COMMUNITY HEALTH WORKERS' PERCEPTIONS ON THE TRAINING SERVICES OFFERED BY MASIKHULISANE: A CASE STUDY OF INANDA, NTUZUMA and KWAMASHU IN ETKETHWINI MUNICIPALITY IN KWAZULU NATAL

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DECLARATION

I Dumisani Patrick Sosibo, declare that this dissertation is my own work and has not been submitted previously for any degree in any University.

Dumisani P. Sosibo

LIST OF ABBREVIATIONS

ABE	-	Adult Basic Education
ABET	-	Adult Basic Education and Training
AIDS	-	Acquired Immune Deficiency Syndrome
AMREF	-	African Medical Research Council
ANC	-	African National Congress
ART	-	Antiretroviral
CBO	-	Community Based Organization
CBHS	-	Community Based Health Services
CBHP	-	Community Based Health Programmes
CCG	-	Community Care Giver
CHW	-	Community Health Worker
CHF	-	Community Health Facilitator
CETD	-	Community Education Training and Development
DOTS	-	Directly Observed Therapy
DHS	-	District Health Systems
ECDP	-	Early Childhood Development Practitioner
EPWP	-	Expanded Public Works Programme
EMS	-	Emergency Medical Services
FETC	-	Further Education and Training Certificate
GETC	-	General Education and Training Certificate
HASA	-	Hospice Association of South Africa
HWSETA	-	Health and Welfare Education and Training Authority
HR	-	Human Resources
INAN AMA	-	Inanda Amaoti
INAN NCH	-	Inanda Newtown C Hall
INK	-	Inanda Ntuzuma KwaMashu
KFA	-	Key Focus Area
MK	-	Masikhulisane
MECC	-	Mashu E Community Court
MLH	-	Mashu L Hall
MRC	-	Medical Research Council

NCoP	-	National Council of Provinces
NDoH	-	National Department of Health
NHS	-	National Health System
NGO	-	Non Governmental Organization
NHRC	-	National Health Research Committee
NET	-	Ntuzuma E Thandolwethu
NTF LIB	-	Ntuzuma F Library
PPHC	-	Progressive Primary Health Care
PPHCTB	-	Provincial Primary Health Care Training Board
PHC	-	Primary Health Care
SANC	-	South African Nursing Council
SAAVI	-	South African AIDS Vaccine Initiative
SGB	-	Standard Generating Body
SPSS	-	Statistical Package for Social Sciences
HIV	-	Human Immune Virus
SAQA	-	South Africa Qualifications Authority
FBO	-	Faith Based Organization
KFA	-	Key Focus Area
RDP	-	Reconstruction and Development Programme
TB	-	Tuberculosis
WHO	-	World Health Organization
PMTCT	-	Prevention of Mother to Child Transmission
OSD	-	Occupation Specific Dispensation

ABSTRACT

Access to medical care remains a challenge worldwide. It is particularly severe in developing countries and it is estimated that one million more health care workers are needed in Africa to meet the health related Millennium Development Goals. Though many countries have made significant strides in improving health service delivery by increasing their spending on health care, many health systems remain weak. The situation is no different in South Africa.

Community health workers (CHW's) are thought to be an answer to improving health care delivery. They can be trained to do specialized tasks, such as providing sexually transmitted disease counselling, directly observed therapy and act as birth attendants. Others work on specific programmes performing limited medical evaluations and treatment. With proper training, monitoring, supervision and support, CHW's have shown to be able to achieve outcomes in terms of health care service delivery.

The researcher undertook this study to investigate the perceptions of CHW's on the training services offered by Masikhulisane (MK). A case study of Inanda, Ntuzuma and KwaMashu (INK) used a mix method approach to determine the perceptions of community health workers on the training services offered by Masikhulisane. The researcher distributed questionnaires to six groups of CHW's in the INK area at different venues.

The findings of the study are useful in making evidence-based improvements in the MK education programme that targets various sectors, including CHW's. From the findings of this study, it was concluded that CHW's can make a valuable contribution to improved access and coverage of communities with basic health services.

It is recommended that the Masikhulisane training programme should be accredited, the Masikhulisane sectoral approach should be broadened to reach more sectors not reached before and the training content should be revisited to ensure acceptability and appropriateness for targeted sectors.

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DEDICATION

I dedicate this work to my late parents, Victor and Sara Sosibo, for it is every parents' dream to see their children achieve in life. This study would have made them proud.

To my late sister, Revival Sosibo, she always wanted the best for me and all of us as a family. This would have made her proud as well.

TABLE OF CONTENTS

CHAPTER TWO: Literature review

CHAPTER THREE: Research methodology

CHAPTER FOUR: Data presentation, analysis and interpretation

CHAPTER FIVE: Conclusions and recommendations

LIST OF FIGURES

LIST OF TABLES

LIST OF APPENDICES

CHAPTER 1

Context of the study

1.1 Introduction

According to the World Health Organization (WHO) AIDS Epidemic Update (WHO, 2009:5), an estimated 2.7 million new HIV infections occurred and an estimated 2 million deaths occurred due to AIDS related illnesses worldwide during 2008. The estimated number of new HIV infections was approximately 30% lower than at the peak of the epidemic in 1996. The South African Department of Health has produced good sentinel surveillance data that assists in monitoring the HIV epidemic prevalence trends in the 15 - 49 years old female population. In 2009, the HIV prevalence in the population age group between aged 15-49 was estimated at 17.8%, or 5.63 million adults and children were infected with HIV and AIDS. Of these, 5.3 million were adults aged 15 years and older, 3.3 million were females and 334 000 were children. The highest provincial HIV prevalence was recorded in KwaZulu-Natal which increased from 38.7% (95%CI 37.2% – 40.1%) in 2008 to 39.5% (95%CI: 38.1 – 41.0) in 2009 (WHO, 2009:5). The alarming statistics highlight the need for intervention measures to address the growing cases of HIV and AIDS.

In the context of any comprehensive health care programme, research is preparation for quality health care provision. Universal health care is a broad concept that has been implemented in many countries in several ways. The common denominator for all such programmes is some form of government action aimed at extending access to health care as widely as possible, while setting minimum standards. Most implement universal health care through legislation, regulation and taxation. Legislation and regulation direct what care must be provided, to whom, and on what basis (Berman, Gwatkin and Burger, 1987:443-459).

According to the Alma Ata Declaration (1978:1), governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the world community in the coming decades is to achieve a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice (Alma Ata Declaration, 1978:1).

The Alma Ata Declaration (1978:1) further provides that primary health care (PHC) is essential health 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 community whereby the national health system brings health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process (Alma Ata Declaration, 1978:02). In this regard, community health workers (CHW's) play a pivotal role in any primary health care (PHC) system.

According to Southwood (2007:1), community health workers (CHW's) are, therefore, targeted as group that could be trained on health research and development processes and eventually cascade research related information to the communities in which they work. The CHW's activities as an educator can have far reaching effects than all his or her preventative and curative activities combined. Individuals, groups, organisations and community health workers, in particular working at a local level, can be trained on all the processes involved in research and development. Community members, who form part of the catchment area for research, are targeted to be invited to participate in HIV prevention research involving microbicides, diaphragms,

and HIV vaccines. Trial communities hosting HIV vaccine research often experience benefits through development of research infrastructure, training and other skills development which may include increased knowledge around HIV, HIV vaccine development and issues associated with HIV vaccine clinical trials, increased clinical trials and laboratory capacity (International AIDS Vaccine Initiative, 2009:17).

Werner and Bower (1982:1) state that a health worker's most important job is to teach to encourage sharing of knowledge, skills, experiences and ideas. Community members and other stakeholders must be well informed of the reasons for conducting clinical trials in their community. For health workers at the interface between the population and the health services, the challenge is much more complicated than for a specialized referral service, managing a well defined disease is a relatively straightforward technical challenge. Dealing with health problems, however, is complicated as people need to be understood holistically with respect to their physical, emotional and social concerns, their past and their future, and the realities of the world in which they live. Failure to deal with the whole person in their specific family and community contexts misses out on important aspects of health that do not immediately fit into disease categories. People want to know that their health worker understands them, their suffering and the constraints they face (Starfield and Macinko, 2005:457).

Southwood, Hutton, Hamilton and Galloway (2008:5) state that the South African AIDS Vaccine Initiative (SAAVI) is a lead HIV and AIDS Programme of the South African Medical Research Council (MRC). SAAVI is a network of various stakeholders involved in the development and research of a locally relevant and affordable HIV vaccine. Masikhulisane (MK) is a community involvement programme of SAAVI whose vision is a South African society working in mutually beneficial and meaningful partnerships with researchers in a vibrant human and legal rights environment (Southwood *et al.*, 2008:5).

Community educators employed by MK develop annual plans which translate to individual plans using a sectoral approach that targets various sectors. Targeted sectors include the health and political sectors, Faith Based Organizations (FBO's), Non Governmental Organizations (NGO's), Community Based Organizations (CBO's), business, labour, youth, traditional healers, traditional leaders, adolescents, women and men sectors. CHW's within the health sector are among the targeted groups that are trained on the background to vaccines, science and research, HIV vaccine development process, ethical issues, legal and human rights and community involvement and participation (Southwood *et al.,* 2007:11).

The training is conducted over one day introductory workshops or two day awareness raising workshops. After receiving the training, CHW's are expected to include health research information gained as part of their health education and health promotion. As researchers continue to conduct their research, it is crucial to look at the effects of the training provided by MK to CHW's and the changes that might be necessary to improve training (Southwood *et al.*, 2008:8).

1.2 Rationale for the study

The role of CHW's includes providing support, being of a leader who can maintain confidentiality, collaborate with a family and be a bridge between health care centres and the community. These are critical not only for the continuing care of the patients, but also in creating an environment in the community where research is supported and trusted. CHW's in Inanda, Ntuzuma and KwaMashu (INK) which is in eThekwini municipality in KZN are community members who are employed by Progressive Primary Health Care (PPHC), which is an NGO. They were targeted to be trained by MK because of their role as health workers in the community. Despite years of ongoing training provided to the CHW's in the areas under investigation, no formal scientific study has been conducted as a means to promote evidence-based interventions and continued evidence-based improvements.

This study investigated the perceptions of community health workers' perceptions on the Masikhulisane training services provided by SAAVI in the INK area. It is important to investigate whether the training services offered by MK had any impact on CHW's in the areas under investigation, and to further ascertain the views of CHW's on the importance of the training provided by MK. Further, the value the CHW's attached to the training provided by MK needs to be established to ensure the relevance of the training they receive. The results of the envisaged study will benefit both MK in making evidence-based improvements in their training programmes as well as benefit the CHW's in acquiring current, up-to-date and relevant information on health research and development, which can be disseminated to the communities.

1.3 Research aim and objectives

This study aims is to investigate the perceptions of CHW's on the training services provided by MK community educators.

The objectives of the study are:

- to determine the nature of the training provided to CHW's;
- to examine the perceived relevance of the training provided by MK to CHW's and their work;
- to identify perceived barriers to effective training of CHW's; and
- to determine the impact of the training on CHW's and their work.

1.4 Preliminary literature review

According to the Constitution (South Africa, 1996:26-28), everyone has the right to health care services, including reproductive health care, sufficient food and water and social security and appropriate social assistance. The Constitution also provides that everyone has the right to body and psychological integrity, which includes the right to make decisions concerning reproduction, the right to security and control over their body; and the right not to be subjected to medical or scientific experimentation without their informed

consent. The Constitution highlights the role of the state taking reasonable legislative and other measures within its available resources to achieve the progressive realisation of each of these rights (South Africa, 1996:50). It is stated in the National Health Act (South Africa, 2003: 70-72) that the National Health Research Committee (NHRC) must identify and advise the Minister on health research priorities. In identifying health research priorities, the NHRC must have regard for the burden of disease, the cost effectiveness of interventions aimed at reducing the burden of disease, the availability of human and institutional resources for the implementation of interventions at the level closest to the affected communities, the health needs of vulnerable groups such as woman, older persons, children and people with disabilities and the health needs of communities.

According to the National Health Act (South Africa, 2003:18), the NHRC shall control research on or experimentation with humans, animals or human or animal material performed by employees of the MRC, or persons performing such research or experimentation for or on behalf of the Medical Research Council (MRC). Also with research aid by the MRC, the Board may determine ethical directives which shall be followed in such research or experimentation and take such control measures as it may deem necessary in order to ensure ethical directives are complied with. SAAVI, as a unit within the MRC, is a network of various stakeholders involved in the development and research of an HIV vaccine. SAAVI is a government initiative, established in 1999 with a mandate to coordinate the research and development of an affordable, effective and locally relevant HIV vaccine for Southern Africa.

According to the SAAVI Masikhulisane Strategic Plan (SAAVI, 2007:2), MK has three broad key focus areas (KFA) with various objectives: Organisational development and strategic collaboration; communication, education, training and development; and human rights, ethics and law. Objective one is to develop an understanding of the context of the target groups and their educational, training and learning needs in HIV vaccine research and development. Objective two is to develop, implement and evaluate learning

programmes to facilitate education. Objective three is to develop and disseminate appropriate information, education, media and communication materials, and the fourth objective is to continuously identify best practices and lessons learnt in Community Education, Training and Development (CETD).

To meet the aforementioned objectives, MK community educators target various sectors, including CHW's, to train them on the background to vaccines, science and research, HIV vaccine research and development, ethical issues, legal and human rights and community involvement and participation. For the purpose of this study, the objective of KFA 2 communication, education, training and development will be highlighted to determine the relevance of the envisaged research study. The aim of this training is to provide CHW's with information so that they further educate communities where health research is conducted to ensure that communities are informed about health research so that there is meaningful community involvement and participation in research. CHW's are primary targets because of the role they play in communities, the nature of their work and the role they can play in disseminating research literacy information (SAAVI, 2007:15).

Community health is the identification of health needs and the protection and improvement of collective health within a geographical area. Community health can best be understood by examining six basic components, which, when combined, encompass the services and programmes pertaining to community health: (1) promotion of healthful living, (2) prevention of health problems, (3) treatment of disorders, (4) rehabilitation, (5) evaluation and (6) research (Spradley and Allender, 1996:13). The role of the CHW is six-fold and only one aspect focuses on education, namely that of the educator. The other five roles, which are also integral in enabling CHW's to have an impact on the community, include: resource brokers, community developers, partnership developers, advocates and catalysts and, lastly and importantly, empowerers. CHW's play an integral role in disseminating research-related information. They are not only recipients of research literacy information, but

their capacity can be developed to provide research literacy information (Spradley and Allender, 1996: 28). Therefore, the role of MK in providing training to develop the capacity of CHW's is integral for community education.

According to Cruse (1997:14), in South Africa, the Provincial Primary Health Care Training Boards (PPHCTB) have the responsibility for the training of CHW's. Their functions include assessing the needs of CHW's and recognising where the trainees are from; establishing guidelines for content according to adult education methods; controlling standards; provision of training centres and materials, and planning on-going training. Up to now, only two centres in Southern Africa have provided formalised training for trainers. In Kenya, the African Medical Research Foundation (AMREF) has fulfilled this role. In South Africa, KwaZulu-Natal has a centre created for the formal training of enrolled nurses as Community Health Facilitators (CHF's). This programme has not been accredited by the South African Nursing Council (SANC). Training spans over two years with six months practical periods between "live-in" blocks. Plans are now underway to develop CHW training courses that will be accredited by the government, and a draft core curriculum is being reviewed by regional stakeholders. The aforementioned is indicative of the lack of training for CHW's, as well as the need to have training programmes recognised by the education authorities (Cruse, 1997:14).

According to Community Care Worker Management Policy Framework (South Africa 2009:27), CHW's within the Department of Health's broader approach to health care will form part of the service delivery teams within the District Health Systems (DHS). They are expected to promote PHC and Community-based Health Services (CBHS) objectives. International experience has shown that the role of CHW's must be clearly defined and appropriate to meet the priority problems in their particular communities. Their key function is to work at a community level in advocating for and accessing health services, while assisting communities to become better informed about health priorities. Health prevention and promotion activities should be the main objective of CHW's (South Africa, 2009:27).

Within Community Based Health Programmes (CBHP's), CHW's are ideally placed to set up links with other sectors such as agriculture, sanitation, housing and water supply, which impact substantially on community health and development. These links can be strengthened if each sector is represented in the local development committee, with which CHW's are involved. Seen in this context, the CHW plays a broader role of a development worker within the community (Cruse, 1997:4). Health promotion is a relatively new field in the health sector. Having been born as a result of observed weaknesses in the implementation of primary health care (PHC) strategies, it has been slow to develop in many countries. The Reconstruction and Development Programme (RDP) states that the PHC system must encourage the training, use and support of CHW's as cost-effective additional or alternative personnel and be well supported by the rest of the health services and NGO's working with them (Cruse, 1997: 5). In view of this, the role of MK is pivotal in addressing these goals. Therefore, attempts should be made to ensure relevance and appropriateness of the training provided to CHW's.

The value of CHW's is that they are local or community based and in order to ensure the quality of service provided by CHW's, appropriate training interventions aimed at developing their capacity to reach their full potential are necessary. They can be trained to do specialized tasks such as providing sexually transmitted disease counselling, directly observed therapy, or be trained as birth attendants where comprehensive health service delivery is still lacking. MK included CHW's as their target group to be trained on the background to vaccines, science and research, HIV vaccine research and development, ethics, legal and human rights, community involvement and participation because of the nature of their work which allows them to interact with community members. They are a suitable group to be trained on health research and development processes so that they will educate community members about health research.

