in the implementation of the WBOT programme.

This section discusses data related to the respondent's experiences in the WBOT programme implementation. In the questionnaire, the researcher aimed to assess the respondents experiences and their roles when working in the community, challenges and successes that the respondents experienced with WBOT, whether there are any challenges regarding the referral processes, the interaction with community structures, whether the respondents have been informed or trained on WBOT, their opinions about the programme and any benefits of the programme to the respondents and the patients. The results of objective one of this study, which is to evaluate the experiences of Community Health Workers (CHW) in the implementation of the WBOT programme in the Kgetleng Sub-district, are presented in tabular and graphical form in the following section.

4.5.1. Question 1.1: Explain your experiences of working in the community and the role that you play?

Of the twelve respondents, eight (67%) were able to talk about their experiences and know their roles and indicated that they find it wonderful and interesting working in the community, in addition, they said they are able to give back and the community needs them. They said that working with people it is a real challenge but helping them is the best experience ever. However, the roles and experiences of the other four (33%) respondents were not indicated in the questionnaires. The responses are illustrated in table 4.4 below.

Table 4.4: Experiences of working in the community and their roles

Respondent No.	Response from the Questionnaire for question 1.1.
1.	It is a great experience being able to help my community and making sure that their health status is managed well. I assess the household and identify health problems and any other problems, and then I refer to the necessary stakeholders.
2	I find it a wonderful experience coming close in contact with individuals from the community in their own homes I identify conditions and clients that would not come for treatment, find networks, make inroads for the programme. Identify community problems and work on them with team for success.
4	I have experienced that a lot of people are having problems and (a) lack of information, not knowing where they should go for help. My role is to identify problems in a household and refer it to the relevant stakeholders such as children not having birth certificate

	and I refer the mother to Home Affairs. Prevent ill health by giving children under-5 de-worming and vitamin A at their household. Provide treatment for minor ailments and provide information and educate communities on a range of health and related matters.
5	The experience is that some community members do not allow us sometimes to enter in their houses and others are still in denial. The role that I play is to give community information and to ensure that they know the importance of being healthy.
6	Improving a lot of people's lives by giving them the relevant information regarding their health issues. Identifying and registering households, refer and receive referrals and for health promotions.
7	It is very interesting because I am able to give back to the community I live in. My role is to ensure that all patients are adhering to their medication. To bring services from the facility to the community so that we are able to reduce number of defaulters.
10	I have experienced a lot because I can identify problems and referring people to different stakeholders, like Home Affairs. Social grants, health promotion and encourage the patients to eat healthy and check the RTHC if the baby did not get immunisation, Vitamin A and de-worming. Perform basic first aid if needed. Support counselling to make sure that the community members stay on their medicine and follow treatment exactly as prescribed.
12	People are starting to open up and welcome us at their households. Starting to practice health promotions and knowing and understanding their rights. I do health promotions and condom distribution.

From the responses in table 4.4 above, it came out clear that many respondents know their roles very well and they are happy that they are able to help their community and making sure that their health status is managed well. According to WHO (2007) the roles of the CHWs that they have to conduct are not limited to home visits, but may include environmental sanitation and provision of water supply. Furthermore, first aid and treatment of simple and common ailments, health education, nutrition and surveillance, maternal and child health and family planning activities, TB and HIV/AIDS care, referrals, record keeping and collection of data on vital events are among their duties. These are roles that the respondents had indicated in the questionnaires. In addition, one respondent indicated that "I assess the household and identify health problem and any other problems, and then I refer to the necessary stakeholders"

4.5.2 Question: 1.2. Challenges and even successes that you experienced with examples and give your view of the WBOT programme?

All the twelve (100%) respondents indicated that they have encountered challenges and even successes with WBOT programme. The respondents indicated that they worked hard in spite of the challenges to achieve the WBOT goals and objectives. However, there are also successes with this programme such as many patients are able to adhere to treatment and live their healthy lives. The responses are tabled below.

Table 4.5: Challenges and successes with the WBOT programme

Respondent No.	Response from the questionnaire for question 1.2.
1.	One of the challenges is that some patients don't want people know their problems; they even hide sick children in their homes; at least I managed to heal others and some are adhering to treatment and live a healthy life.

2	Early bookings of ante-natal clinic is a challenge, it is a taboo because you don't advertise pregnancy in early months. Post-natal clinic also not allowed in homes before 10 days. Advantages of early booking and prevention of mother to child transmission, adherence to ARV.
3	Shortage of treatment such as vitamin A and de-worming for the under-5 children as well as immunisation. Parents loosing children's *Road to health* booklets. We educate and counsel them and they improve their lives.
4	People were not comfortable for telling us their status when this programme started. They were hiding clinic cards for their babies and people who are on treatment, they were not having enough information about how they could drink their medication, and this programme change(s) their life a lot having us treating them and showing them the importance of drinking their medication and visiting (the) clinic on the date given by professional nurses.
5	TB and ART defaulter; patients disclosing their status. The programme assists to reach the household with problems.
6	Clients give wrong addresses; others refuse to give us their personal information when we register them.
7	I managed to teach the community and (to) reduce (the) number of defaulters and bed-ridden.
8	I have a challenge of patient(s) disclosing (their) status and when they are pregnant. They don't want to show us the maternity book and not giving us the right addresses when we want to trace them
9	Others refuse to register their houses and some are not open with their health issues. I managed to help those (who) allowed me to take care of them and their health issues.
10	I used to have a TB patient one day and he was not on treatment and I refer(ed) him to the clinic and he got his treatment, and after 2 weeks he was feeling better and he thank(ed) me a lot.

	This programme help(s) a lot of people because some people they don't have knowledge of importance of taking treatment.
11	Challenges are there when patients refuse to co-operate and knowing very well that you cannot let that person be in their conditions.
12	Challenge is sometimes (that) vitamins and deworming is only enough for the clinic. Lack of materials such as first aid kits; and our OTL are not enough for our number; we are too many for them.

The responses in table 4.5 above indicate that there are challenges and successes in the WBOT programme. The challenges are such as patients not wanting the CHWs to know their status, early booking of anti-natal clinic, adherence to antiretroviral (ARV) regime, shortage of vitamin A or patients giving wrong addresses. However, there are successes in the programme such as patients being able to be referred to the clinic for treatment early or the community being able to get knowledge on different diseases in a form of one on one and campaigns. Nxumalo and Choonara (2014) state the importance of mobilizing, communicating with and involving local stakeholders including Department of Health to generate support and develop networks that can continue to support WBOT to address the challenges highlighted above.

4.5.3. Question 1.3: Which other health professionals are involved in WBOT programme and their roles?

Of the twelve respondents, seven (58%) indicated the other health professionals that are involved in WBOT programme and their roles. However, five (42%) of the respondents indicated only OTL. They indicated that they work with Professional Nurses and their Outreach Team Leader (OTL) at the clinics for referrals, Environmental Health Practitioners for making sure that water and sewerages are maintained; Health Promoters organise community campaigns and oversee their

progress in the community members. The responses are mentioned in table 4.6 below.

Table 4.6: Response about other professionals involved in the WBOT programme and their roles

Respondent No.	Response from the questionnaire for question 1.3.
1	OTL is to oversee the work of CHW, go to the community and assess the problems that the team encounters. Health promoter: He organise community campaigns and oversee(s) their progress in the community members.
2	OTL professional Nurse: supervises implementation of programme and maintains the standard, manages resources, conduct in-service and assess competence of CHW. Health promoter: promote and prevent using Health education, conduct campaigns and community meetings. Environmental officer: which in the mean time we don't have, should control the dumping sites, purification of water, control noise pollution and sanitation.
4	Our OTL is very involved in the WBOT because every time when we have (got a) problem from the committee, he is just with us and helping us with the problem and making follow-up. The challenge is that our social workers are not involved, because we send patients to them but they don't get help and too much (sic!) excuses
6	Environmental health officer: Monitor, manage and control health hazards, unsafe sanitation and land pollution. Health promoter-promote health by organising campaigns and give the community health education. Professional nurse/OTL: train, mentor and coach PHC team members, then writes monthly reports

10	Professional nurse: manages the work. If we a (sic!) problems at the community. We report to him and take it from there. He also writes monthly reports. Conduct home visits to post-natal women. Act as an advocate for improving health services. Maintain household and health records. Monitor and evaluate services rendered.
11	OTL – she makes sure that all our work is up to date and there is a team working between us. Professional nurse – makes sure that our patients have medications and that if we have any questions they are there to help us. Health promoter- he gives us and the community health talks or health information.
12	OTLs are there to supervise us and help us when we refer to other stakeholders such as South Africa Social Security Agency (SASSA) and Home Affairs. Health promoter: organise campaigns in our wards.

From the responses in the table 4.6 above, it is evident that respondents know other professionals working with them in the WBOT team, even though some respondents indicated stakeholders such as SASSA and Home Affairs as other professionals. According to NDOH (2011), for WBOT to be implemented optimally, other professionals such as a professional nurse, health promoters or an environmental health practitioner should form part of the team in the community.

4.5.4. Question 1.4. What challenges have you experienced regarding the referral processes?

All twelve (100%) respondents indicated that they had challenges with referral processes. One of the respondent indicated that some stakeholders don't fill in the back referrals and they had to go back to them to fill them. The responses are indicated in table 4.7 below.

Table 4.7: Responses on challenges experienced during referral processes

Respondent No.	Response from the questionnaire for question 1.4.
1	some stakeholders don't fill the back referrals and we had to go to them to fill them
2	(Sic!)It very frustrating. Patients are reluctant to take referrals to the respective places. You will go several times to collect referrals without success.
3	They are not filled up (sic!) and given to clients and patients don't go (to) where they are referred (to).
4	Some patients tell us they don't have time to go to the clinic
5	When (a) referral is issued to the patient, they don't go (to) where they are referred (to). They don't fill the back referral
6	We issue referrals to the nurses but we never get them back or we either get them (with nothing) written nothing at the back, this includes other government sectors.
7	In most cases patients don't come to (the) clinic when they are referred
8	You write referral to patients, he/she does not go to health facility
9	When I refer, others don't go to (the) places (they have been) referred (to) due to money problems for transport, others complain about clean clothes and food.
10	Some stakeholders don't fill the referral form while we refer patients, and some they don't get help until they die.
11	When we refer patients maybe to SASSA or cares they don't really help them, they make them wait with no success.
12	Sometimes nurses don't fill the referral form and our OTL will complete the form on their behalf. Patients don't go (to) where they are referred (to).

From the responses above in table 4.7, respondents indicated that there are challenges in the referal processes. According to NDOH (2011), CHWs responsibilities include the following: knowing the demography of the catchment population, knowing the epidemiology, health promotion, prevention, screening and referal. Challenges exist, such as patients not going to the facility where they are refered to, some nurses don't complete the back referal form, some patients said they don't have time to go to the clinic.

4.5.5. Question 1.5. What successes/benefit have you experienced regarding the referral processes?

All the twelve (100%) respondents indicated that they had seen success and benefits regarding the referral processes. Most of their responses indicate that people are getting help, like at the Department of Home Affairs: people now have got ID books; birth certificates and can apply for social grants. The benefit and successes are illustrated in table 4.8 below.

Table 4.8: Successes/benefits regarding referral processes.