1.5 Problem formulation

According to the Proposed Framework for Primary Health Care Delivery for Communities (South Africa, 2004:5), the role of CHW's is to mobilize communities, act as advocates to improve health, coordinate the access of other health workers, provide specified primary health care services to community members, provide basic counselling services, disseminate health information, carry out health promotion activities and transfer health and wellness skills to community members. One hundred and thirty (130) CHW's from INK were trained by SAAVI's MK. They also received other training related to their work from Progressive Primary Health Care (PPHC). INK has been the catchment area for the TB, HIV Prevention Research and the HIV Vaccine Research Units of the South African Medical Research Council in Durban for the past six years. It is important to ascertain the following: dissemination of the information gained from training by CHW's, impact of information provision on CHW's and their work, contribution of training to development and mechanisms to effectively disseminate research related information to communities. According to Southwood *et al.* (2007: 2), the major challenge to any trainer, educator or facilitator is how to teach in the most effective way possible so that workshop participants gain new and useful information, understanding, attitudes and skills. Furthermore, it is important to develop the capacity of people so that they can function more effectively. While SAAVI's MK is providing an important education programme for CHW's, it is imperative that the intended outcomes are achieved. This study aims to investigate the perceptions of CHW's regarding the training provided by MK, as no other research has been undertaken in this pivotal area of primary health care service provision.

1.6 Research questions

For the purpose of this study, the following questions were formulated:

- **Research question 1:**

What are the CHW's perceptions of the MK training programme, i.e., its importance, relevance, value, usability and organization?

- **Research question 2:**

  How is the training programme structured, i.e., was there enough time, what were the facilitation methods like, did the workshop meet the participants expectations?

- **Research question 3:**

  How is the training programme presented, i.e., were the instructions clear, was clarity given where needed, was the participants existing knowledge recognized?

- **Research question 4:**

  What were the personal attributes of the facilitators, i.e., were they pleasant, friendly, boring, nasty, tense and rejecting?

- **Research question 5:**

  What impact has the training programme provided by MK had on CHW's and their work?

1.7 Research methodology

According to Brynard and Hanekom (1997:28), research methodology focuses on the research process and the decisions the researcher has to make to accomplish the research project. Research methodology has to comply with the principles of validity, truth and objectivity. According to Fox and Bayat (2007: 145), validity means that a measurement represents what it is supposed to measure and a valid measure accurately represents the relationship between things.

According to Thomas (2011:3), the case study method is a kind of research that concentrates on one thing, looking at it in detail, and not seeking to generalise from it. Thomas (2011:3) further provides that the main feature of

the researcher's choice of case will be the interest that the researcher has in the subject of the study. The researcher is closely connected with it, as he facilitates the training of CHW's in health research and development in KwaZulu-Natal.

The rationale for using this case study involving CHW's in Inanda, Ntuzuma and KwaMashu is the convenience of easy accessibility as the researcher works in the INK area as one of MK community educators in Durban. The area has also been used by various research institutions including SAAVI, TB, and HIV Prevention Research Units of the MRC for their research. It becomes important to ensure that communities receive research-related information through building the capacity of CHW's that work in the area.

This study was conducted within both the qualitative and quantitative paradigms. The mixed method approach used quantitative (questionnaire) and qualitative (documents) and open-ended questions.

1.8 Instrumentation and data collection

This study is both qualitative and quantitative in nature and investigated the perceptions of CHW's on the training services provided by MK in the INK area. Continuous recording of data is an essential part of the research process and includes protocols as well as predetermined forms on which or in which the data collected during interviews or observation is recorded (Fox and Bayat, 2007: 74). The study used a questionnaire to collect data for the purpose of analysing participants' responses. The processes of data collection, data recording and data storage all run concurrently. A sound storage and filing system was developed as an large amount of data was collected.

According to Susan (1996:8), researchers from many disciplines use the case study method to build upon theory, to produce new theory, to dispute or challenge theory, to explain a situation, to provide a basis to apply solutions to

situations, to explore, or to describe an object or phenomenon. The advantages of the case study method are its applicability to real-life, contemporary, human situations and its public accessibility through written reports. Case study results relate directly to the common readers everyday experience and facilitate an understanding of complex real-life situations. The case study was used to investigate the perceptions of community health workers involved in the field of HIV and AIDS on the training services offered by MK.

1.8.1 Sampling

Fox and Bayat (2007: 53) define a population as a group of individuals, events or objects that share a common characteristic and represent the whole or sum total of cases involved in a study. This study used a census sampling method drawing a sample of a total of 130 CHW's from INK, who are involved in the field of HIV and AIDS and were trained by MK on health research in South Africa from 2010 to 2011. The population encompassed CHW's trained by MK.

1.8.2 Census of respondents

Survey research involves collecting data by putting a set of pre-formulated questions, in a pre-determined sequence in a structured questionnaire, to a sample of individuals drawn so as to be representative of a given population (Fox and Bayat, 2007:71). The study used the census method. Census is the collection of information about all the units of population, also called a 100% sample survey (Fox and Bayat, 2007:71). All the 130 CHW's, who were trained by MK in INK during 2010 and 2011, were invited to participate in the study. Census is a recording of every element in a population.

1.8.3 Data collection

The researcher collected questionnaires from respondents at all venues in Inanda, Ntuzuma and KwaMashu. The returned questionnaires were coded and processed into the Microsoft Excel Programme. The researcher ensured that all 130 questionnaires were returned by the respondents. A document analysis of learning materials used by MK and reports was undertaken to determine the nature of the training provided to the CHW's in the INK area.

1.8.4 Procedure for data analysis

The statistical analysis was done at the Statistics Department at the Durban University of Technology. The researcher, research supervisor and the statistics practitioner were involved in the planning and execution of the data analysis. The Statistical Package for Social Sciences (SPSS) was used for data management and analysis.

1.9 Clarification of concepts

A community health worker (CHW) is a member of community who is chosen by community members or organizations to provide basic health and medical care to their community (Magongo, 2004).

Community development workers (CDW's) are community-based resource persons who collaborate with other community activists to help fellow community members to obtain information and resources from service providers with the aim of learning how to progressively meet their needs, achieve goals, realize their aspirations and maintain their well-being (South Africa, 2009:1)**.**

The Expanded Public Work Programme **(**EPWP) was launched in South Africa in April 2004 to promote economic growth and create sustainable development. The immediate goal of the EPWP Phase 1 was to help alleviate unemployment by creating at least one million work opportunities, of which at

least 40% of beneficiaries will be women, 30% youth and 2% people with disabilities (South Africa, 2004:2).

District Health System (DHS) relates to all health services that operate within a District. This is inclusive of all PHC, hospital services, emergency medical and rescue services. The aim of this programme is to improve the health status of all individuals living within a District (South Africa, 2007:05).

Occupation Specific Dispensation (OSD) means revised salary structures that are unique to each identified occupation in the public service (South Africa, 2007:1).

Training refers to organized activity aimed at imparting information and or instructions to improve the recipient's performance or to assist him or her to attain a required level of knowledge or skill (Southwood *et al.,* 2008:15).

Community refers to different people who look, feel and believe differently from each other, but are linked because they share something in common (Southwood *et al*., 2008:158).

Primary health care (PHC) is essential health 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 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 process (Alma Ata, 1978:3).

1.10 Ethical considerations

In order to uphold the integrity of the research, the researcher complied with all the ethical principles as contained in the code of ethics of Durban University of Technology. The purpose of the research was explained to all stakeholders including the respondents. Each respondent was assured that all the information he or she gave would remain confidential and that he or she will remain anonymous. The respondents were informed that the research will benefit both MK and the respondents in making evidence-based improvements on the programme. All information gathered from other research, publications or anyone, whether directly or indirectly, has been acknowledged in the research.

1.11 Structure of the chapters

The purpose of this section is to give an overview of the research. It is divided into sequential chapters so that the reader has an overview of the research study.

Chapter 1: Context of the study

This chapter introduced the study and focused on a synopsis of the research methodology and literature review.

Chapter 2: Literature review

This chapter focuses on the review of related literature, health related legislation and policy documents, and an overview of international practices of CHW programmes. The South African health context, training practices of CHW's, training curriculum for CHW's, and the purpose of SAAVI MK training for CHW's are outlined.

Chapter 3: Research methodology

Chapter three describes the research framework and explains how the respondent sample was drawn. It includes discussions on the questions posed, data collection instruments and processes.

Chapter 4: Analysis and presentation of data

This chapter presents an analysis of the results of the study. It further discusses appropriate testing that was utilized in the study.

Chapter 5: Conclusions and recommendations

Chapter five presents the conclusions relating to community health workers perceptions of the training services offered by Masikhulisane in the INK area and provides recommendations for further consideration amongst community health workers.

1.12 Conclusion

The training of CHW's remains an interesting area to be further investigated. This chapter has provided a comprehensive background to the study including a brief statement on the research problem, the rationale for the study, methodology and the analysis of data. The chapters for the study have also been outlined. Chapter two discusses the literature review of the study.

CHAPTER TWO

Literature Review

2. 1 Introduction

This chapter reviews the literature relating to health, legislation and health policy within the South African context. International practices of CHW programmes are also presented.

The objective of this chapter is to provide an overview of the relevant literature on CHW programmes and the training provided to CHW's in an attempt to investigate perceptions of CHW's on the training services provided by MK community educators. The perceived relevance of the training provided by MK to CHW's and the identification of the perceived possible barriers to effective training of CHW's are also examined.

Although national governments tended to steer clear of CHW programmes in the 1990s, CHWs did not disappear from health systems. There was extensive evidence of use of lay or community health workers at sub-national or local level, even in the first world (Witmer, 1995; Abbatt, 2005; Lewin, 2005; Lehmann and Sanders, 2007). Rather than the generalist CHWs of the previous generation, these workers tend to be associated with specific programmes, like Maternal-Child Health or disease intervention initiative like Directly Observed Therapy, Short Course (DOTS) for tuberculosis (TB) and malaria treatment. In recent years, a rapid expansion in HIV/AIDS funding and programmes and renewed interest in child survival have provided the impulse for a significant shift in international thinking back toward large-scale deployment of lay or community health workers (World Health Organization, 2006:23). Against this background, this chapter aims to review relevant literature to the issue of the training of CHW's from an international and South African perspective.

2.2 Historical perspective

Over the last decade in South Africa, a rapid growth in programme activities and budgetary allocations for the comprehensive response to HIV/AIDS has been responsible for the large lay health worker infrastructure which encompasses CHW's. It began in the mid-1990s with state support for non-governmental organizations (NGO's) employing home and community-based carers, and the training of lay counsellors to promote voluntary HIV testing and of directly observed treatment support (DOTS) supporters for the parallel epidemic of TB (Russel and Schneider, 2000:20). Health workers are also part of the Comprehensive Care Management and Treatment Programme governing antiretroviral treatment (ART) and access (South Africa, 2003:12), where they have been described as an indispensable extension of the strength of professional involvement in ART services (Steyn *et al.*, 2006: 113).

The development of lay or community health workers is by no means a new phenomenon in South Africa or internationally. In the years following the 1978 Alma Ata Declaration on Primary Health Care (PHC), CHW's were promoted to become part of any developing country's health system (Walt, 1988:25). While there was enormous variations in the type of CHW's and forms taken by CHW programmes, these international experiences gave rise to a set of core debates on the role of CHW's in the health system and highlighted common problems associated with their management (Lehmann, Friedman and Saunders, 2004:59). While successful experiments across a variety of contexts provided an inspiration for CHW programmes, numerous difficulties arose in the process of shifting from effective and small-scale local projects to national CHW schemes. Common problems included the lack of integration and conflict with health professionals, unrealistic expectations, unsupportive environments, poor supervision, lack of appropriate incentives, high turnover and, ultimately, poor quality and cost-effectiveness (Walt, 1988:32; Gilson *et al.,* 1989:10).

In many countries, CHW programmes were introduced in an overly hasty and top-down manner with little planning. Rather than being the leading edge of a

transformed approach to health care, CHW's often ended up becoming poorly resourced, an undervalued extension of the existing health service (Walt, 1988:21). In the face of these difficulties and of the severe economic crisis, enthusiasm for national CHW programmes declined internationally in the 1980's and 1990s (Abbatt, 2005:49).

2. 3 South African scenario

International experience and debates influenced views on the role of CHW's in South Africa as the country entered the period of major political and health sector change in the early 1990's (Mathews, Van Der Walt, and Hewitson, 1991:15). During this period, there were a number of generalist CHW's programmes in the country. Some were coordinated by NGO's and provincial governments. Despite considerable political support for the concept of PHC, a national CHW programme was not part of the health reforms instituted by the new democratic government immediately after 1994. Although policies and legislation are in place to ensure that efficient capacity exists to monitor service delivery, there are still gaps in health service provision at the primary care level. In addition, synergetic partnerships have been enforced between government departments, legislatures and Health Committees at the local government level to highlight service delivery issues at the community level with regard to health (Kuhn and Zwarenstein, 1990:62; Mathews *et al*., 1991:79; Friedman, 2005:9).

2. 4 South African health policies and legislation

According to the White Paper on Reconstruction and Development Programme (RDP) (South Africa, 1994:7), the RDP is a policy framework for integrated and coherent socio-economic progress. It seeks to mobilize the resources of all citizens of South Africa toward the final eradication of the results of apartheid. The RDP has highlighted the need for massive reform in the provision and delivery of health services in South Africa in view of gross

mal-distribution of health care resources between the public and private sectors, regionally and between levels of care (South Africa, 1994:7).

The RDP (South Africa, 1994:34), advocates that health reform must not only consider the state of existing service delivery infrastructure and the changes that could be implemented to ensure improved efficiency, but reform must also consider a model that provides health services equitably to a minimum level that is acceptable for the whole country. The RDP further emphasizes the need for training in the transformation process and highlights the following:

- Co-operation between national and provincial governments on training to avoid unnecessary duplicated expenditure on consultants to conduct civil service training at provincial level;
- Focus on research and development, training and international comparative programmes are integral to meeting the needs of both the public service and the wider community;
- The introduction of educational programmes in project management, and the introduction of human rights law issues to enhance RDP implementation and management;
- The accreditation of institute training programmes within the context of the National Qualifications Framework are necessary; and
- The Training Board for Local Government Bodies has an equally important role to play with respect to the training and retraining of local government personnel and councillors (South Africa, 1994:34).

2.5 South African community health worker policies

Following input from a wide range of stakeholders who attended the October 2003 Lekgotla, a national CHW Policy Framework (CHWPF) was drafted and was released in early 2004. The framework was developed by the national Department of Health (NDoH) in consultation with other departments, provinces, municipalities, NGOs, academic institutions, other civil society structures, the Health and Welfare Sector Education and Training Authority

(HWSETA) and the South African Qualifications Authority (SAQA). In essence, the document provides an outline of what is envisaged for future national CHW programmes. The document stated that the following should be addressed (Friedman, 2005:25):

- The demands created by managing Home Community-Based Care within the social cluster as part of the Expanded Public Works Programme;
- Functional and substantive gaps in implementing the CHWPF to manage a rapidly expanding cadre;
- The need to reframe the understanding of legislation relating to the Basic Conditions of Employment Act; and
- The deterioration in people management practices relating both to a lack of specific guidelines and accountability (Friedman, 2005:25).

According to the NDoH (South Africa, 2006b:6), there are several features of current policy on CHW's in South Africa that have a bearing on the consideration of sustainability for PHC. In the first instance, currently, CHW's have not been an isolated phenomenon of the health sector and have emerged as part of the broader cross-sectoral responses to HIV/AIDS as well as employment creation strategies. The Department of Social Development, for example, has developed its own category of community caregivers (CCG's) in addressing the needs of orphaned and vulnerable children. At the same time, as the community workers were emerging to service new HIV initiatives, the national government declared 2002 the '*year of the volunteer'*, running campaigns to mobilize community volunteers across all sectors. The notion of volunteerism has influenced the discourse on community caregivers in the health sector, while conversely, the presence of lay health workers provided a ready model for organizing the volunteers emerging from other sectors (South Africa, 2006b:7). A recent census counted nine categories of community workers; community development workers, community development practitioners, mid-level worker, community caregivers, community health workers, child & youth care workers, youth worker,

probation officers/community service officers and early childhood development practitioners (South Africa, 2006b:8). The NDoH (South Africa, 2006c:10) stated that in 2003 these workers were all brought under the banner of the government's Expanded Public Works Programme (EPWP), which is currently one of the government's poverty alleviation strategies for the country. The EPWP is tied to the Department of Labour's Skills Development Strategy, which includes the accreditation of community-based training through structured learnerships. Steps have also been taken to standardize and accredit CHW training. By 2006, the Department of Health had registered four community worker qualifications in terms of the National Qualification Framework, thereby creating the possibility for career paths for CHW's as mid-level health workers. The evolution of CHW's has thus been an integral part of the general economic and social policy platforms of the South African government (South Africa, 2006c:10).

A second important feature is that although the CHW infrastructure is a direct consequence of state investment, the government has avoided being the employer of CHW's. The CHW Policy Framework (South Africa, 2004:6) is clear on this when it states that '*the employment of CHW's would be through NGO's funded by government*". CHW's thus fall outside the public service and the regulatory processes governing employment in South Africa. Magingxa (2011:17) states that, in the 2005 – 2006 financial year, the National Department of Health allocated R68 million for provincial funding of NGO's involved in HIV/AIDS and TB care and support activities, a large proportion of whom act as intermediaries for the employment of CHW's. A significant amount of donor funding is also oriented to funding and capacity building of NGO's and community based organizations (CBO's) to drive the training of CHW's. For example, the European Union committed R 250 million over five years (2002 – 2007) to support the development of partnerships between the government and the NGO's in the health sector, with specific emphasis on HIV/AIDS (Magingxa, 2011:17).