Respondent No.	Response from the Questionnaire for question 1.5
1.	People are now having ID books and birth certificates and they are able to apply for social grants.
2.	Treatment continuity is achieved, Social grants are accessed and Birth certificates are achieved.
3	It is a good communicating tool. Clients are assisted quickly when referred.
5	They get help like when referral to SASSA and Social workers.
7	I managed to refer 4 patients last year and they were treated and cured other two are on treatment.
8	I gave the client a referral to social grant and she received grant for her children.

9	When I refer to home affairs for birth certificate, they go and others they get money from SASSA due to the referral I made.
11	Our patients get help every time we refer them to the clinic even though sometimes they don't complete their work
12	If I see abuse in the house, I refer to Immanuel hope centre.

The responses in table 4.8 above show that there are successes and benefits regarding the referral process. It is said "that people are now having ID books and birth certificates and are able to apply for social grants" (Respondent 1). The successes as mentioned by the respondents are as follows: Treatment continuity is achieved, social grants are accessed, and clients are assisted quickly when referred. According to WHO (2007), referral system is one of the key roles and input approach for the optimal implementation of the WBOT programme.

4.5.6. Question 1.6: What would you recommend with regards to improving the referral process?

Of the twelve respondents, five (42%) recommended to improve the referral process, however seven (58%) did not make any recommendations but indicated that the programme is doing well; it is just that as CHWs, they need to be taken seriously. The recommendations are indicated in the Table 4.9 below.

Table 4.9: Recommendations to improve referral processes.

Respondent No.	Response from the Questionnaire for question 1.6
1.	Some stakeholders are far, so if we had transport to collect the referrals it would be better.
2	Education to all departments on the importance of the treatment and perhaps review of the document itself.
3	All stakeholders should be educated about the referral process.

6.	They should give back the referrals so that at the end of the months, we cab able (sic!) to report. They should also write the outcomes, to see if the client has been assisted.
10	It will be better if other stakeholders can be informed about CHW and how they work, to be able to work hand in hand.

Respondents' recommendations in table 4.9 above show that there is a need for involving all stakeholders in the WBOT programme for optimum implementation. Respondents indicated that they recommended for a transport as some of the patients are too far away to reach and for education to all stakeholders in terms of the importance of referral system. As indicated by WHO (2007), that referral system plays a key role for CHWs in the WBOT programme. NDOH (2011), states that referral forms should be completed by Outreach Team Leaders (OTL) and sent to the clinic and the clinic to the OTL.

4.5.7. Question: Have you been informed and trained about WBOT programme

Table 4.10: Responses on information and training on WBOT

Response from the questionnaire for question 1.7		
Number of responses	**Frequency**	**Percentage (%)**
Yes	**12**	**100**
No	**0**	**0**
Total	**12**	**100**

Table 4.10 (above), shows that all the twelve (100%) respondents indicated that they have been informed and trained on WBOT programme. This is a requirement for being recruited in the WBOT programme. According to NDOH (2011), there are guiding principles for the employment of CHWs, which indicate that the CHWs should have the knowledge, skills competence. In addition, the new recruits will develop their skills and competence through an extensive orientation, training, mentorship and supervision programme.

4.5.8. Question: 1.8. If yes, what do you know about it?

All the twelve (100%) respondents indicated that they know about the WBOT programme and in addition, they indicated that it is a programme consisting of 6 CHWs, one OTL, health promoter, municipal officer and school nurse. One respondent indicated that she gained clarity in her role as OTL. The responses are indicated in table 4.11 below.

Table 4.11: Responses for "Yes" question

Respondent No.	Response from the questionnaire for question 1.8
1.	It is a programme consists of 6 CHWs, one OTL, (a) health promoter, (a) municipal officer and the school nurse; They help the community in many ways.
3	The programme is to go to the community and attend to identified problems and refer them to the clinic for health issues, for psychosocial problems.
4	This programme taught me a lot about how I must represent myself when I get in a household, how to talk with people
5	Is a national programme and is to bring services to the community.
6	It is a programme that promotes health of the community by giving them care that is essential/accessible and affordable.
8	WBOT give services to the people in their own homes.
11	We have been taught about deworming and vitamin and muac and on how to check children's weight.
12	The WBOT is there to help and reach people in our community. Refer to social services by the need of homes.

The responses in table 4.10 above show that all the respondents agreed and indicated that they have been given information and trained on the WBOT

programme before they were recruited. In addition, they indicated that the information given is as follows: It is a programme consists of 6 CHWs and one OTL, a health promoter, a municipal officer and the school nurse; they help the community in, many ways. According to NDOH (2011), CHWs are trained and given information once they are recruited to be part of the programme. In addition, CHWs are trained for a period of two weeks before they commence with their community work.

4.5.9. Question: 1.9. What are the benefits of the WBOT programme?

All the twelve (100%) respondents indicated that there are benefits to WBOT programme. Their responses are indicated in the table below. They mentioned that since they started with the WBOT, they have gained a lot of experience and knowledge about treating patients at their homes. They also mentioned that the clinic queues are reduced because of WBOT. The respondents indicated that despite all the challenges, the WBOT programme contributed to the success and was beneficial for the teams and the patients to provide community services. In addition, some of the respondent's views indicated that treating more controlled cases at the household has alleviated the overcrowding in the clinics.

Table 4.12: Responses on the benefit of WBOT on CHWs

Respondent No.	Response from the Questionnaire for question 3.1.11
1	The programme is working and help the community, the queues at the clinic are minimized. My community trust(s) me with their problems, because they know, I am trained. Other patients don't have to go to the clinic monthly because they take the treatment at home, pensioners are followed by OTL at home for vital signs, and the disadvantage is that the workload is too much but no salary.
2	Knowing the community, bringing health to their door steps, reducing long queues in health facilities. The clients are health

	oriented and taking care of them. They (sic!) are no disadvantages.
3	WBOT helps the community to improve their lifestyles, through educating them. Triaging defaulters, counsel them. Some patients who were about to die, recovered. Those who are sick are able to phone the ambulance.
4	No benefits, asking permanent job as CHW. People who were not walking because of illness, they are walking now because of this WBOT and others going back to their jobs.
5	Since this programme started many people are getting help. I get experience and more information. TB cure rates and ANC early bookings
6	We are being recognised, the clients cooperate well with me. They adhere well to their treatment. I benefit because all my clients complete their treatment. ANC patients are able to book early to avoid maternal dearth (sic!). My TB patients completed the treatment. Elderly patients no longer go to clinic monthly.
7	Reduces waiting time at the facilities. CHW visit the patients in their homes.
9	HIV/ADS defaulters are very low and children are less infected (sic!) with the virus.
11	Patients get help quickly because of this programme, the disadvantage is that we (CHWs) also get sick due to their status and the advantages are that we learn about people's situations every day.
12	We now understand our community, households and needs. Patients now have access to IDs and applying social grants.

According to NDOH (2012), the main benefit is to promote good health and prevent ill health in a variety of interventions based on the concept of a healthy community, a healthy family, a healthy individual and a healthy environment. From the responses in table 4.12 above, it was clear that there are benefits in the WBOT programme.

Some respondents indicated that the programme is working and helping the community. In addition, they indicated that the queues in the clinic are minimized. One respondent said, “My community trust me with their problems now. I am trained and other patients don’t have to go to the clinic because they take their treatment at home because of this WBOT.”

4.6. Respondents knowledge of factors that facilitate the implementation of the WBOT programme

In this section, the researcher discusses the factors mentioned by respondents that facilitate the implementation of the WBOT programme. The respondents’ difficulties in working with the nurses in the facilities are mentioned as well as whether there are any benefits and difficulties in working with patients, their views on the community structures that encourage and allow the community to be involved in health issues including the WBOT programme and decision, challenges with these structures in the community that encourage and support the participation in the WBOT programme and finally their recommendations on what could be done to improve community participation.

4.6.1. Question 2.1. What are the difficulties of working with nurses in the health facilities?

All the twelve (100%) respondents had different forms of difficulties working with nurses in the facilities. Difficulties such as bad attitude, not taking us (CHWs) seriously, not completing the referral forms, not wanting to touch the patients because of bad smell were major difficulties indicated by respondents in working with nurses in the facilities. The difficulties mentioned by respondents are written in the table 4.13 below.

Table 4.13. Difficulties working with nurses

Respondent No.	Response from the questionnaire for question 2.1.
1.	Some are being rude to the patients when we have referred them and therefore result in patients refusing to go to the clinic when we refer them.
2.	There (sic!) are less informed about the programme. They don't respond to our challenges such as you refer a patient but (there is) not (a) referral back to us.
3.	Failure to record after issuing medication and patient is traced as a defaulter only to find that they have medication.
4.	Our clinic is too small for our communities, our Nurses can't reach the number attending clinic. Most patients going back to their home without help and it is (a) very serious problem to come back to the clinic (a) gain, that's where we got the defaulters. They told us that the clinic is too full and wait for longer hours.
5.	Nurses don't give the client's time to allow themselves when consulting. They don't have patience and they don't touch them, they say they do not smell ok.
6.	The Nurses make things difficult for us because when I accompanied the client to clinic, I have to follow the queue like everyone else for the whole day, what about my other patients at the community.
7.	Staff attitude of some of the Nurses causes tension and make patients default, because they are not treated with respect.
8.	They think we are nothing when we refer the patients. They don't fill the referral form even when we want medication for our patients, we must follow the queue.
9.	They issue medication and forget to write on the file and the file will remain and patients become defaulter.
10.	Some are being rude to the patient when we refer them to the

	clinics and therefore the results in patients refusing to go to the clinic when we refer them to the clinic.
11.	Nurses think that they are better, than us, they think they know everything; they don't consider us as one of them. They humiliate us in front of everyone even patients.
12	Nurses when they come from the workshop, they don't give us information especially about post-natal care, ante-natal care, under-5s if (there) are changes of information, so when the mistake(s) happen they come and tell us, shouting at us.

From the responses in the table 4.13 above, it is clear that there are difficulties in working with nurses in the health facilities. Respondents indicated that some nurses are being rude to the patients when they referred to the facility, this results in patients refusing to go to the clinic when referred. Nxumalo and Choonara (2014) highlight the importance of working with all stakeholders including nurses for optimal implementation of the WBOT programme.

4.6.2. Question 2.2. What are the benefits of working with nurses and patients in the health facilities?

All the twelve (100%) respondents indicated the benefits of working with nurses and patients in the health facilities. The respondents indicated that some nurses do co-operate and help us by talking to patients in a correct manner. They make things easy for us and the patients. Regarding the patients, they indicated that they become impossible, refusing to take treatment, and even to go to the clinic for admissions.

Table 4.14: Responses of the benefits of working with nurses and difficulties with patients

Respondent No.	Response from the Questionnaire for question 2.2.
1.	Some nurses are cooperative and help us by talking to the patients in a correct manner and they even fill the referral forms. They (sic!) are difficult patients who refuse taking treatment and going to the clinic.
2.	Patients become impossible and make it difficult if they don't agree with admissions.
3.	Nurses are knowledgeable in the field of health and able to give relevant advice and where not competent, patients are referred to (a) medical officer.
4.	Benefit (of) working with Nurses is that when we send the patient(s) to them, they helped them. Difficulties of working with patients are that they move from one place to the other.
5.	When accompanied the patient to the facilities, they get help and don't stay in long queues. Patients refuse to go to facilities and refuse sometimes to take medication.
6.	Giving advises (sic!) on how to deal with patients who give troubles. Patients swearing at me and refusing to drink medication
7.	Good relationship between the nurse and CHW. Patients don't want to disclose their status and give us wrong addresses, some even provoke us.
8	The stigma of disclosing their status.
9	We gain experience, because they teach us everything in the health facilities. The patient does not come for the next check up; they send us to go to fetch them in their homes.
10.	We have reduced overcrowding of patient(s) in the clinic; sometimes they chase us away from their homes due to their

	lack of knowledge.
11	If we have questions we can ask them because they are closer (sic!) to us and difficulties with patients is that they do not cooperate even though it is their health at risk.
12	Our OTL is helping a lot especially with his car. Because when patient(s) see the doctor he collect(s) them to the house and take(s) them to the hospital.