A third feature of CHW's is that national policy has developed incrementally over time, rather than constituting a tightly formulated strategy from the top (Friedman, 2005:85). By the time the CHW Policy Framework was agreed

upon and the programme launched, funding of NGO's and the involvement of community health workers was already well established across the country. It was a highly diverse and fluid terrain with multiple NGO/CBO initiatives and single purpose cadres deployed at local and provincial levels. They included lay counsellors, home-based carers, DOTS supporters, prevention of mother to child transmission (PMTCT) counsellors, adherence counsellors and support group facilitators (Friedman, 2005:86). The national policy framework provides an overarching concept, some standardization and possibilities for alignment with central government initiatives such as the Expanded Public Works Programme. At the same time, it is sufficiently loose to allow for a degree of ambiguity and interpretation such as proposing remuneration for CHW's, while not precluding ongoing recruitment of volunteers, being oriented to more traditional notions of CHW's (community-based generalist workers), while acknowledging the reality of a more limited purpose of CHW's (Friedman, 2005:86).

Finally, it is important to point out that CHW's in South Africa represent the most formalised end of a continuum of community participation around HIV/AIDS, from treatment literacy training programmes for people living with HIV to members of their social networks volunteering to be TB or ART "treatment buddies", and participation in right-based activists networks (Prasad, 2007:2).

While the policy framework on CHW's will be finalised in 2010/11, the NDoH Strategic Plan (2010/11 – 2012/13) has as one of its priority areas, the improvement of human resources planning, development and management by re-opening nursing schools and colleges, focus on training of PHC personnel and mid-level health workers and manage the coherent integration and standardization of all categories of CHW's. According to the NDoH Strategic Plan (2010/11 – 212/13) (South Africa, 2010:10), priority 7 aims at accelerated implementation of the HIV and AIDS and Sexually transmitted Infections National Strategic Plan and the increased focus on TB and other communicable diseases. Activities in this priority will include the training of 3000 health professionals annually in the management of TB. Two thousand

five hundred (2500) non-health professionals (CHW's) will also be trained annually to support TB patients and to facilitate successful treatment completion.

2.6 District health system and primary health care

According to the White Paper on Transformation of the Health System (South Africa, 1997:22), the South African health system adopts the PHC approach because this approach is the most effective and cost effective means of improving the population's health. The approach involves a health system led by PHC services, which are at the base of an integrated district health system.

The PHC approach traces its origins partially, to a small health unit situated in rural KwaZulu-Natal, South Africa in the early 1940s. The Pholela Health Centre model, a forerunner to community-oriented primary care (COPC) was among the earliest demonstrated efforts to inform and define the practice of PHC. Unique in its focus on the health of families and the community, rather than individual health alone, the Pholela Health Centre sought to identify and address the social conditions and determinants that influence population health, broadly targeting hygiene and sanitation, nutrition, water, housing conditions and occupational threats. Specialized programmes and interventions to address the health needs of vulnerable and high risk groups, particularly women and children, were further incorporated into the localized package of health services, which included mandatory immunizations, school-feeding schemes, the establishment of household and community food gardens, child growth monitoring, breastfeeding and baby food supplementation, communal childcare services and family planning (Kark and Cassel, 1952:101-104).

A pioneering feature of the Pholela model was its reliance on social and epidemiological investigation of the local population (or 'defined community') to inform the provision of services. Kark *et al*. (1952:101-104) rightly argued that a detailed evidence base and empirical understanding of the community health profile (a 'community diagnosis') must be established in order to

assess the appropriateness of care and adapt local health services to meet the specific needs of the population. Through regular extension of the enumerated population and continual updating of individual and household records, the Pholela model also allowed for the measurement of changes over time and provided a longitudinal understanding of health and disease changes in the population, a defining feature of COPC (Tollmani *et al.*, 2005:217).

According to Tollmani *et al*. (2005:218), based on the aforementioned discussion on pioneering work in PHC, the District Health System (DHS) was adopted as means to achieve 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 organisation. It is the manifestation of a set of activities that includes community involvement, integrated and comprehensive health care delivery, intersectoral collaboration and a strong bottom-up approach to planning, policy development, and management. The PHC approach and the DHS model apply to the whole of the health system and at all levels of health care delivery (Tollmani *et al.*, 2005:218). These models do not just apply to the primary level of the health system, or just to the district level. In a DHS, the organisation and management of the entire health system is district-based, meaning that even policy areas such as health sector financing, utilization of regional and tertiary hospitals, the relationship with the private sector and governance should be DHS-based. The underlying essence of the DHS is the organisation of health care according to geographic sub-divisions of a country, which are managed through a decentralized management structure. The district management structure is supposed to be the point and level at which different health service activities are integrated into a comprehensive and holistic approach to health care (Tollmani *et al.*, 2005:219).

According to the Reconstruction and Development Programme (RDP) (South Africa, 1994:9), the DHS represents a profound break from the apartheid health system which was characterized by fragmentation, inefficiency, centralized authoritarianism and the separation of curative services from preventive care. The principles of PHC have informed policy development in

South Africa since the early 1990's. Policy work around PHC, particularly by the African National Congress (ANC) Health Desk, conceptually laid the ground for the post-1994 health sector transformation and built on the recommendations made in the Alma Ata Declaration. The Reconstruction and Development Programme (RDP), which built on the work of the ANC Health Desk, called for the complete transformation of the entire delivery system, and argued for the introduction of the district health system. It suggested that the whole National Health System (NHS) must be driven by PHC approach (South Africa, 1994:10).

According to Lehmann (2008:164), the Alma Ata Declaration of 1998 emphasises the attainment of acceptable levels of health for all, through, amongst other things, active community participation in planning and organizing health care, and the involvement of health care workers from physicians to CHW's to work as a health team and to respond to the expressed health needs of the community. This requires a redistribution of resources away from specialist curative care to community and primary level care.

2.7 Human resources within the district health system

The South African Health Act (South Africa, 2003:58) states that the minister may make regulations regarding human resources within the national health system in order to ensure that adequate resources are available for the education and training of health care personnel to meet the human resources, requirements of the national health system; ensure the education and training of health care personnel to meet the requirements of the national health system; create new categories of health care personnel to be educated or trained; and identify shortages of key skills, expertise and competencies within the national health system.

The South African Health Act (South Africa, 2003:60) further states that the Department of Health should prescribe strategies which are not in conflict with the Higher Education Act (South Africa, 1997:18) for the recruitment of health

care personnel from other countries and the education and training of health care providers or health workers in the Republic in order to make up the deficit with respect to scarce skills, expertise and competencies. It also expected to prescribe strategies for the recruitment and retention of health care personnel within the national health system, ensure the existence of adequate human resources planning, development and management structures at national, provincial and district levels of the national health system. There is also a need to ensure the availability of institutional capacity at national, provincial and district levels of the national health system to plan for, develop and manage human resources; ensure the definition and clarification of the roles and functions of the different spheres of government with regard to the planning, production and management of human resources, while prescribing circumstances under which health care personnel may be recruited from other countries to provide health services in the Republic (South Africa, 2003:65).

According to Lehman (2008:169), the national human resource plan, finalised in 2006, echoes a strong focus on training and continuing development of human resources. However, it does not suggest mechanisms to redirect resources for deployment and training, nor for primary and community levels of care as recommended by the National Health Act. The Alma Ata Declaration (1978:4) calls for a reorientation and broadening of the skills of health personnel to enable them to respond to the challenges of implementing PHC and to work in teams as well as with other sector professionals and communities, particularly to work more closely with communities and with other sectors and to function in a decentralised health system (Lehman, 2008:5). Therefore, it is imperative that human resource planning takes cognisance of these guidelines as contained in the Alma Ata Declaration.

Naicker (2003:73) stated that the government's 1999-2004 Health Sector Strategic Framework refers to fast tracking the training of CHW's, which constitute a shift in national policy, since this was previously left to provinces. CHW programmes have to be developed in an enabling environment, with clear role definitions, appropriate selection, propped training, accreditation and on-going support from national government (Naicker, 2003:73).

According to the White Paper on a New Employment Policy for the Public Service (South, Africa 1997:7), human resource planning is essential in order to ensure that an organisation's human resources are capable of meeting its operational objectives. Human resource planning ensures that an organisation:

- Obtains the quantity and quality of staff it requires;
- Makes the optimum use of its human resources;
- Is able to anticipate and manage surpluses and shortages of staff; and
- Develops a multi-skilled, representative and flexible workforce, which enables the organisation to adapt rapidly to a changing operational environment.

The White Paper on Transformation of the Health System (South Africa, 1997:8) reiterates that human resource planning consists of three main steps:

- An assessment of the human resources which will be required to deliver the operational objectives in the organisation's strategic plan;
- An assessment of the organisation's existing human resource capacity; and
- A plan for how the gap between existing human resource capacity and the future human resource requirement will be filled, within the financial resources available.

According to the White Paper on a New Employment Policy for the Public Service (South Africa, 1997:9), the assessment of human resource requirements must be conducted on the department's short, medium and long-term operational objectives as set out in its strategic plan with respect to the assessment of human resource requirements within the DHS. There is also a need to identify the numbers and skills of staff currently employed, and their potential for meeting future requirements through, for example, development and training. It will also identify the gaps in numbers and skills and employment equity targets which need to be filled (South Africa, 1997:9).

In addition, it is important when considering CHW's that standard human resource management instruments are applied such as recruitment, training, promotion, redeployment and career management.

Further, direction is given in the White Paper on Transformation of the Public Service (South Africa, 1995: 19-22), which states that the development of the country's human resources is central to the realisation of all the RDP's strategic objectives. Responsibility for developing the creative energies and talents of South Africa's diverse communities does not lie exclusively with the state. For this reason, the government foresees that a variety of social forces and institutions will become its active partners in building capacity for good governance. These will include community organisations, private sector agencies and institutions of tertiary education (South Africa, 1995:19-22). The White Paper further states that, training and education will assist the government to develop the professional capacities of public servants and to promote institutional change. Training can contribute to the strategic goals of the state in the following ways with respect to CHW's (South Africa, 1995: 19-22):

- Training can provide CHW's with the necessary knowledge, skills and competencies to carry out their jobs effectively in pursuit of the new vision and mission for the public service;
- Training will form an integral part of the process of increasing the representativeness of the public service;

- Training can enable CHW's to acquire new development-oriented professionalism which entails the development of a new work ethic, knowledge and skills with which to implement the RDP;

- Training can also enable officials to reorient many of the values and practices which they acquired under the previous dispensation and

- Training, if properly conceived and structured, can be a powerful instrument for anticipating as well as facilitating the introduction of changes within the DHS.

Training should thus become a key component of the institution-building process. For this reason, it cannot be developed in isolation and must be integrated within the overall strategic plans of public sector organisations. Appropriate training can assist CHW's in developing a better understanding of the needs of the communities which they are serving, as well as a developing capacity to respond to these needs. Accordingly, training can be used to develop a community-centred health sector.

Government is well aware that the need for training currently outstrips the existing capacity to deliver, both at national and provincial levels. Therefore, the government is open to the ongoing involvement of training organisations outside of the public service in support of its programme of human resource development and capacity building. Community-based and non-government organisations possess a rich tapestry of knowledge, expertise and experience which should be directly and continuously used as a resource base for the public service. From these agencies, CHW's can learn about the increasingly diverse and complex needs of local communities. They may also gain knowledge about negotiation and consultative skills, participatory learning and teaching, as well as human rights and civic consciousness training (South Africa, 1995:19-22).

2.8 Training of community health workers

CHW's are considered vital to the implementation of PHC. Their area of expertise and scope of practice remains contested and they have therefore remained on the sidelines of the health systems.

2.8.1 International context

The World Health Report (2006:4), focussed the world's attention on human resources as a key ingredient for successful health functioning and highlighted the growing human resource crisis, particularly in low-income countries. The late Director-General of World Health Organization argued that (World Health Report, 2006:4):

CHW's have evolved with the community based health care programme and have been strengthened by PHC approach. However, the conception and practice of CHW's have varied enormously across countries, conditioned by their aspirations and economic capacity. In most countries CHW's have had education up to primary level education, with 8 to 10 years of schooling.

It is, therefore, clear that training programmes for CHW's require considerable attention, because they are often selected without any prior experience and professional training in community health (Abbatt, 2005:15). In Nicaragua, in the 1980's, CHW's were as young as 15 years old and were given short-duration training, not longer than 2 weeks, particularly in curative services (Bender and Pitkin, 1987:515-528). These were exceptions necessitated by political turmoil during that period in Nicaragua. CHW's in countries such as India receive training for about 3 months, while, in other countries like Brazil, they receive training for about 6 to 8 months at the beginning of their career (Campos *et al*., 2004; Leslie, 1985:923-930). Career prospects for CHW's and their aspirations do influence their performance. For example, some studies from the United States of America have shown a significant drop out of CHW's, due to lack of career prospects (Ballester, 2005:154; Scott and Wilson, 2006:113). Thus, career prospects along with training and salaries for CHW's are strong incentives not only in retaining them, but also in enhancing their performance.

The empirical analysis on the content and approach of various training programmes both locally and internationally and their influences on

performance of CHW's have been minimal. For example, the algorithm developed by the WHO on managing multiple childhood illness was found to be ineffective as CHW's reported serious difficulties in understanding training manuals (Kelly, Osamba, and Grag, 2001:1617-1624) and similar findings were reported in India by an Oxfam study about CHW's having difficulty in understanding training manuals (Ramprasad, 1988:239-234). The findings from the national survey on CHW's in the US suggest on the job-training to overcome these difficulties in understanding training manuals (Kash, May and Tai-Seale, 2007:32-42).

2.8.2 South African context

Currently in South Africa, CHW programmes remain disease-focussed, particularly toward HIV and AIDS and TB care treatment and support. There is no policy that governs the CHW programme and there is also no standardized training to be followed when training this cadre. As a result, different organizations develop and train particular groups of CHW's according to the mandate that they are supposed to fulfil for a particular project in which they may be engaged in at the time (Magingxa, 2011: 4).

This is indicative of the lack of consistent and uniform training for CHW's as well as the need to have training programmes recognised by the education authorities. Magongo (2004:11) is of the view that training is a critical point of CHW programmes. According to Cruze (1997:14), in South Africa, the Provincial Primary Health Care Training Boards (PPHCTB) has the responsibility for the training of CHW's. Their functions include assessing the needs and recognising where the trainees are from, laying down guidelines for content, according to adult education methods, controlling standards, provision of training centres and materials and planning on-going training (Cruze, 1997:15). At this point, only two centres in Southern Africa have provided formalised training for trainers. KwaZulu-Natal has a centre created for the formal training of enrolled nurses as Community Health Facilitators (CHF's). This programme has not been accredited by the South African

Nursing Council (SANC). Training spans two years with a six-month long practical period between “live-in” blocks. Plans are underway to develop CHW training programmes that will be accredited by the government, and a draft core curriculum is being reviewed by regional stakeholders (Cruze, 1997:14).

There is still debate with regard to the full content of the curriculum, the name of the qualification, and the National Qualifications Framework (NQF) level for such workers. However, it has been deemed urgent that the health sector formalise this type of health worker in all provinces in the country (Lehmann, 2008:171-172).

The Health and Welfare Sector Education and Training Authority (HWSETA) proposed a qualification for community-based health workers where they would be known as Ancillary Health Workers. In the consultation process with stakeholders, a scope of practice was proposed. This was to be guided by the level of competence, regulations and policies pertaining to the context in which the CHW should operate. According to Magongo (2004:11), the following tasks were proposed:

- Promote and assist with the maintenance of the health of a client, family and the community;
- Disseminate information on health including HIV/AIDS, TB, and Maternal and Child Health (MCH) to the community;
- Assist the community in identifying health-related issues including, but not limited to, social and health-related needs and to formulate a plan of action to address identified needs;
- Participate in drawing up simple care plans to guide the family of a person receiving home-based care;
- Promote and assist in maintaining the environmental hygiene of families and communities;
- Promote and maintain the comfort, rest, sleep and exercise of a client;
- Participate in preventing deformity and other complications in a client;

- Assist with the mobility of the client and assist in the activities of daily living;
- Participate in the activities of the dying;
- Promote communication with clients, families and communities;
- Refer community members appropriately and timeously;
- Care for clients during transfer to hospital or clinic;
- Take responsibility for the client's possessions and valuables during transfer to a hospital or clinic;
- Assist the family to administer and provide palliative care principles when caring for the client; and
- Assist and support the bereaved, including orphans.

Based on the proposed scope of work, there were several questions that were raised. The questions include: what would the selection criteria be for CHW's? What would the level of education requirement be for this type of work? What would happen to existing CHW's who do not meet the educational criteria? What would the plan be for upgrading them? Who will provide their training? What methods would be acceptable for training CHW's and how would these training methods be monitored? What would be the career path of these workers and who will carry the cost of training CHW's? (Magongo, 2004:12). In addressing these issues, it is necessary to consider collaboration from primary through to tertiary care levels, collaboration between vertical programmes, whose ultimate success is dependent on the synergy that exists between such programmes and to bridge the divide between public and private provision (Friedman, 2005:8). The MK training programmes incorporate some of these tasks to enable CHW's to fulfil their roles more efficiently by providing reliable, relevant and up-to-date information on HIV and AIDS, tuberculosis and other diseases.