From the responses in table 4.14 above, it came out that despite the difficulties working with nurses, there are benefits of working with the nurses in the facilities. According to Nxumalo et al. (2014), it is indicated that working hand in hand with the government, the community structures, nurses and patients is critical in the success of WBOT programme. It has been shown in these responses that working together with nurses will improve the programme.

4.6.3. Question 2.3: What are the views from the community that allow the community to be involved in WBOT programme?

Of the twelve respondents, eleven (92%) respondents indicated views from the community that influenced the community to be involved in the WBOT programme. However, one (8%) felt that as CHWs, they are not been taken seriously. These views are written in the table 4.15 below.

Table 4.15: Views of the community about WBOT

Respondent No.	Response from the questionnaire for question 2.3
1	They see our work and approve that we are helping the community. They also wish we were permanent and receive (d) enough salary.
2	All the above.

3	Community structures view the WBOT as the cornerstone of their wellbeing. We are accused if we spend a day not communicating with them.
4	NGO and ward community seeing us that we work very hard in our community they think that we are permanent and we are not permanent.
5	To plan together and do campaigns.
6	Support groups and door to door campaigns.
7	Some appreciate the WBOT programme and (there are) those who are against us.
8	When we mobilise for MMC and teenage pregnancies campaigns.
10	They see our work and approve that we are helping the community. They also wish we were permanent and receive (d) enough salary.
11	The WBOT is trying very hard to get the community involved in the health system
12	SASSA and Home Affairs when they have campaigns, they invite us.

Responses in the table 4.15 above clearly indicate that the community view the WBOT as working and helpful. It is indicated that the community approves of the WBOT and respondent 1 said “community wish if they were permanent employees and receiving enough salary”. Lewin and Lehman (2013:3) indicate that most comprehensive Primary Health Care (PHC) programmes that are successful are so as a result of community and individual participation. In this study, there is still a challenge of community involvement in the WBOT.

4.6.4. Question 2.4. What challenges do you think these community structures face to encourage and support the WBOT programme and what strategies are there to improve community participation?

All the twelve (100%) respondents indicated that there are challenges that are facing community structures with WBOT and also highlighted the strategies that can improve community participation in the WBOT programme. They indicated that it is important for all relevant structures and stakeholders to meet and plan together; otherwise the community would not be able to attend these meetings. They also indicated that the community is tired by meetings and campaigns that are coordinated separately without its involvement. It is noted in the survey that community mobilisation and involving local stakeholders to generate support is critical. The challenges and strategies are written in a table 4.16 below.

Table 4.16: Challenges community structures face with WBOT and strategies to improve community participation.

Respondent No.	Response from the questionnaire for question 2.4.
1	Community campaigns are the best to make the community to be more involved.
2	All structures to meet and coordinate the programme and try to call the meetings and give others slots rather than calling endless meetings and (the) community end(s) up tired and disinterested.
3	When community structures are mobilized to send their children for immunization, there must be enough medication, because they come. Our gazebos must be improved big and strong to withstand different weather conditions.
4	Lack of protective clothing. Short term contract for stipend.
5	To bring community together with meetings and plan together.

6	The Department of Health and other stakeholders does not involve the community members in the campaigns or other activities, they do not make decisions. They do things that are the same but different dates, these bore the community. The department together with other stakeholders such as ward committees should come together and discuss (a) year plan to do campaigns and meetings that include both of them.
7	There is no good relationship between the community structures and the community because they are not given information. There should be campaigns, community dialogues, and sports or recreational games.
8	The community need(s) training and education of the importance of WBOT programme.
9	Stakeholders should meet and make one plan to address the community at least once or twice in a year.
10	I think if we can form a support group with the help of those who are above us for example the church leaders/politicians/ward counsellors to organise a match or something to attract them and educate them about WBOT.
11	Communication is important in our community so that they can have a relationship with their leaders.
12	Listen to the community issues and help even if not but give them feedback. Our WBOT programme must be involved in their meetings to let them know that they work together. They must understand the community issues and work with them.

According to Dennill et al. (1998), community participation is a critical support activity for PHC system to achieve the goal of health for all. The responses in the table 4.16 above indicate that respondents are in agreement that there are challenges that the community structures are faceing to encourage and support WBOT. Some of those challenges are: the Department of Health does not listen to the community needs, the feedback is not taken seriously, and there is a great need for educating the

community and their leaders in terms of WBOT. It came out clearly in these responses, that stakeholder involvement and participation is a key in the success of the WBOT programme.

4.7. SUMMARY

The findings of the WBOT programme implementation survey have been presented in tabular and graphical format thereby providing a clear picture of the level of successes and challenges facing the WBOT programme in its implementation in the rural area of the Kgetleng Sub-district.

4.8 CONCLUSION

The results from the respondents have shown that there are successes, challenges and lesson learned from this study. The study results indicate that the programme is being implemented well even though it is in its pilot phase in the sub-district. It has shown that more and more people are being helped by CHWs in their own homes. The long queues in the clinics have been reduced, because many patients are treated at home by the CHWs. The programme has managed to improve and it saves many lives in the communities of the Kgetleng Sub-district. In addition, the findings of the study also indicated challenges such as bad attitude of some nurses in the facilities, nurses not able to complete the referral forms, wrong addresses by patients and refusal of some patients to allow the CHWs to visit and enter their homes. Furthermore, the findings of this survey highlighted the importance of mobilizing and involving local stakeholders to generate support. They also can develop networks that can continue to support WBOT implementation.

CHAPTER FIVE

SUMMARY OF RESULTS, CONCLUSION AND RECOMMENDATIONS

5.1. INTRODUCTION

The purpose of the study was to evaluate the implementation of the WBOT programme. This chapter outlines the summary of results that were collected using questionnaires to collect data within the rural area of the Kgetleng sub-district. The chapter further summarizes the conclusions and the recommendations that were made based on the data collected from participants in this study. In the section below, the main objectives of the study are listed and the findings are indicated. This is followed by a discussion of the strengths and weaknesses of the study and recommendations stemming from the findings.

5.2. SUMMARY OF THE RESULTS

5.2.1. Demographic information

5.2.1.1. Age group for the respondents (N=12)

Of the twelve respondents, five (42%) fell in the 20 and 29 age range, while five (42%) fell in the range of 30 and 39 years of age, the other two (17%) fell between the age range of above 60 years. This is to be expected because the requirement for one to be recruited as CHW is that one should be able to read and write. However, for OTL, only retired nurses are recruited to supervise the CHWs.

5.2.1.2. Gender for the respondents (N=12)

Of the twelve respondents, ten (83%) were female and two (17%) were males. The gender in this study is vital because this job is regarded as the female work by communities.

The Department of Health is dominated by women. Women are seen as caring and loving in the community. CHWs have to attend to household issues such as bathing the patients, helping them to eat and taking medication.

5.2.1.3. Highest qualifications for the respondents (N=12)

Ten (83%) respondents in this study were having highest qualifications of between Grade 8 and 12. Two (17%) of the respondents have the highest qualifications of a Bachelor Degree. The ten respondents were Community Health Workers (CHW) and the two were Outreach Team Leaders (OTL) who are retired Nurses and appointed to lead the WBOT team. It is an indication that CHWs still need further training and development.

5.2.1.4. Number of years in the post of the respondents (N=12)

Some 67% of the respondents fell in the range of 1 and 3 years in the post and a lower number of the respondents (33%) have been in the post between 4 and 6 years. It is an indication of the new programme that has been piloted since 2011 and many of these CHWs were recruited in 2012. This situation shows that some CHWs might be less experienced and still need more mentoring and supervision from the OTL.

5.2.2 Objective 1: To evaluate the experiences of CHWs in the implementation of the WBOT programme.

The findings showed that respondents regarded WBOT as a good programme and as one that is doing well. Experiences by CHWs such as unwillingness of the patients to disclose their status, giving wrong addresses, patients swearing at the CHWs, lack of knowledge of the community regarding WBOT, and finally, a lack of community participation were found to hamper the successes of the programme. However, willingness and commitment to help the community from the CHWs enhanced the WBOT programme implementation.

Despite challenges that the CHWs experienced in their duties, they continued working and helping the community to be a better and healthier one.
According to the WHO (2008), community participation is a critical support activity for the PHC system to achieve the goal of health for all. In addition, participation should be active, communities have the right and responsibility to exercise power over the decisions that affect their lives and there must be mechanisms to allow for the implementation of the decisions by the community (Dennil et al., 1998).

The findings for the study indicated that there are still challenges regarding optimal community participation in the health issues in the community. One respondent indicated that “when they organise campaigns, some people don’t attend, so the information is not spreading as it should’. Furthermore, the findings indicated in this study that the referral system is a big challenge for the respondents when conducting their work. According to WHO (2007), a referral system plays one of the key roles and gives input to the approach for the optimal implementation of the WBOT programme.

In addition, the CHWs role in the household is to assess and identify health problems in the community, and if needs be, refer to the nearest facility. According to the NDOH (2011), referral forms should be completed by the Outreach Team Leader (OTL) to the clinic and the clinic to the Outreach Team. However, this is not the case according to the respondents. They encounter problems of nurses not completing the back referral form and they indicate that this causes the patients to default. The findings from this objective is a clear indication that CHWs, community structures, all stakeholders should be supported, planning together with government entities and ward counselors in the community would achieve the desired goals that will help the community to get more involved in the WBOT programme.

5.2.3 Objective 2: To identify and evaluate factors that facilitates the implementation of the WBOT programme

The section on factors facilitating the implementation of the WBOT programme have shown that working hand in hand with the community structures, ward counsellors and the nurses in the clinics is critical to the success of the WBOT programme. Of the 12 respondents, eleven (92%) share their views of what they encounter from the community regarding the WBOT programme. However, one (8%) of the respondents felt that as CHWs, they are not being taken seriously. Nxumalo and Choonara (2014), in their rapid assessment of the WBOT programme findings, highlight the importance of mobilizing and involving local stakeholders to generate support and also develop networks that can continue to support the WBOT programme implementation. The findings of this study further indicated all twelve (100%) respondents encounter some form of difficulties with nurses when working in the health facilities.

The difficulties mentioned by the respondents are (but not limited to): bad attitude, being rude to patients, failure to record after issuing medication, not being taken seriously, nurses not completing the back referral form, not wanting to touch the patients because of a bad smell. These were major difficulties that the respondents encountered when working with the nurses and they indicated that they sometimes compel the patients in the household not interested to go to the health facility (clinic) when referred. However, there are also benefits of working with nurses in the health facilities. The respondent number one (1) indicated that "*some nurses are cooperative and help us by talking to the patients in a correct manner and they even fill out the back referral forms*". Respondent number three (3) indicated that nurses are knowledgeable in the field of health and are able to give advice; and where they are not competent, they refer to the medical officer.