In the past decade, in the absence of a coherent CHW policy, multiple programmes have been set-up, leading to an array of uncoordinated health auxiliaries. The growth in number has been large and unregulated. One important exception has been the establishment of a 59-day training course

for home-based care workers developed by the Hospice Association of South Africa (HASA). Although not accredited by SAQA, this programme has provided a standardised form of training which has greatly accelerated the provision of quality community-based care, often under supervision of hospices. During the training, caregivers attend a three-month, course on basic skills of home care. Training is holistic and based on the curriculum developed by HASA and approved by the NDoH for home-based care (Friedman, 2005: 28).

However, despite the valuable training offered by HASA, in many instances, CHW cadres with different skills levels have worked competitively in the same communities, often resulting, not only in wasted resources, but in conflict between the workers. The Ancillary Health Worker Standard Generating Body (SGB) has written unit standards and qualifications for four SAQA levels for ancillary and community health workers. As a result of their work, there is now a framework for CHW training that is recognized by the SAQA. Ultimately, it may be possible for CHW's to gain access to tertiary education or career as a professional health provider. The training starts from basics at level one of the National Qualifications Framework (NQF), which is equivalent to grade 9 in the normal schooling system or Adult Basic Education (ABE) level 4 shown in Table 2.1. This first level of the SAQA qualification is foundational and qualifies the learner to work as a basic home caregiver. On completion of this phase, the learner can obtain a General Education and Training Certificate (GETC) in Ancillary Health Care. This qualification then forms an entry to higher education leading through levels 2 and 3 of the NQF to level four at which stage the Further Education and Training Certificate (FETC) in Community Health Work can be obtained (South Africa, 1995:1).

The second level qualifies the learner to be a "senior" home caregiver. Level 3 provides skills for a basic community health worker with level 4, being the qualification of a fully fledged CHW (Friedman, 2005: 33). These standards have all been approved by SAQA. The last of these were registered in January 2005. Quality is assured through Health and Welfare Services Education and Training Authority (HWSETA) (Magongo, 2004:13).

Table 2.1: National Qualifications Framework

NQF Level	Description	NQF Category
NQF: One	• Grade four to Grade Nine (Standard two to Standard Seven)	GET - General Education and Training
NQF :Two	• Grade Ten (Standard Eight)	FET - Further Education and Training
NQF: Three	• Grade Eleven (Standard Nine)	FET - Further Education and Training
NQF: Four	• Grade Twelve (Standard Ten / Matric) • Trade Certificate	FET - Further Education and Training
NQF: Five	• National Certificate National Diploma • Occupational Certificate	HET: Higher Education and Training
NQF: Six	• Bachelors Degree (Three Years) • Higher Diploma	HET: Higher Education and Training
NQF: Seven	• Honours Degree • Post Graduate Certificate	HET: Higher Education and Training
NQF: Eight	• Doctorate • Masters	HET: Higher Education and Training

Source: (South Africa, 1995: 1)

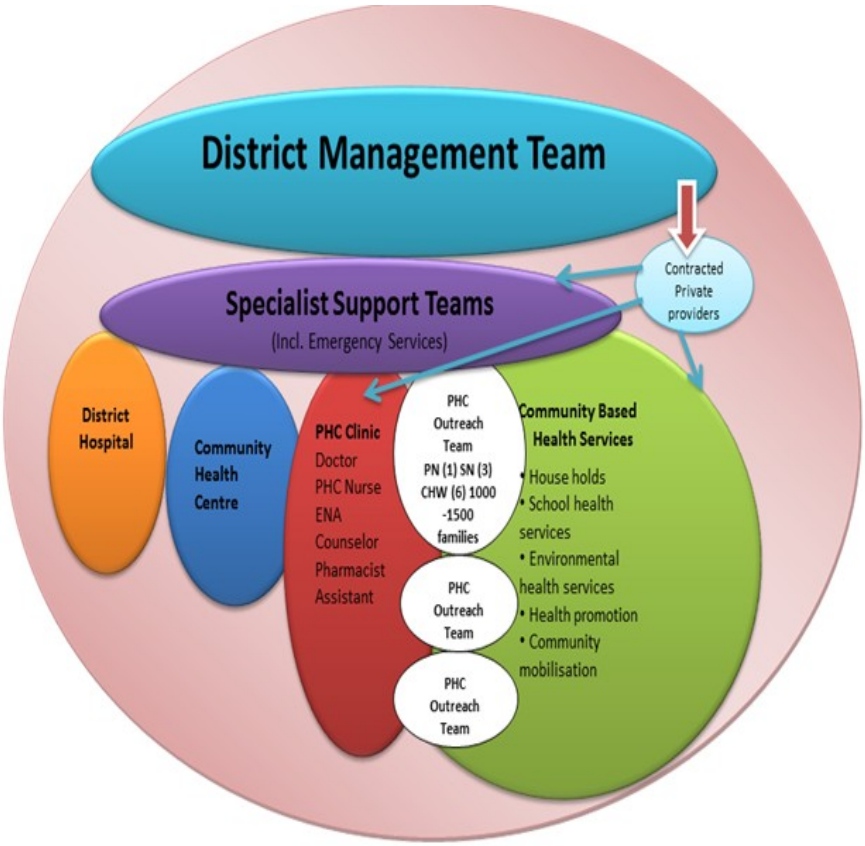
SAQA has adopted an eight level framework with levels 1 and 8, respectively, being regarded as open-ended. Level one accommodates three Adult Basic Education and Training (ABET) certification levels as well as the General Education and Training Certificate. This new qualification framework provides some guidelines for standardised training, but still leaves open the question of coordination and the development of training programmes for the optimal functioning of CHW's.

Figure 2.1 illustrates the PHC model within the DHS. According to Pillay and Baron (2011:1), although South Africa already has around 72000 CHWs, health outcomes are generally accepted to be sub-optimal, especially in the areas of maternal and child health. Reasons for this sub-optimality include a

number of factors related to CHWs. These factors include inadequate training, inadequate support and supervision, random distribution with poor coverage, no link between community based services and services offered by fixed health facilities. Many of these factors can 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 as well as the catchment population for whom they are responsible. 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 (Pillay and Baron, 2011:1).

Pillay and Baron (2011:2) stated that the 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. This means that district management, sub-district management as

Figure 2.1. PHC model within the district health system

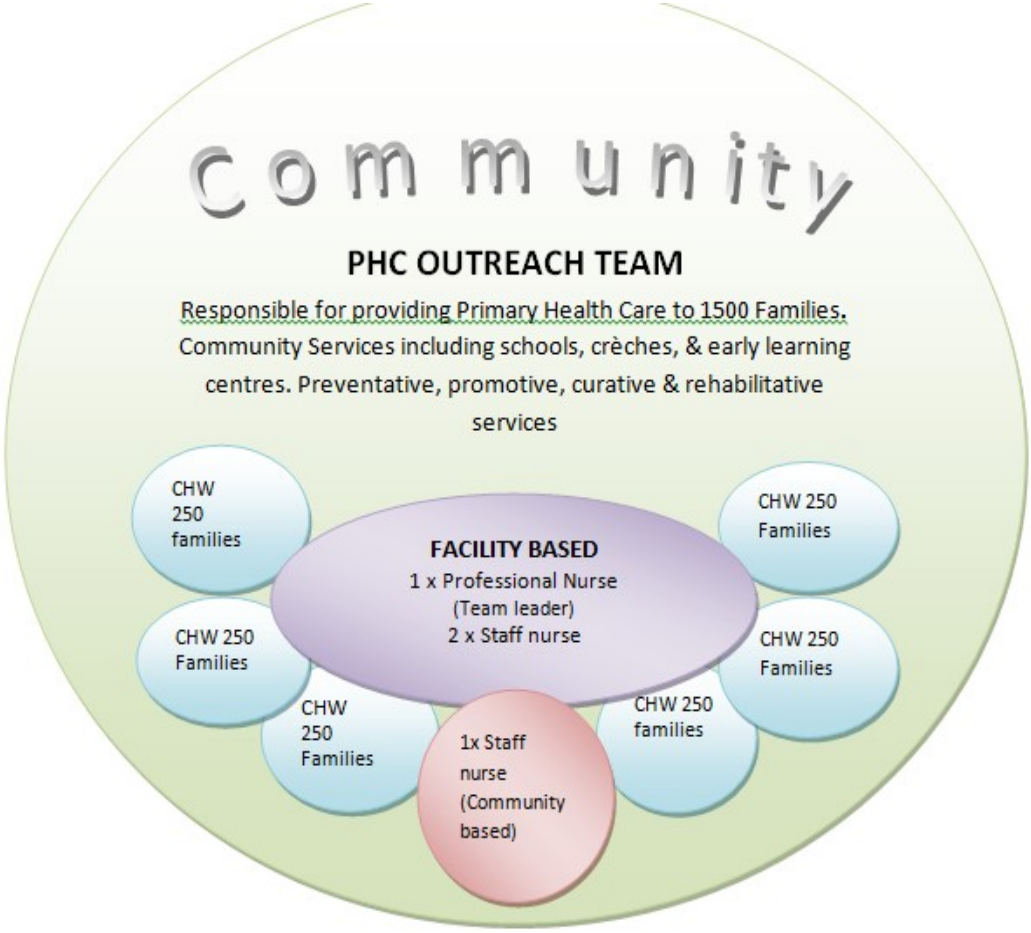


Source: (South Africa, 2010:4)

well as management of all facilities within the district must continue to be strengthened, that district health plans are developed and strengthened and that the existing information systems be used to monitor and strengthen service delivery (Pillay and Baron, 2011:1).

According to the proposed PHC outreach teams approach, each team will provide comprehensive PHC services to a defined number of families with CHW's forming part of the outreach teams. Staffing calculations estimate that a CHW can, on average, assume responsibility of approximately 250 households. The PHC outreach teams will comprise of 6 CHW's with approximately 1500 households per team. This team approach is illustrated in Figure 2.2.

Figure 2.2: Primary Health Care Outreach Team



Source: (South Africa, 2010)

Table 2.2: Role of the CHW's

Comprehensive CHW roles

	Maternal Neonatal Child Health	HIV & TB	Chronic Non – communicDiseases	Violence & Injury
HOUSEHOLDS				
Screening, assessment & referral	Pregnant women, newborn & infants	HIV Testing, regular CD4, early HAART, TB symptoms	Screen for hypertension, diabetes	Substance abuse, domestic violence
Information & education	Feeding, hand washing, Oral Rehydration Therapy (ORT)		Diet, exercise, lifestyle	
Psychosocial support		Integrated approach to adherence support		Victim support
Basic home treatment	ORT, worms, refer pneumonia, Vitamin A		Foot care	First aid
COMMUNITY, SCHOOLS & EARLY LEARNING CENTRES				
Assessments, campaigns, & screening	Immunisation, water and sanitation, nutrition, food security	Condom distribution, youth programmes	Diet, exercise	Pedestrian safety

Source: (South Africa, 2010:9)

According to the Re-engineering Primary Health Care in South Africa discussion document (South Africa, 2010:9), CHW's will form part of the PHC outreach teams of the district health system, as shown in Figure 2.1 and Figure 2.2. CHW's form a central element of the reorganized and proactive community-based services, shifting from a predominant focus on 'dehospitalized' care through top down referral to a systematic, bottom-up and comprehensive approach to households. Herein, community-based services form part of coordinated inter-sectoral action at a local level. A number of priority roles for CHW's have been shown in Table 2.2.

There is a need to consolidate and standardize the basic training of CHW's, through national agreement on appropriate competencies, consolidation of existing unit standards, skills programmes and qualifications, while re-examining the most appropriate institutional environment for training provision. There can be little doubt that while policy direction of the human

resources sector has a firm commitment and orientation toward a PHC approach and the goals set in the Alma Ata Declaration, implementation remains a big challenge (Lehman, 2008:11).

While there has been some success in resource redistribution within the public sector, there still remains a challenge of standardized training for CHW's to enable them to fit into the outreach teams for the proposed approach to PHC. Lehman (2008:11) puts forward three aspects of training health workers that require urgent attention:

- Presently, slowly growing production, particularly of nurses, has to be substantially accelerated to catch up with growing demands and attrition;
- Skills development and the reorientation of curricula towards PHC have to remain a priority. The redefinition of academic health complexes to include all levels of care contained in the National Health Act; and
- The training of mid-level and community-based cadres requires acceleration and standardization.

Currently, Lehman's suggestions still require comprehensive attention within the PHC system.

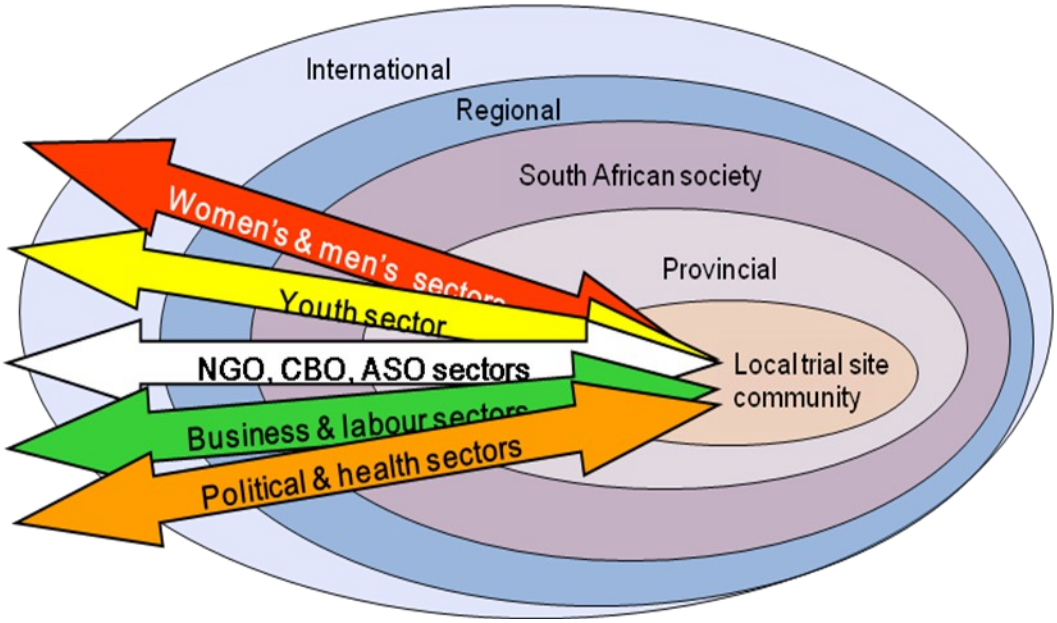
2.9 Training provided by Masikhulisane

The South African AIDS Vaccine Initiative was established in 1999 by the South African Government to co-ordinate the research and development of an affordable, effective and locally relevant HIV vaccine for Southern Africa (SAAVI, 2007:5). SAAVI is a lead programme of the South African Medical Research Council (MRC). Funding from the National Department of Health (NDoH) to SAAVI is used to support research in five trial sites across South Africa and to prepare and maintain these sites for clinical trial research. In addition, the NDoH funding also contributes to the activities of MK, SAAVI's community involvement programme.

2.9.1 Purpose of the training

Masikhulisane means “let’s grow together” and its vision is to promote a South African society working in a mutually beneficial and meaningful partnership with researchers within a vibrant human rights environment. The strategic goals are to promote and entrench a human rights culture; ethics and good participatory practice; promote sustainable community involvement; facilitate strategic collaboration locally, regionally and internationally on community involvement in health research and the HIV vaccine development process (SAAVI, 2007:25). Furthermore, MK aims to develop itself as an effective, efficient, accountable and sustainable learning organisation which has adopted a sectoral approach, as shown in Figure 2.3 (SAAVI, 2007:32).

Figure 2.3: Sectoral approach by MK



Source: (SAAVI, 2007:15)

According to the White Paper on the Transformation of the Public Service (South Africa, 1995:4), community-based and non-governmental organizations possess a rich tapestry of knowledge, expertise and experience which should be directly and continuously used as a resource base for the public service. From these training workshops, government can learn about the increasingly diverse and complex needs of local communities, while

CHW's can also gain knowledge about negotiation and consultative skills, participatory learning and teaching as well as human rights and civic consciousness training.

MK anticipates that by developing positive, respectful and collaborative experiences with community members, community involvement and participation in vaccine research can be facilitated because negative experiences and unfavourable community reactions can greatly impede success in future vaccine clinical trials. In Kegeles, Johnson, Strauss, Ralston, Hays, Metzger, McLellan-Lemal and MacQueen (2006:564), many respondents spoke of the need for the information to be comprehensible to people of different education levels and appropriate for different cultural groups. They did not want the information to be presented to all in a single simplistic way, but wanted the information to be tailored to the cultural groups and to the individual. CHW's in the INK area can play a pivotal role in ensuring that communities receive current and up-to-date information about vaccine research and other health research. It is for this reason that CHW's in the area under investigation were targeted by MK to be trained in health research and development.

Sahay, Mehendale, Sane, Brahme, Brown, Charron, Beyrer, Billinger, and Paranjape (2005:163) stated that, in previous studies, lack of information about HIV and HIV vaccines and the consequence of trial participation are key concerns for potential trial participants. Participants expressed a need for information, and often described this need as a crucial missing element in motivating people to participate in HIV vaccines trials. Most participants held the view that accurate and relevant information played an important role in enhancing willingness to participate in trials. To this extent, accurate and well-timed information may likely dispel fears about risks involved in trial participation, address misconceptions about trials and the HIV status of trial participants, and clarify procedures involved in the conduct of trials. CHW's in the INK area, after receiving training by MK, are expected to demonstrate understanding of the research processes and the risks involved in participating in health research. Their role in this regard will be to provide

relevant research-related information to the community they work with and to allow community members to make informed decisions about whether or not to participate in clinical trials.

Previous surveys have suggested that trial methodologies and procedures, anticipated health complications and support in dealing with these incentives for participation, and the anticipated and the future availability of vaccines would be the types of information most sought (Kegeles *et al*., 2006:564). Therefore, the study of this nature will highlight the importance of effective training for CHW's in fulfilling their roles as community educators.

2.9.2 Nature of the training

Targeted sectors go through a two-day awareness raising workshop. This is often the first community learning event hosted by MK in a community. The content, detail and depth of the workshop are largely determined by the community's expressed needs, as well as existing levels of health knowledge and awareness. The training envisages that CHW's will thereafter educate their communities on HIV and AIDS research and development. The two-day workshop takes the format of two separate one-day learning events, about one to two months apart, with the same attendees and community educators at each learning event.

The attendees come from different groups and MK ensures that people are involved in various structures from different groups. These include community health workers providing home-based care, community health facilitators providing education, NGO volunteers, church ministers and congregants, community development workers, clinic committees, teachers, youth workers, women's organizations, youth organizations, traditional leaders, traditional healers, political leaders, other key stakeholders and interested members of the general public. Each workshop usually comprises 25 to 30 people. Invitations are sent to all the groups in each area. In this case study, it is people from Inanda, Ntuzuma and KwaMashu. The selection of the specific individual attendees from the above group is undertaken by each of the

groups themselves, selecting 2 representatives to attend the workshop. This process assumes that those with the greatest level of interest in the subject will attend.

The specific topics to be discussed at each learning event are selected according to the needs and immediate interests of the community based on submissions made before the start of the workshop. Topics are covered in varying degrees of depth, in order to be responsive to community needs and interests. The programme generally targets health and development issues such as Tuberculosis; HIV and AIDS, immunization and health; and development in general, but with an educational focus on TB, HIV and AIDS. Commonly the topics include (SAAVI, 2007:10-95):

- Understanding the background to HIV, AIDS and vaccines.

  Outcomes:

- Discuss the impact of HIV and AIDS worldwide, in the sub-Saharan Africa and in South Africa;
- Outline the four principles together with their main goals of the HIV and AIDS Strategic Plan for South Africa;
- Describe the immune system and the impact of HIV on it; and
- Understand what a vaccine is and how it works.

- Science and research in health.

  Outcomes:

- Explain what we mean by science and research and the modern scientific approach;
- Describe steps used in modern scientific approach;
- Explain what we mean by clinical research;
- Name the different types of clinical research with special focus on randomized controlled trials;
- Explain the importance of concepts like, sample size, placebo and randomization;
- Describe the four stages in the process of developing a drug or vaccine

and

- Name and describe briefly each phase of clinical trials.

- HIV vaccine research & development.

  Outcomes:

- Explain the difference between therapeutic and preventative vaccines.
- Describe which type of study design is used for HIV vaccine trials and why it is used;
- Discuss the policies and guidelines and laws that apply to HIV vaccine research and development; and
- Explain which parties are involved in approving, running and quality assurance for HIV vaccine clinical trials.

- Ethical issues.

  Outcomes:

- Explain what is meant by ethics;
- Describe the ethical principles that should guide our research with human beings;
- Understand that ethical principles need to be balanced against each other; and
- Identify key requirements for ethical research.

- Legal issues and human rights.

  Outcomes:

- Describe what human rights are;
- Explain different kinds of human rights;
- Describe what legal rights are; and
- Identify which rights are important for HIV vaccine trial participation and why.

- Community involvement.

Outcomes:

- Explain what we mean by community and what makes you part of the community;
- Explain what we mean by involvement and participation;
- Discuss why it is important to have community involvement and participation in HIV vaccine research; and
- What steps are involved in participating in an HIV vaccine clinical trial? (SAAVI, 2007:10-95).

The specific content for these topics are detailed in the Masikhulisane HIV Vaccines Learner's Handbook (SAAVI, 2008: 5-49) and in the Masikhulisane HIV Vaccines Facilitator's Manual (SAAVI, 2007:1-150). The aim is to facilitate meaningful community involvement and participation in HIV vaccine clinical trials through building capacity of targeted groups or sector. This will ensure that communities are informed on clinical trials that are conducted in their communities.

2.10 Conclusion

In many developing countries, especially in Sub-Saharan Africa, there are critical shortages of highly educated health professionals. This situation is no different in South Africa. Current medical and nursing schools cannot train enough workers to keep up with the increasing demand for health care services, internal and external emigration of health workers, deaths from HIV and AIDS and other diseases, low workforce productivity and population growth.

Programmes involving CHW's have demonstrated that utilizing such workers can help improve health outcomes for large populations in under-served regions. The shifting of primary health care functions from professional health workers to community health workers is considered to be a means to make more efficient use of human resources currently available and improving the health of millions at a reasonable cost. However, community health workers

are given limited training, supplies and support to provide essential primary health care services to the population.

The importance of the supportive role of CHW's in the provision of health care services in South Africa has been extensively documented. The Department of Health has adopted a multi-professional team-based approach to health care delivery, where each member of the team will have a defined role to ensure that there is no duplication and overlapping of functions using the PHC outreach team approach.

The next chapter discuses the methodology that was used in the process of data collection.

CHAPTER THREE

Research methodology

3.1 Introduction

According to Polit and Beck (2008:19), research is undertaken to enhance or extend fundamental knowledge about social reality or within a discipline. Research encompasses the process of enquiry, investigation, examination and experimentation. It is required that these processes are executed in a systematic, diligent, critical objective and logical manner (Alpaslan, van Rensburg, du Plooy, Gelderblom, van Eeden and Wigston, 2010:81).

For the purpose of this study, research is considered as a means of investigating the perceptions of CHW's on the training services offered by MK. The research activity is linked to a theoretical framework in the field of training CHW's in an endeavour to determine the impact of the training on CHW's and their work.

This chapter outlines the theoretical framework for this research which focuses on a case study of training provided to CHW's in the INK area by MK. A description of the qualitative and quantitative techniques used, sampling design and data analysis are presented.

3.2 Objectives of the Study

The study aims to investigate the perceptions of CHW's on the training services provided by MK community educators. The objectives of the study are:

- To determine the nature of training provided to CHW's;
- To examine the perceived relevance of the training provided by MK to CHW's and their work;

- To identify perceived barriers to effective training of CHW's; and
- To determine the impact of the training on the CHW's and their work.

To achieve the above objectives, the researcher designed a study that ensured that the collection of data relating to the research was valid and reliable.

3.3 Research methodology: Case study using qualitative and quantitative techniques

For the purpose of this study, a case study using the mixed method was adopted. As there are 130 CHW's that were trained by SAAVI's MK in health research and development, there is diversity among CHW'S in the INK area. This means that the findings of a study of this nature may not necessarily apply to all CHW's in a generalised manner. Therefore, a case study approach is most appropriate as it considers contextual factors that promote a particular way of doing things. Case studies allow for illumination of issues that are deeply rooted in every day practice within particular settings.

In using the mixed method, i.e., quantitative and qualitative methods, there are strengths and limitations. According to Welman, Kruger and Mitchel (2005:188-189), qualitative research can, theoretically speaking, be described as an approach rather than a particular design or set of techniques. He further iterates that it is an umbrella phrase covering an array of interpretive techniques which seek to describe, decode, translate and otherwise come to terms with the meaning of naturally occurring phenomena in the social world. Therefore, the qualititative research approach is also fundamentally a descriptive form of research. Welman, Kruger and Mitchel (2005: 188-189) further state that qualitative field studies can be used successfully in the description of groups, small communities and organizations, whereas quantitative research methods may be more useful in hypothesis-testing research. Qualitative field studies, in turn, may lend themselves more aptly to studying cases that do not fit into particular theories.

A questionnaire differs from interview schedules or interview guides, because the respondents fill in the questionnaire without the researcher's assistance. This is known as a self-administered questionnaire (Alpaslan, Du Plooy, Gelderblom, Van Eeden, Van Rensburg, and Wigston, 2010: 186). Questionnaires in this study were given to groups of respondents for them to fill-in at different venues.

In using the census method, the researcher attempts to collect data from every member of the population being studied rather than choosing a sample. The other is a specific form of social survey organized by governments with the aim of collecting information from every household in the country. Government censuses are organized at regular intervals – most commonly every ten years with the information collected affecting political structures and social policies. Taking the first meaning of a census, some populations can be easily identified, such as every CHW trained by MK in the INK area in 2010 and 2011 (Jupp, 2006:115).

According to Fox and Bayat (2007:77), quantitative research can be distinguished from qualitative research because of its particular characteristics. These characteristics may be summarised as data in the form of numbers, the focus is concise and narrow, i.e., data is collected by means of structured instruments such as questionnaires. Results supply less detail as far as behaviour, attitudes and motivation are concerned, results are based on larger samples representative of the population, given its high reliability. The research can be repeated or replicated and analysis of results is more objective. Therefore, quantitative research embodies investigations where the relative data can be analysed in terms of numbers that may be qualified or summarized.

The questionnaire used in this case study was designed to elicit quantitative data using Likert scaling. The Likert scaling used the anchor of strongly agree, agree, neutral, disagree and strongly disagree. According to Schulze (2009:12), quantitative research systematically overlooks critical features of human phenomena so that results are often of limited value, i.e., criticised as

being dehumanising. Qualitative research techniques can overcome these shortcomings. On the other hand, qualitative research may appear to be fraught with subjectivism and questionable precision, rigour or credibility. Quantitative research is suited to theory testing and developing universal statements while qualitative research provides the researcher with in-depth knowledge, although this is not generalised (Schulze, 2009:12). This study used a structured questionnaire to collect data from all 130 CHW's that were trained by MK in the INK area during 2010 and 2011.

3.4 Rationale for using the case study

According to Fox and Bayat (2007:69), a case study refers to the fact that a number of units of analysis, such as an individual, a group or institutions are studied. In a case study, if a single individual is studied, he or she should be highly representative of a particular population. Such an individual should be extremely atypical of the phenomenon being studied. The merit of a case study approach is that it facilitates the use of a variety of research methods. It also allows the use of multiple sources of data, thereby facilitating the validation of data. This approach can fit in well with the needs of small-scale research by concentrating effort on one research site or just a few sites (Denscombe, 2003:38).

The role of CHW's is that of providing support, being a leader who can maintain confidentiality, being a collaborator with the family and a bridge between health care centres and the community. These are critical not only for the continuing care of the patients, but also in creating an environment in the community where research is supported and trusted (SAAVI, 2007:10). CHW's in Inanda, Ntuzuma and KwaMashu (INK) are community members who are employed by Progressive Primary Health Care (PPHC), an NGO. They were targeted to be trained by MK because of their role as health workers in the community. Despite years of ongoing training provided to the CHW's in the areas under investigation, no formal scientific study has been conducted as a means to promote evidence-based interventions and continued evidence-based improvements.

This study investigated the community health workers perceptions of MK training services in the INK area. It is important to investigate if the training service offered by MK has had any impact on CHW's in the areas under investigation, and to ascertain the views of CHW's on the importance of the training provided by MK. Further, there is a need to establish if there is any value attached by the CHW's to the training provided by MK. The results of the study will benefit both MK in making evidence-based improvements in their training programmes as well as CHW's in acquiring current, up-to-date and relevant information on health research and development, which can be disseminated to the communities.

The rationale for using this case study involving CHW's in Inanda, Ntuzuma and KwaMashu is based on convenience of easy accessibility as the researcher works in the INK area as a MK community educator employed by SAAVI. The area has been also used by various research institutions, including SAAVI, and the TB, and HIV Prevention Research Units of the MRC for their research. It becomes important to ensure that communities receive research-related information through building the capacity of CHW's that work in the area.

For the past 6 years, the researcher has worked in SAAVI under the MRC. The researcher's duties include developing, designing, implementing, monitoring and evaluating annual plans for creating a broader awareness in health research and development; capacity development for targeted communities; promoting community involvement in health research and development; identify, establish, liaise, coordinate and maintain relationships with various stakeholders; write reports; financial administration and budgetary control (Southwood *et al.*, 2007:2).

3.5. Research design

De Vos, Strydom and Delport (2008:308) state that research designs are all those decisions a researcher makes in planning the study. In quantitative studies, this refers to only those groups of small, worked-out formulae from which a quantitative-oriented researcher can select or develop one or more that may be suitable for a specific research goal. He further states that there is a difference in the way in which quantitative and qualitative-oriented researchers view the nature of research designs. Whereas quantitative researchers consult their lists of possible designs and select one or develop one from the models available, qualitative researchers always develop their designs as they go along, using one or more of the available strategies or tools as an aid or guidance. He concludes by pointing that qualitative research deals with data that are principally verbal, while quantitative research deals with data that are principally numerical (De Vos *et al*., 2008:308). In this case study, the questionnaire was designed to collect quantitative and qualitative data. Document analysis also formed part of the qualitative approach. By using the mixed method approach in the research design, quantitative and qualitative techniques provided valuable data for the research.

According to Bryman (2006:126), the word design sounds almost too orderly for the iterative process that unfolds in most qualitative studies. Whereas quantitative researchers share a common language for designs, e.g., experimental, quasi-experimental, time-series, etc., no uniformity exists in qualitative inquiry. Most qualitative researchers opt for a straightforward description of what they plan and how they plan to do it, using as many descriptors as are applicable (case study, ethnography, phenomenology, etc.).

This case study aimed to examine the perceptions of CHW's that were trained by MK in the INK area, using a census of all 130 CHW's that were trained by MK in 2010 and 2011. Structured questionnaires were distributed to CHW's in a venue closer to the area they worked in and were collected by the researcher after they have been completed. According to Durrheim and Terre Blanche (2004: 29), a research design is a strategic framework for action that

serves as a bridge between research objectives and research questions and the execution or implementation of the research. This was ensured in the questionnaire and document analysis.

According to Durrheim, Painter and Terre Blanche (2006:34), research design is a strategic framework for action that serves as a bridge between the research questions and the execution or implementation of the research. Research designs are plans that guide the arrangement of conditions for collection and analysis of data in a manner that aims to combine relevance to research purpose with economy procedure.

This study used a structured questionnaire to collect data from all the 130 CHW's that were trained by MK in the INK area during 2010 and 2011. A questionnaire is a printed document that contains instructions, questions and statements that are compiled to obtain answers from respondents. The questionnaire was designed such one section of the questionnaire aimed at eliciting qualitative data from the respondent to ensure that critical elements of the phenomenon being studied are not left out. Document analysis also formed part of the qualitative approach. By using the mixed method approach in the research methodology, qualitative and quantitative techniques in collecting data were used in different parts of the design

Dzurec and Abraham (2011: 271- 275) suggest that "*the objectives, scope, and nature of inquiry are consistent across methods and across paradigms*". Researchers and research methodologists need to be asking when each research approach is most helpful and when and how they should be mixed or combined in their research studies.

According to Padgett (2008:221), all research designs operate from a premise of intentionality. An experiment, for example, promises random assignment and one or more comparison groups. The study design may not work out as planned, but it is presented as an obligation the researcher intends to fulfil. Mixed methods, designs point to the desire to link or integrate. As such, they portend specific procedures to carry this out (Padgett, 2008:221).

3.5.1 Survey

The study used a survey to collect data. It was used to help the researcher in ascertaining the perceptions of CHW's on the training provided by MK. Survey research involves collecting data by putting a set of pre-formulated questions, in a pre-determined sequence in a structured questionnaire, to a sample of individuals drawn so as to be representative of a given population (De Vos *et al*., 2011:310). .

3.5.2 Sampling techniques and description of the sample

The process of selecting cases is called sampling. A sample, then, is quite simply those units or elements that are included into a study. Durrheim *et al.* (2006:133) further state that the population is the larger pool from which sampling elements are drawn and to which generalised findings are sought.
This study used a census method. Census is the collection of information about all the units of population which is also called the 100% sample survey (Biz/ed encyclopaedia of education, 1996). All the 130 CHW's that were trained by MK in INK in 2010 and 2011 participated in the study. Census is a recording of every element in a population (Encyclo's encyclopaedia of education, 2007:1).

3.5.3 Defining the population

According to Alpaslan *et al.* (2010:150), a population can be defined as the entire group of persons or set of objects and events the researcher wants to study. A population contains all the variables of interest to the researcher. For this study, the total population were all CHW's that were trained by MK in different clustered areas.

3.5.4 Reasons for selecting this population

According to the Proposed Framework for Primary Health Care Delivery in Communities (South Africa, 2004:5), the role of CHW's is to mobilize communities, act as advocates to improve health, coordinate access of other health workers, provide specified primary health care services to community members, provide basic counselling services, disseminate health information, carry out health promotion activities and transfer health and wellness skills to community members. One hundred and thirty (130) CHW's from INK were trained by SAAVI's MK. They also received other training related to their work from the provincial and national Department of Health and NGO's like Progressive Primary Health Care (PPHC). INK has been the catchment area for the TB and HIV Prevention Research and the HIV Vaccine Research Units of the South African Medical Research Council in Durban for the past six years. Therefore, it is important to ascertain the following: dissemination of the information, gained from training, by CHW's; impact of information provision on CHW's and their work; contribution of training to development and mechanisms to effectively disseminate research related information to communities. According to Southwood (2007: 2), the biggest challenge to any trainer, educator or facilitator is how to teach in the most effective way possible so that workshop participants gain new and useful information, understanding, attitudes and skills. Furthermore, it is important to develop the capacity of people so that they can function more effectively. While MK is providing an important education programme for CHW's, it is imperative that the intended outcomes are achieved. This study aims to investigate CHW's perceptions of the training provided by MK.

3.5.5 Defining the sample for the study

A sample is any subset of the elements of the population that is obtained for the purpose of being studied. The process by which elements are drawn from the population is called sampling (Fox and Bayat, 2007:54).