5.2.4 Objective 3: To make recommendations to the District Management Team with regards to the findings of the study to be implemented.

The respondents suggested various strategies and recommendations to improve the WBOT programme implementation. All the twelve (100%) respondents suggested that they needed support beyond the normal duties that they conduct in the communities, such as taken seriously and be appointed permanently as government workers. Suggestions for improvements included:

- Local stakeholders in the community to meet, plan and coordinate together
- Improve mobilization and involving local stakeholders
- Training and education of the community about WBOT
- Strengthen communication amongst the community structures and
- Conducting community campaigns and dialogues so that the community can understand WBOT and get involved.

5.3. RECOMMENDATIONS TO THE DISTRICT MANAGEMENT TEAM

It is recommended that:

- The North West Department of Health (NWDOH) should recruit more male CHWs for gender representations in the community structure making males to see the contribution they can make in the WBOT programme. There is a need to formulate a gender mainstreaming policy on hiring of CHWs in this programme. Information on all aspects of CHWs appointment criteria should be known to all members of community.
- According to Carmen (1999) a lack of transparency and accountability in the hiring and promotion procedures allows those in power freedom to reproduce the institution in their own image.
- NWDOH should recruit more CHWs under the age of 40 years because they are still young and able to cover the long distance walking.
- The respondents ought to be trained and to be provided with career pathing. The CHWs have been provided with Phase 1 training and are still to continue to

Phase 2 training and Phase 3 NQF qualifications, which is a one year occupational training accredited by QCTO; finishing this they would be able to enter into health promotion field. The NWDOH should continue to recruit more OTL and CHWs to cover all the wards needed for optimal implementation of the WBOT programme.

- Professional development and mentoring opportunities for CHWs and the OTLs should be provided, as many of them have a working service of between 1- 3 years.
- A conducive working environment should be created by providing good working relationships with providers of service such nurses, social workers, health promotion and environmental health practitioners to respond to needs of the communities.
- Policy changes need to be communicated efficiently, both to health professionals and the community to avoid resistance and confusion.

5.4. RECOMMENDATIONS FOR FURTHER RESEARCH

This study has shown that one of the ways to learn about WBOT programme is to adopt a more in-depth approach, to understand the experiences of CHWs and those who receive the services.

- Despite this level of depth, there is a crucial need for more in-depth research regarding the experience of the users of WBOT services.
- There are currently various studies taking place in the pilot sites to evaluate WBOT in which CHWs are central. The CHW research studies or assessments could be extended beyond the life of the pilot site evaluations.
- Another area requiring further research is the exploration of mechanisms that address the social determinants of ill health in a more multi-faceted and integrated approach. A detailed analysis is needed of the implementation failures of various policies meant to address the factors that render poor households vulnerable.
- Finally, to conduct a similar study looking into the urban area, which would allow comparing and contrasting the rural and urban area findings?

- Does WBOT programme implementation in the urban areas also experience challenges that the rural WBOT is experiencing?

5.5. LIMITATIONS OF THE STUDY

One of the study's main limitations is its restriction to one sub-district in a rural area which is part of the pilot. As such, the findings are not necessarily to be generalised to the entire district. Further studies could be conducted in different sub-districts in urban areas in the North West Province to compare and contrast the responses.

This study provides lessons learned from a single sub-district from the pilot site, which limits our knowledge of factors that facilitate the WBOT programme implementation in the community in sites that are not included in the pilot. To cover the whole district which comprises of five sub-districts would have provided a more comprehensive understanding of the programme implementation both urban and rural.

5.6. CONCLUSION

In this chapter the researcher presented a summary of findings according to the objectives of the study mentioned in chapter 1, offered recommendations stemming from the findings from the WBOT programme implementation and further research.

This study aimed to evaluate the implementation of the WBOT programme in the rural area of the Kgetleng Sub-district and to explore the experiences and factors that enable and constrain them in achieving this. Table 4.5 illustrates the challenges and successes with the WBOT programme, based on the responses from the respondents. This study indicates that CHWs provide services in communities that live in poverty and therefore face multiple problems that contribute to ill health.

This study shows that the successful WBOT programme provides a more holistic approach to addressing the health needs of all individuals promotes the development of infrastructure, provision of relevant staff and is critical for sustained improvements in the health of communities.

In addition, resources are needed to support CHWs to navigate uncoordinated and fragmented government services. Furthermore, this study shows that CHWs can make a valuable contribution to community development and more specifically, they can improve access to and coverage of communities with basic health services.

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ANNEXURE A: QUESTIONNAIRE FOR THE RESPONDENTS

SECTION A: INFORMED CONSENT

My name is Rodney Azwinndini Mulelu. I am currently registered for a Master's Degree in Business Administration (MBA) with the University of Limpopo for the year 2015. My research topic is "**Evaluate the implementation of the Ward Based Outreach Teams (WBOT) programme in a rural area: the case of Kgetleng sub district, North West Province".** The objectives of the study are:

- To evaluate the experiences of CHWs in implementation of the Ward Based Outreach Teams (WBOT) programme
- To evaluate factors that facilitate implementation of the WBOT programme
- To make recommendations to the District Management Team with regard to the findings of the study to be implemented.

Kindly be advised that the interview will take 30 minutes to 1 hour. It will not affect in anyway how the interviewer treats me. You are also advised that participating in this study is voluntary and should you feel uncomfortable I can stop the interview at any time. No names of participants are required as part of the study and confidentiality of any information divulged is of utmost importance.