Sample size depends on what one wants to know, the purpose of the inquiry, what is at stake, what will be useful, what will have credibility, and what can be done with available time and resources (Patton, 2002: 244).

For this research, the sample was made up of all the 130 CHW's that were trained by MK in the Inanda, Ntuzuma and KwaMashu area in 2010 and 2011. This area is of interest to the researcher, since it has been used by various research institutions including MRC to invite volunteers to participate in their research. A census of all the 130 CHW's was conducted.

3.5.6 Sample size

The sample size depends on what the researcher wants to do with the results. If the intention is to produce large amounts of cross tabulations, the more people contact constructed, the better. A general rule in quantitative research is that the larger the sample, the more accurate the results (Dawson, 2002:49). According to Alpaslan *et al.* (2010: 164), sample size refers to the number of elements in a sample. There are no hard and fast rules for determining sample size. Instead, the researcher must consider the research purpose, the design, the size of the population and the type of sample used. Dawson, (2002:49) states that, generally, with the exception of case studies, the larger the sample, the more valid and precise the study. Dawson (2002:49) points out that this is because the larger sample is more likely to be representative of the population.

In this study, the population was made up of all the 130 CHW's that were trained by MK in the INK area during the period under focus. A census of all the 130 CHW's was conducted.

3.6 Data collection

Data can be considered as pieces of information collected by the researcher. Data can be collected by using primary and secondary sources. In this study,

the primary data is the questionnaire that was administered to the respondents. The secondary sources involved the analysis of documents like books, reports and official government publications. The uses of multiple sources are complementary and useful for a case study.

3.6.1 Questionnaires

A questionnaire is a list of carefully structured questions, chosen after considerable testing, with a view of eliciting reliable responses from a chosen sample. The aim is to find out what a selected group of participants do, think or feel (Collis and Hussey, 2005:173).

De Vos *et al.* (2011:186) state that questionnaires differ in scales in that they are usually not standardized and contain a wide range of items and are products of a scientist's creative efforts or theoretical conceptualisations. De Vos *et al.* (2011:186) further state that questionnaires may be refined or validated during the research project. Questionnaires can provide facts and opinions.

The researcher must ensure that there is clarity about whether the information being sought has to do with facts and opinions (Denscombe, 2003:155). Walliman (2005:281) is of the opinion that the questionnaire is a very flexible tool as a method of data collection. However, he cautions that it must be used carefully in order to fulfil the prerequisites of a particular piece of research.

3.6.1.1 Questionnaire design

According to Welman, Kruger and Mitchell (2005:174), the decision to conduct a questionnaire survey should itself be the culmination of a careful process of thought and discussion, involving considering all possible techniques. The concepts and variables involved and the relationship being investigated possibly in the form of hypothesis, theories, models or evaluation frameworks should be clear and should guide the questionnaire design process (Welman, Kruger and Mitchel, 2005:174).

For this study, the questionnaire was divided into five sections and questions focussed on obtaining the following information:

Section A: Demographic information (information on race, gender, age and qualification) was requested and is important for statistical reasons;
Section B: Provision of MK training programme. The aim of this section was to gather information on how respondents view the provision of the MK training programme;
Section C: Content of the MK training programme. This section was essential to elicit information on how respondents perceive the content of the MK training programme;
Section D: Facilitation of the MK training programme. The aim of this section was to elicit information on how the facilitators in MK facilitated training sessions;
Section E: Impact of the MK training. This section was vital in that it aimed at eliciting information on the perceived impact of the training on the sample population.

3.6.1.2 Questionnaire format

The format of a questionnaire will be influenced by whether the questionnaire will be emailed, telephonic, group-administered or other type of questionnaire, as well as where, under what circumstances and by whom it will be completed. All questionnaires should be accompanied by a covering letter, which serves to introduce and explain the questionnaire to the respondent. The questionnaire must be clear and well formatted for the respondents to record their responses (De Vos *et al.*, 2011:193).

According to Gomm (2008:217), many surveys include both closed-ended and open-ended questions, according to the use to which the resulting information will be put.
Gomm (2008:217) further states that closed-ended questions are usually preferred by survey researchers, because the object of most surveys is to make point-by-point comparison between different kinds of people, or

between the same kinds of people at different times. Open-ended questions may, sometimes, be asked. However, respondents may be allowed to use their own words, but what these words mean may not always be clear to the researcher (Gomm, 2008:217).

Scaled questions are framed in such a way that the respondents can provide their answer by marking a certain score on a scale, for example, in a question about a respondent's salary, the answer could range from 'satisfied' to 'unsatisfied' on a scale from 1 to 5 (Fox and Bayat, 2007:94).

Survey research involves collecting data by putting a set of pre-formulated questions, in a pre-determined sequence in a structured questionnaire, to a sample of individuals drawn so as to be representative of a given population. The questionnaire focused on gathering demographic data and to determine the provision, content, facilitation and the impact of the MK training programme on CHW's and their work (Fox and Bayat, 2007:94).

According to Simons (2010:01), a rating scale, which is often referred to as a Likert scale, requires respondents to rate their level of agreement to a statement along an evenly spaced continuum. These scales are often used to measure the intensity of attitudes and usually have a score "in the middle" to allow the respondent to feel "neutral" about a subject.

In this study, a structured questionnaire using the Likert scale was used to collect data from the respondents. This approach was chosen because it is appropriate for a census study. This is supported by Fox and Bayat (2007:94), who state that the Likert scale is the most popular scale used in social sciences, because it is easy to compile. It consists of a collection of statements about the object. Respondents had to indicate the extent to which they agreed or disagreed with its content on, for example, a five-point scale (strongly disagree; disagree; neutral; agree; strongly agree). Some statements denote a negative attitude while others suggest a positive attitude towards an object. Open-ended questions were structured at the end of the questionnaire.

3.6.1.3 Administering of questionnaires

According to Walliman (2005:282), there are four basic methods of delivering questionnaires, personally, email, post and telephonically. The benefits of personal delivery are that a respondent can be assisted to clearly understand questions and the researcher can ensure a higher response rate through personal persuasion. The disadvantage is that the personal involvement of the researcher enables more complicated questions to be devised and the problems concerning time and geographic location limit the scope and extent to which this method of delivery can be used. Postal and emailed questionnaires do not have these limitations. However, the significant problem is that the response rate is not easy to foretell or control. Telephonically administered questionnaires depend on time and availability of respondents. A high non-response rate can have serious consequences on the validity of the sample by introducing bias into the data collected.

In this study, questionnaires were administered personally to groups of CHW's at different venues, as indicated in Table: 3.1. These CHW's were receiving further training in 2012. Alpaslan *et al.* (2010:199) state that when questionnaires are administered directly to the sampled individuals as a group, during one session (in a school hall), this is called a *group administration*. The advantages of group administration include:

- A high response rate (because respondents are all present and fill in the questionnaire simultaneously);
- Data collection time is short; and
- The researcher can verbally explain the purpose of the survey and answer any questions (Alpaslan *et al.,* 2010:199).

Table 3.1 illustrates how the questionnaires were administered at the various venues.

Table 3.1: Administration of questionnaires

Date	Venue	Number of respondents	Number of questionnaires collected	Response rate
29/01/2012	**Ntuzuma F - Library**	**19**	**19**	**100%**
13/02/2012	**Inanda Newtown C Hall**	**22**	**22**	**100%**
27/02/2012	**Mashu E Community Court**	**22**	**22**	**100%**
28/02/2012	**Inanda – Qadi Tribal Court**	**22**	**22**	**100%**
01/03/2012	**Mashu L Hall**	**22**	**22**	**100%**
07/03/2012	**Thandolwethu Community Centre**	**23**	**23**	**100%**

3.7 Validity and reliability

Validity and reliability are the traditional criteria by which scientific research is judged. This is accepted by most quantitative researchers in the social sciences and by many qualitative researchers (Gomm, 2008:33).

Validity refers to the degree to which a scale measures what it is supposed to measure (Alpaslan *et al*., 2010:195). Validity means that a measurement represents what it is supposed to represent. A valid measure accurately represents the relationship between things (Fox and Bayat, 2007: 145). Validity was ensured through the use of a variety of sources in the literature review and the design of the questionnaire which was scientifically compiled and analysed.

Reliability refers to the fact that if a test, model or measurement is consistent, then it is reliable, supplying the same answer at different times. When

measurements are consistent from one research session to another, they are reliable, and some degree of faith may be placed on them (Fox and Bayat, 2007: 145). Reliability was established when the researcher conducted a pilot study with a few CHW's who were not part of the sample population. After the pilot test, the questionnaire was refined and thereafter administered to the sample group.

Salkind (2006:146) refers to truthfulness, accuracy, authenticity, genuineness and soundness as synonymous for validity. Salkind (2006:146) further iterates that reliability occurs when an instrument measures the same thing more than once and results in the same outcomes. The reliability of a measurement procedure is thus the stability or consistency of the measurement.

3.8 Data analysis and interpretation

Carpi and Egger (2011:154) state that data collection is the systematic recording of information, while data analysis involves working to uncover patterns and trends in data sets. Data interpretation involves explaining the patterns and trends. They further state that scientists interpret data based on their knowledge and experiences. Thus, different scientists can interpret the same data in different ways. By publishing their data and the techniques they used to analyse and interpret that data, scientists give the community the opportunity to both review the data and use it in future research (Carpi and Egger, 2011:154).

Bogdan and Bilken (1992:145) define qualitative data analysis as "working with data which are textual, non-numerical and unstructured, organising it, breaking it into meaningful units, synthesising it, searching for patterns, discovering what is important and what is to be learned and deciding what to tell others. Cobin and Strauss (2008:01) state that quantitative data analysis is a numerical process of examining and interpreting data in order to elicit meaning, gain understanding and develop empirical knowledge. Qualitative data included the analyses of various types of documents and the responses to open-ended questions in the questionnaire. Quantitative data included the

analysis of the questionnaire under the various themes aligned to the research objectives.

3.9 Statistical analysis of the questionnaire

This study used SPSS Windows (version 17) as a method of data analysis to analyse the survey instrument. SPSS stands for Statistical Package for the Social Sciences. SPSS is one amongst other computer software programs that can be used by researchers and students when conducting computer-assisted data analysis. SPSS is most commonly used and is available for Windows as well as for Mac OS X.

The study used the Statistical Package for Social Sciences (SPSS) as a data analysis tool. It is particularly easy to use and can cope with most kinds of data (Ghosh, 1992: 178). The researcher benefited from using the SPSS because it works with several kinds of computer files, data files, output files and syntax files. Data files are those computer files that contain the information the user wants to statistically analyse. Output files contain the statistical analysis, tables, graphs and charts (Wagner, 2007: 75).

In this study, a basic descriptive statistical analysis was undertaken using frequencies and cross-tabulation data.

3.10 Limitations of the study

Although the aspect of continued training programmes for CHW's is provided by various institutions, this study focussed on the training provided by MK to CHW's in the INK area and the information offered is research related. As a limitation, only the 130 CHW's in the INK area that were trained by MK during 2010 and 2011 on research-related information were chosen for this study. The limitation in this research is that the CHW's who were trained by other institutions could not be included, because they were not trained on research-related information.

3.11 Conclusion

This chapter outlined the research method and design that was adopted for this study. A rationale was developed to use the case study approach. A census of 130 CHW's was used to collect data. The justification for this sample was that CHW's in the INK area are community members who work in the community where various clinical trials have been conducted in the community. The study used both qualitative and quantitative research methodologies. An approach that was used to collect data was a questionnaire using Likert scaling and an analysis of relevant documents. The questionnaire was administered to respondents at different venues, in different places at different times. The questionnaires were analysed using the SPSS for Windows.

Chapter 4 will constitute data presentation, analysis and interpretation.

CHAPTER FOUR

Data presentation, analysis and interpretation

4.1 Introduction

The previous chapter outlined the methodology for this research that was informed by using a case study adopting qualitative and quantitative techniques.

This chapter presents the results and discusses the findings obtained from the questionnaire that was used in this case study to investigate community health workers perceptions on the training provided by Masikhulisane in the INK area. Briefly this chapter presents the data, analyse and interprets it. The objectives of the study were as follows:

- to determine the nature of training provided by MK to CHW's;
- to examine the perceived relevance of the training provided by MK to CHW's and their work;
- to identify perceived barriers to effective training of CHW's; and
- to determine the impact of the training on CHW's and their work.

The questionnaire was administered to all the 130 CHW's that were trained by MK in the INK during 2010 and 2011 at six separate venues. The questionnaire was designed within five sections as follows:

- Section A – Demographic information;
- Section B – Provision of MK training programme;
- Section C- Content of the MK training programme;
- Section D – Facilitation of MK training programme; and
- Section E – Impact of the MK training programme.

Data collected from the responses was analysed using SPSS Windows (version 17). The results were presented in the form of graphs, cross tabulations and other figures.

4.2 Reliability

Reliability refers to the property of a measurement instrument that causes it to give similar results for similar inputs. Cronbach's alpha is a measure of reliability. More specifically, alpha is a lower bound for the true reliability of the survey. Mathematically, reliability is defined as the proportion of the variability in the responses to the survey that is the result of differences in the respondents. This means that answers to a reliable survey will differ because respondents have different opinions, and not because the survey is confusing or has multiple interpretations. The computation of Cronbach's alpha is based on the number of items on the survey (k) and the ratio of the average inter-item covariance to the average item variance (Kerr, Hall and Kuzoh, 2004:12).

$$\alpha = \frac{k(cov/var)}{1 + (k-1)\ (cov/var)}$$

Factor analysis attempts to identify underlying variables, or factors, that explain the pattern of correlations within a set of observed variables. Factor analysis is often used in data reduction to identify a small number of factors that explain most of the variance that is observed in a much larger number of manifest variables. Factor analysis can also be used to generate hypotheses regarding causal mechanisms or to screen variables for subsequent analysis such as identifying collinearity prior to performing a linear regression analysis (Douglas, William, and Robert, 2004; 24).

Table 4.1 to Table 4.8 below reflect the Cronbach's alpha reliability scores for the different sections of this research.

Table 4.1: Case processing summary

		N	%
Cases	Valid	126	96.9
	Excluded	4	3.1
	Total	130	100.0

Table 4.2: Reliability statistics

Cronbach's Alpha	N of Items
.820	6

Table 4.3: Case processing summary

		N	%
Cases	Valid	120	92.3
	Excluded	10	7.7
	Total	130	100.0

Table 4.4: Reliability statistics

Cronbach's Alpha	N of Items
.762	4

Table 4.5: Case processing summary

		N	%
Cases	Valid	108	83.1
	Excluded	22	16.9
	Total	130	100.0

Table 4.6: Reliability statistics

Cronbach's Alpha	N of Items
.802	11

Overall

Table 4.7: Case processing summary

		N	%
Cases	Valid	99	76.2
	Excluded	31	23.8
	Total	130	100.0

Table 4.8: Reliability statistics

Cronbach's Alpha	N of Items
.875	21

The reliability scores for the components of the ordinal sections are high. These findings indicate a high degree of acceptable, consistent scoring for the different categories of the data for this research. The sections have high acceptable reliability values.

4.3 Factor analysis

Factor analysis is a statistical technique whose main goal is data reduction. A typical use of factor analysis is in survey research, where a researcher wishes to represent a number of questions with a small number of hypothetical factors. For example, as part of a national survey on training for health workers, participants may answer three separate questions regarding training policy for career development, reflecting issues at the local, provincial and national levels. Each question, by itself, would be an inadequate measure of attitudes toward training policy for career development, but together they may provide a better measure of the attitude. Factor analysis can be used to establish whether the three measures do, in fact, measure the same thing. If so, they can then be combined to create a new variable, a factor score variable that contains a score for each respondent on the factor. Factor

techniques are applicable to a variety of situations. Certain components in the questionnaire are divided into finer components. This is explained in Table 4.9 to Table 4.11 for sections B, C and D in the questionnaire in the rotated component matrix (Willemse, 2009:13).

Table 4.9: Component matrix: Provision of the MK training programme (Section B)

	Component 1
The purpose of the training offered by Masikhulisane was clearly stated	.741
The information provided during the training is necessary for us as community health workers as well as the community we work in	.832
It is important for me to be fully trained on health research, HIV/AIDS, HIV vaccines and microbicides for me to assist others	.764
Training provided by MK provides opportunities for addressing the needs of community health workers	.839
I feel empowered after attending the training offered by MK	.663
During the training I acquired skills that have enabled me to share up to date information on vaccines and microbicides with patients and community members	.539

Table 4.10: Component matrix: Content of the MK training programme (Section C)

	Component 1
The learning outcomes were clearly stated at the beginning of the training	.715
Health research related information on HIV/AIDS, HIV vaccines and microbicides is relevant to us as community health workers	.827
New and up-to-date information on HIV/AIDS, HIV vaccines and microbicides was presented during the training	.584
The information was easy to understand and allowed me to follow during the training	.723

Table 4.11: Rotated component matrix: Facilitation of the MK training programme (Section D)

	Component	
	1	2
Masikhulisane facilitators are always available for us when we need refresher training courses	.597	.267
The facilitator was well prepared for the training	.730	.087
The training methods were interactive	.707	.076
At the end of the training, an evaluation was conducted to gauge participants understanding of research related information has increased	.605	.089
Adequate time was given for the training	.130	.575
The facilitator's instructions were clear, simple and well explained	.644	.311
The facilitators used participants existing knowledge and experience during the training	-.057	.780
The facilitators used different facilitation methods to ensure that learning was effective	.672	.036
There are support mechanisms for participants after attending the training offered by MK	.356	.668
The facilitator was approachable	.531	.382
The facilitator presented new information that was not easily available	.672	.130

Factor analysis is a statistical technique whose main goal is data reduction. A typical use of factor analysis is in survey research, where a researcher wishes to represent a number of questions with a small number of hypothetical factors (Gliem and Gliem, 2003:84).

With reference to Table 4.9, Table 4.10 and Table 4.11 the following emerged:

- The principle component analysis was used as the extraction method and the rotation method was Varimax with Kaiser Normalization. This is an orthogonal rotation method that minimizes the number of variables that have high loadings on each factor. It simplifies the interpretation of the factors (Steyn, Smit, Du toit and Strasheim, 1994:161);
- Factor analysis or loading show inter-correlations between variables; and

- Items of questions that loaded similarly imply measurement along a similar factor. An examination of the content of items loading at or above 0.5 effectively measured along various components.

It can be noted that the questions that constituted the components of “Provision of the MK training programme” (Section B) and “Content of the MK training programme” (Section C) loaded perfectly along one factor. This means that the statements (variables) that constituted these components perfectly measured the component, meaning that the component measured what it was that was meant to be measured.

However, the other component regarding “Facilitation of the MK training programme” (Section D) has factors that overlap, indicating a mixing of the factors. This means that the questions in the overlapping components did not specifically measure what it set out to measure or that the component split along themes. One possibility is that respondents did not clearly distinguish between the questions constituting the components. This could be with respect to interpretation or inability to distinguish what the questions were measuring.

Respondents grouped together “Adequate time was given for the training”, “The facilitators used participants existing knowledge and experience during the training” and “There are support mechanisms for participants after attending the training offered by MK” in Section D. This could be with regard to interpretation or inability to distinguish what the questions were measuring.

During the training, the facilitators would divide participants into groups, give them an activity to do and instruct them to present during the plenary sessions. Facilitators give participants adequate time to do this activity. After all the groups have presented, the facilitator will do his or her presentation, giving feedback and reinforcing the participants’ existing knowledge, while providing new information. This is where respondents could have identified the relationship and thought it is a form of a support mechanism for participants attending the training.

4.4 Data analysis

Data collected will now be analysed

4.4.1 Section A: Demographic information

Descriptive statistics describe the organising and summarising of quantitative data. Univariate and bivariate analysis are most appropriate for descriptive statistics. Univariate analysis is concerned with measures of central tendency and measures of dispersion. The most appropriate measure of central tendency for interval data is the mean and the most appropriate measure of dispersion for interval data is the standard deviation. Bivariate analysis concerns the measurement of two variables at a time. Descriptive statistics is useful as it summarises results for an experiment, thereby also allowing for more constructive research after more detailed analysis. Descriptive data analysis aims to describe the data by investigating the distribution of scores on each variable, and by determining whether the scores on different variables are related to each other (Lind *et al*., 2004:6).

The successful implementation of the MK training programme is dependent on the demographic make-up of the sample population and how well they can cascade the information they received during the training to the communities. It was considered important to determine the demographic make-up of CHW's that formed part of this study. This study drew a sample of a total of 130 CHW's from INK, from a population of CHW's who are involved in the field of HIV and AIDS and were trained by MK on health research in South Africa.

This section presents the descriptive statistics based on the demographic information of the study.

Figure 4.1 below indicates the sample composition by area.

Figure 4.1: Sample composition by area

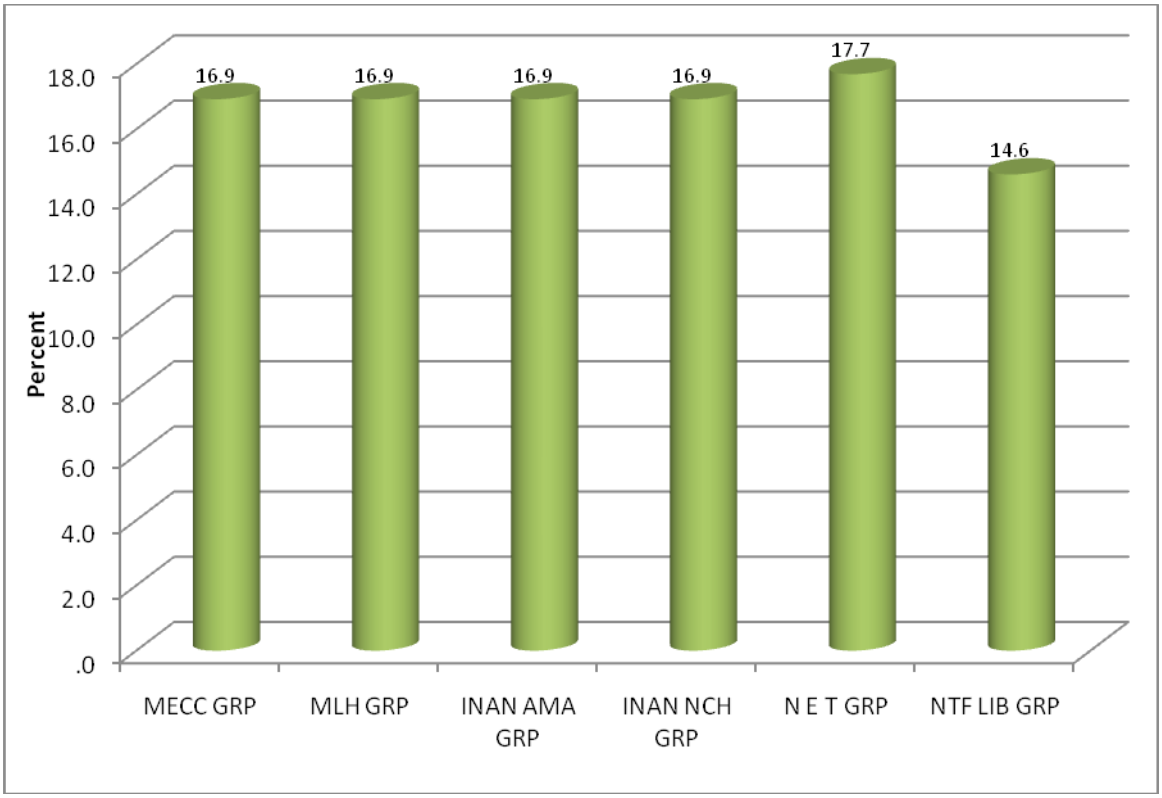


Figure 4.1 indicates the demographic composition of CHW's by area as follows:

- Ntuzuma E Thandolwethu (NET) (17.7%);
- Mashu E Community (MECC) Court (16.9%);
- Mashu L Hall (MLH) (16.9%);
- Inanda Amaoti (INAN AMA) (16.9%);
- Inanda Newtown C Hall (INAN NCH) (16.9%); and
- Ntuzuma F Library (NTF LIB) (14.6%)

Respondents were drawn from 6 different areas in similar proportions. Two groups were drawn from KwaMashu, two groups from Ntuzuma and two

groups from Inanda. The aim was to ensure that the study uses the same number of respondents in each area.

Table 4.12 below indicates the gender of the respondents by age group.

Table 4.12: Gender of respondents by age

			Gender		Total
			Male	Female	
Age Group	16 – 25 years	Count	1	14	15
		% of Total	.9%	12.4%	13.3%
	26 – 29 years	Count	2	6	8
		% of Total	1.8%	5.3%	7.1%
	30 – 39 years	Count	0	37	37
		% of Total	.0%	32.7%	32.7%
	40 – 49 years	Count	0	36	36
		% of Total	.0%	31.9%	31.9%
	50 years & above	Count	1	16	17
		% of Total	.9%	14.2%	15.0%
Total		Count	4	109	113
		% of Total	3.5%	96.5%	100.0%

Seventeen respondents did not indicate gender and/or age. The sample was predominantly female (96.5%). It is observable in any CHW programme that there are greater numbers of females than males. The highest number of respondents in age group is between 30 and 39 years. It is usually observed that there are no or very few males in some CHW programmes. Table 4.12 also shows gender by age group as follows:

- Similar numbers of females were observed (32%) in the age categories of 30 – 39 years and 31% females in the age group 40 – 49 years with 0% males in both the categories;
- The age categories of 50 years and above indicate 9% males and 14.2% females;
- The age categories of 16 – 25 years indicate 9% males and 13.3% females; and
- The age categories of 26 – 29 years indicate 1.8% males and 13.3% females.

Figure 4.2 indicates the common languages spoken by the respondents.

Figure 4.2: Common languages spoken by respondents

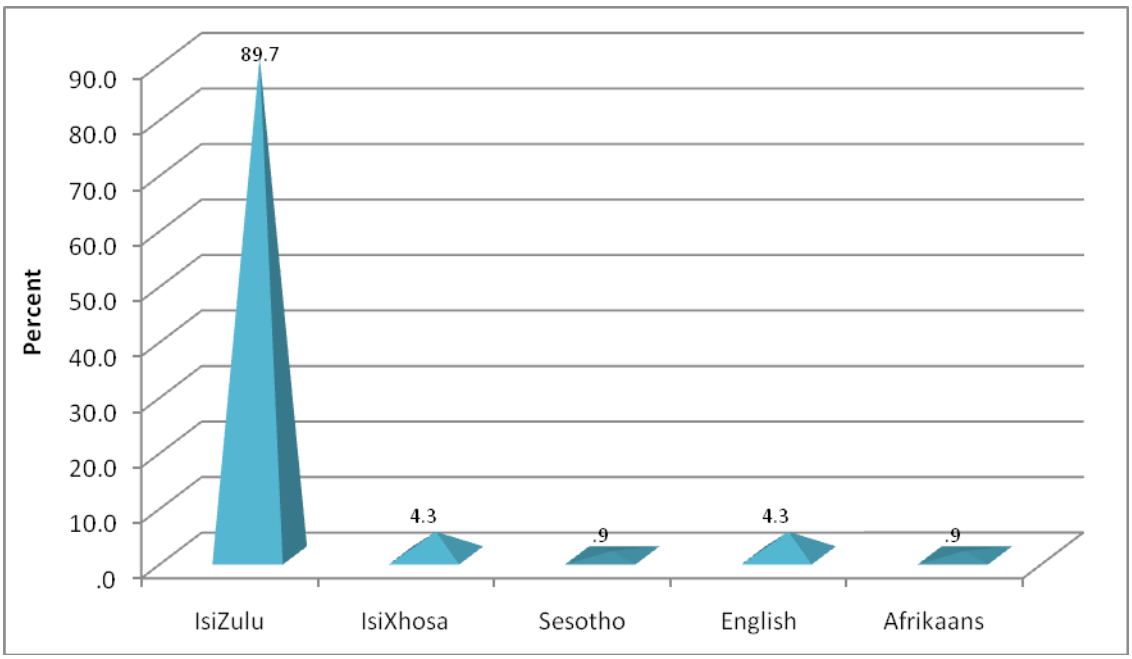
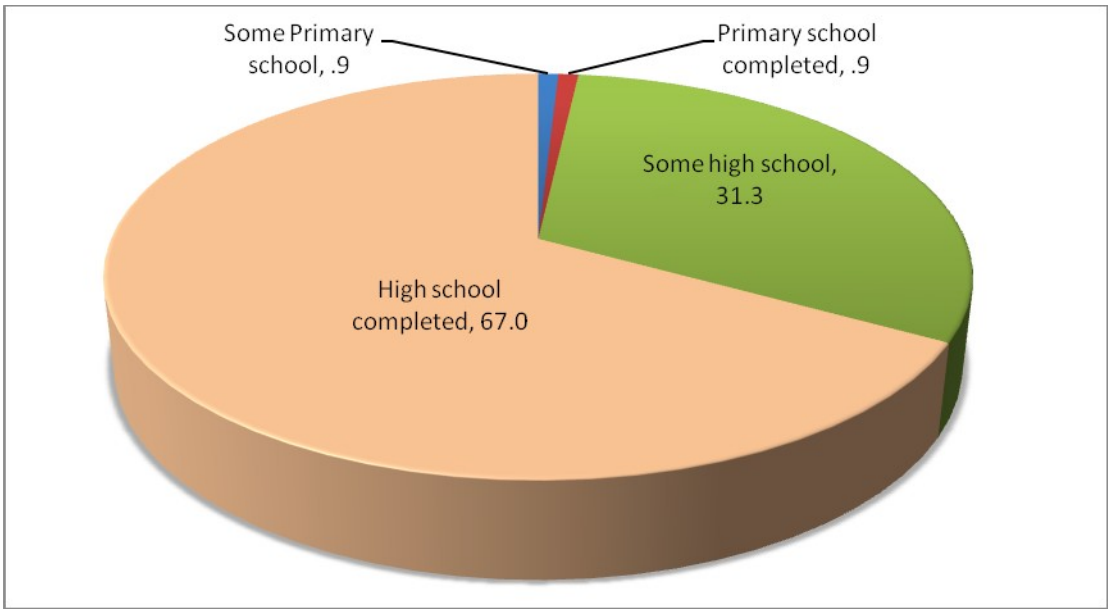


Figure 4.2 indicates that IsiZulu is the predominant language spoken amongst the respondents (89.7%). IsiXhosa and English recorded a similar percentage of 4.3%. A similar percentage of 0.9% respondents speak Sesotho and Afrikaans. Cognisance was taken of the language issue by ensuring that all the questions were in English and IsiZulu. Further, all facilitators are expected to be conversant in English and IsiZulu for purposes of communication.

Figure 4.3 indicates the level of schooling completed by the respondents.

Figure 4.3: Level of schooling completed by respondents



Two-thirds (67%) of the respondents indicated that they had completed high school and 31.3% have some high school education, meaning they did not complete high school education. Less than 1% indicated not having completed primary school and 0.9% respondents indicated that they completed primary school education. These findings were reflected in the comment made by the late Director General of WHO (World Health Report, 2006:4) who stated that, in most countries, CHW's have only 8 to 10 years of schooling. It is an important factor to consider when providing training, since levels of education impact on the learning that takes place during training.

Figure 4.4 indicates the period of service as CHW'S.

Figure 4.4: Period of service as CHW's

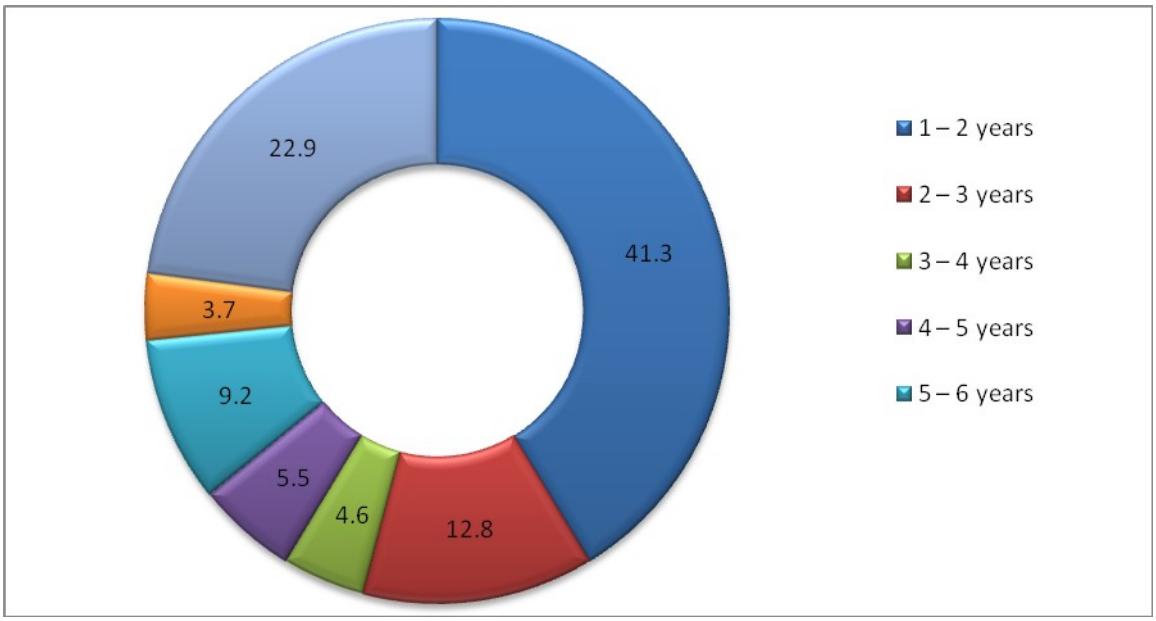


Figure 4.4 indicates that 41.3% of the respondents have been doing community health work from one to two years. 22.9% of the respondents have been doing community health work for more than seven years. 12.8% of the respondents indicated that they have been doing community health work for two to three years. 9.2% of the respondents indicated that they have done community health work for five to six years. Respondents who have done community health work for four to five years were recorded at 5.5%. Respondents doing community health work for three to four years were 4.6% and only 3.7% of the respondents have done community health work for six to seven years.

The figures show that there are more respondents (58.7%) who have four years and less of service as CHW's, with the largest number (41.3%) having between one to two years of service. This finding shows that most of the 130 respondents, who have only between one and two years of service, received training provided by MK in 2010 and 2011.

Table 4.13 indicates the period of service by area (group).