I accept to participate in the study

_____

Participant

SECTION B: QUESTIONNARE FOR RESPONDENTS

Demographical information

Gender

Male	
Female	

Age

20 – 29	30-39	40-49	50-59	60+

Highest Qualification

Grade 0-7	Grade 8-12	National Diploma	Bachelor Degree

Current position

Community Health worker	Outreach Team Leader	Nurse	Administrator

Number of years in the post

1-3	4-6	7-10	11+

Objective 1: Experiences of CHWs in WBOT implementation

1.1. Explain to me your experiences of working in the community and the role that you play as CHWs?

_____

_____

_____

_____

_____

_____

1.2. Please give examples of some of the challenges and even successes that you have experienced with the WBOT and also give your view on the programme itself with regards to implementation in the sub district.

_____

_____

_____

_____

1.3. Which other health professionals are involved in the WBOT programme and what are their roles?

_____

_____

_____

_____

_____

1.4. What challenges have you experienced regarding the referral processes?

_____

_____

_____

_____

_____

1.5. What benefit/successes have you experienced regarding the referral processes?

_____

_____

_____

_____

_____

1.6. What would you recommend with regards to improving the referral processes?

_____

_____

_____

_____

_____

_____

_____

1.7. What are some of the challenges of being involved and interacting with community structures

_____

_____

_____

_____

_____

1.8. Have you been informed and trained about the WBOT programme?

Yes	No

1.9. If yes, what do you know about it?

_____

_____

_____

_____

_____

1.10. What is your opinion on the WBOT programme? What are some of the benefits of the WBOT programme on you as a CHW and your patients?

_____

_____

_____

Objective 2: Factors that facilitates the implementation of the WBOT programme

2.1. What are the difficulties of working with nurses in the health facilities?

_____

_____

_____

_____

_____

2.2. What are the benefits of working with the nurse in the health facilities? What are the difficulties of working with patients?

_____

_____

_____

_____

_____

2.3. What are the views on the community structures in your community that allow the community to be involved in health issues including WBOT and decisions?

_____

_____

_____

_____

_____

2.4. What challenges do you think these community structures face to encourage and support the community to participate in WBOT programme? What could be done differently that would improve community participation?

_____

_____

_____

_____

_____

_____

_____

_____

Thank you for your time

ANNEXURE B: PERMISION TO CONDUCT RESEARCH

36 Barnard Street

Swartruggens

2835

24 August 2015

The District Research Committee Chairperson
Bojanala Health District
Rustenburg
0299

Dear Professor J. Tumbo

RE: REQUEST PERMISSION TO CONDUCT RESEARCH: MULELU R.A.

I, Rodney Azwinndini Mulelu, Student Number: 9340926, Persal number: 90840909 hereby wish to apply for a permission to conduct research study in your District, Kgetleng Sub District. I'm studying towards a Master's degree in Business Administration (MBA) with University of Limpopo.

My study is entitled **"Evaluate the implementation of Ward based Outreach Teams (WBOTs) programme in a rural area: The case of Kgetleng Sub District, North West Province."** I will be conducting research using questionnaires to be provided to the respondents (CHWs, Nurses, OTLs and Community counsellor) in the sub district. I'm enclosing my copy of the research proposal and an approval ethical clearance letter from the University of Limpopo Higher Degrees Committee. I'll appreciate your timeous response as your permission is one of the requirements to start conducting field work of this research.

Thanking you in advance.

Kind Regards

Mr. Rodney Azwinndini Mulelu

ANNEXURE C: APPROVAL TO CONDUCT RESEARCH: UL

TURFLOOP GRADUATE SCHOOL OF LEADERSHIP
Private Bag X1106, SOVENGA, 0727, South Africa
Tel: (015) 268 3537, Fax: (015) 268 3874, Email: TGSL@ul.ac.za

TO: Mr Mulelu RA
Master Student TGSL

CC: **Dr M Lethoko**
Supervisor

Dr J Mbuya
HOD

FROM: Mrs P Manamela
SHDC Secretary (TGSL)

DATE: **26 May 2015**

OUTCOME OF THE HIGHER DEGREES COMMITTEE MEETING

Dear Mr Mulelu RA

I am delighted to let you know that your master research degree proposal served at the Turfloop Graduate School of Leadership (TGSL) Higher Degrees Committee (HDC) meeting that sat on 25 May 2015. The following are the decisions that were taken by the committee:

Committee Decision	
1. Proposal is APPROVED	**X**
2. Proposal Approved with minor MODIFICATIONS (Proposal need not to be resubmitted to the committee but to the HOD)	
3. Proposal NOT approved (Proposal should be resubmitted to the committee)	

Sincerely

Ms P Manamela
Secretary SHDC (TGSL)

ANNEXURE D: APPROVAL TO CONDUCT RESEARCH: NWPG

health
Department of
Health
North West Province
REPUBLIC OF SOUTH AFRICA

3801 First Street
New Office Park
MAHIKENG, 2735

Enq: Keitumetse Shogwe
Tel: 018 391 4504
kshogwe@nwpg.gov.za
www.nwhealth.gov.za

POLICY, PLANNING, RESEARCH, MONITORING AND EVALUATION

Name of researcher : Mr. R.A Mulelu
University of Limpopo

Physical Address _____
(Work/ Institution) _____
_____

Subject : Research Approval Letter- Evaluate the Implementation of Ward Based Outreach Teams (WBOTs) Programme in a Rural Area: The Case of Kgetleng Sub-District, North West Province.

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

Dr. FRM Reichel
Director: PPRM&E

22/09/2015
Date

LEPAPHA LA BOITEKANELO
DEPARTMENT OF HEALTH
Kgetsana Poso /Private Bag X2068
Mmabatho,2735
22 SEP 2015
NORTH WEST PROVINCE
REPUBLIC OF SOUTH AFRICA

Researcher

Date

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Healthy Living for All