Table 4.13: Period of service by area (group)

			Group						Total
			MECC	MLH	INAN AMA	INAN NCH	N E T	NTF LIB	
Period of Service	1 – 2 years	Count	15	8	5	1	10	6	45
		% of Total	13.8%	7.3%	4.6%	.9%	9.2%	5.5%	41.3%
	2 – 3 years	Count	4	2	0	0	5	3	14
		% of Total	3.7%	1.8%	.0%	.0%	4.6%	2.8%	12.8%
	3 – 4 years	Count	0	0	1	0	0	4	5
		% of Total	.0%	.0%	.9%	.0%	.0%	3.7%	4.6%
	4 – 5 years	Count	1	1	1	0	1	2	6
		% of Total	.9%	.9%	.9%	.0%	.9%	1.8%	5.5%
	5 – 6 years	Count	0	1	4	2	2	1	10
		% of Total	.0%	.9%	3.7%	1.8%	1.8%	.9%	9.2%
	6 - 7 years	Count	0	1	0	2	0	1	4
		% of Total	.0%	.9%	.0%	1.8%	.0%	.9%	3.7%
	7 years & above	Count	1	4	10	3	5	2	25
		% of Total	.9%	3.7%	9.2%	2.8%	4.6%	1.8%	22.9%
Total		Count	21	17	21	8	23	19	109
		% of Total	19.3%	15.6%	19.3%	7.3%	21.1%	17.4%	100.0%

Most of the respondents have between one to two years of service (41.3%), with MECC recording a 13.8% and INAN NCH recording the lowest of 0.9% of the respondents who have worked for one to two years as CHW's. This was followed by 22.9% of the respondents who have worked for seven years and above, with INAN AMA recording the highest at 9.2% and MECC recording the lowest at 0.9%.

There are 12.8% of respondents who have worked for two to three years, with NET recording the highest of 4.6% and INAN AMA and INAN NCH recording

0.0% service in the service period of two to three years. A total of 9.2% of respondents indicated years of service of five to six years with the highest of 3.7% in INAN AMA and the lowest of 0.0% in MECC.

Table 4.13 indicates that 5.5% of the respondents have worked for four to five years, with NTF LIB recording a highest of 1.8% and INAN NCH recording the lowest of 0.0%. Table 4.13 further indicates that 4.6% of the respondents have worked for three to four years with the highest in NTF LIB (3.7%) and all the other areas recording 0.0%, except INAN AMA at 0.9%.

The lowest period of service recorded is 3.7% with INAN NCH recording the highest (1.8%) and MECC, INAN AMA and NET at 0.0%. Most groups had a similar period of service (on average, 18.54%), except for INAN NCH, which was at 7.3%.

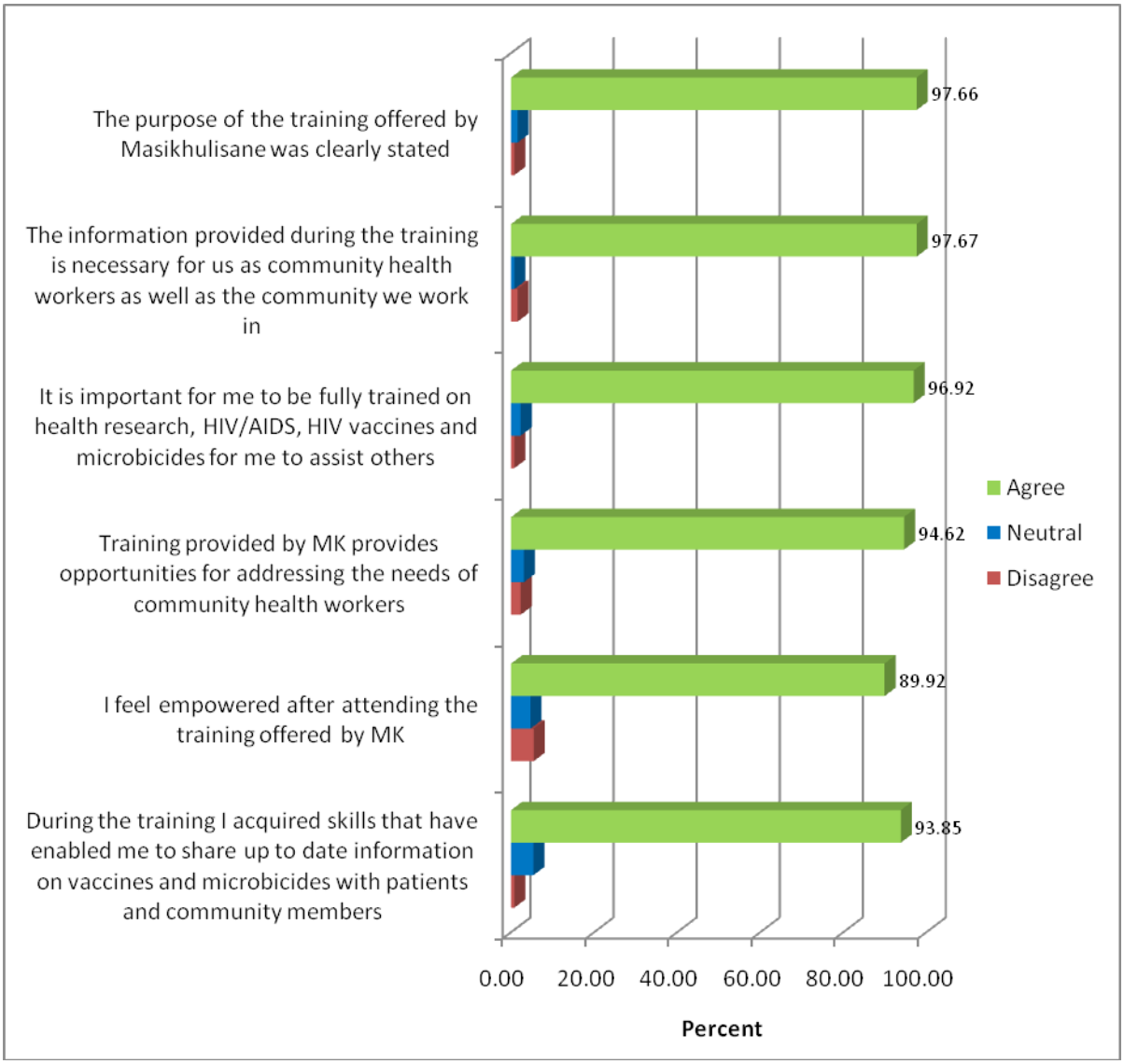
Retaining employees for a longer period of service is a challenge for many organizations, especially if investments in their training and development have been made. It is important to consider initiatives to retain employees who have expertise and skills to provide sustainable services, especially in view of the health care challenges facing South Africa at the PHC level.

4.4.2. SECTION B: Provision of MK training programme

This section presents the results on the provision of training by MK.

Figure 4.5 illustrates the responses to the development of skills and competencies necessary for CHW's.

Figure 4.5: Provision of MK training programme



The success of any training is largely attributable to the responses of trainees toward such training. The relevance and value of training must be determined so that programme evaluations can address factors inhibiting the achievement of the identified outcomes for the provision of specific training opportunities.

There is a strong level of agreement with each statement in this section (average = 95.11%). This is probably because some of the community health workers could not identify areas in which they could use the information in their work situations after the training.

Figure 4.5 indicates a high level of agreement with the statement that the information provided during the training is necessary for the CHW's as well as the community they work in (97.67%). CHW's may now be able to explain or educate the community on what products are being researched to prevent HIV and AIDS after the training. This is the information that CHW's need to have for themselves as well as to inform the community.

There is a 97.66% level of agreement with the statement that the purpose of the MK training was clearly stated. Clear articulation of the purpose of the training is necessary for respondents to be given direction from the commencement of the training. 99.92% respondents felt that it is important for them to be trained on health research, HIV and AIDS, HIV vaccines and microbicides to be able to assist other people in their communities. CHW's were able to recognize or identify the relevance of the information provided during the training. Furthermore, 94.62% of CHW's were able to identify opportunities provided by MK training in addressing the needs of the communities.

There is 93.85% agreement that, during the training, they acquired skills that enabled them to share current and up-to-date information on vaccines and microbicides with patients and community members.

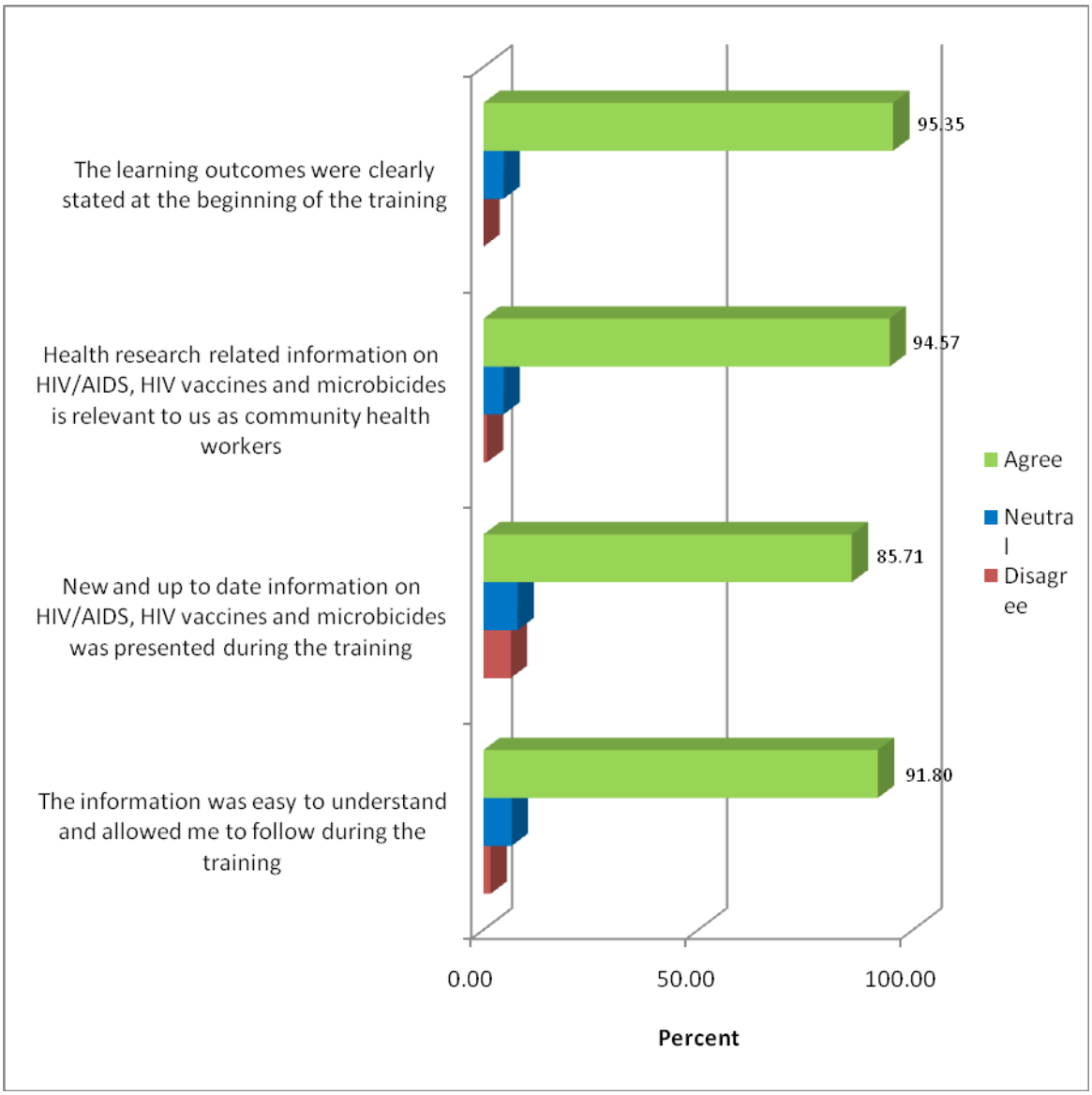
A total of 89.92% felt empowered after attending the training offered by MK. This facilitates information sharing that addresses community needs more than before and the facilitator may have clearly stated the learning outcomes, which were understood by the respondents. However, the level of disagreement with this statement was highest, possibly indicating lack of adequate opportunities to use the information gained during the training in their work situations as community health workers.

4.4.3 Section C: Content of the MK training programme

This section focuses on the content of the MK training programme. The nature of the information provided during the training is important as it determines whether the training objectives will be achieved or not. Furthermore, any training needs to empower trainees with information that is useful and relevant for use within the context of the work undertaken by CHW's.

Figure 4.6 illustrates the responses to the relevance and impact of the content in the MK training programme.

Figure 4.6: Content of the MK training programme



The average level of agreement is 92% for this section. This finding indicates a high level of agreement with the statements that constitute this section. The statement regarding the learning outcomes were clearly stated at the beginning of the training and recorded a highest level of agreement at 95.35%. This finding can be attributed to the need for the CHW's to clearly understand the expected outcomes which are stressed by the facilitator throughout the training. By stating the learning outcomes clearly, explicitly and continuously, effective learning can be monitored throughout the training. By indicating that health research related information on HIV and AIDS, HIV vaccines and microbicides is relevant to the CHW's at a 94.57% response

rate indicates that the CHW's were receptive of the information provided, such that they noticed gaps that existed and where the missing information could be used as they execute their duties.

There was a 91.80% level of agreement to the statement that the information provided during the training was easy to understand and allowed CHW's to follow during the training. The facilitators are aware of the literacy levels of CHW's, their existing knowledge and experience. By taking cognisance of these vital contributors to effective learning, the content and methodology are made as simple as possible, without compromising essential content.

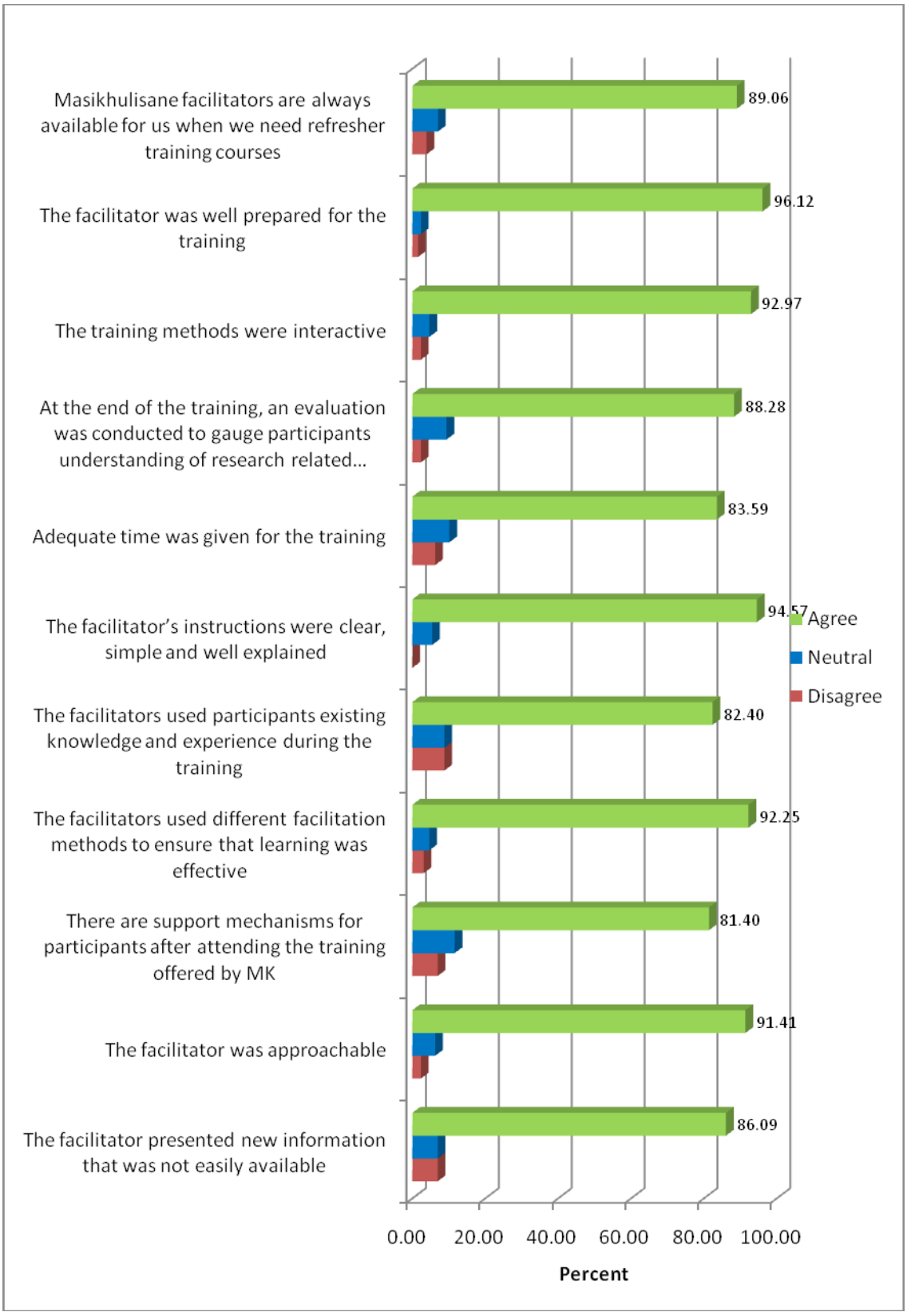
The lowest level of agreement (85.71%) was with the statement that new and up-to-date information was presented during the workshop. Despite this statement having the lowest level of agreement, it shows that the majority of the respondents agreed that the content was not outdated, thereby supporting the use of the latest information from research.

4.4.4 SECTION D: Facilitation of the MK training

This section focuses on how the MK training was facilitated. The researcher considered determining how well the facilitators plan, prepare and facilitate the learning activities. The researcher also considered determining the attributes of the MK facilitators as influential factors that contribute to effective learning.

Figure 4.7 illustrates the responses to the nature of the facilitation of the MK training programme.

Figure 4.7: Facilitation of the MK training programme



The average level of agreement in this section was 89%. This also shows high levels of agreement with the statements in this section. The highest level

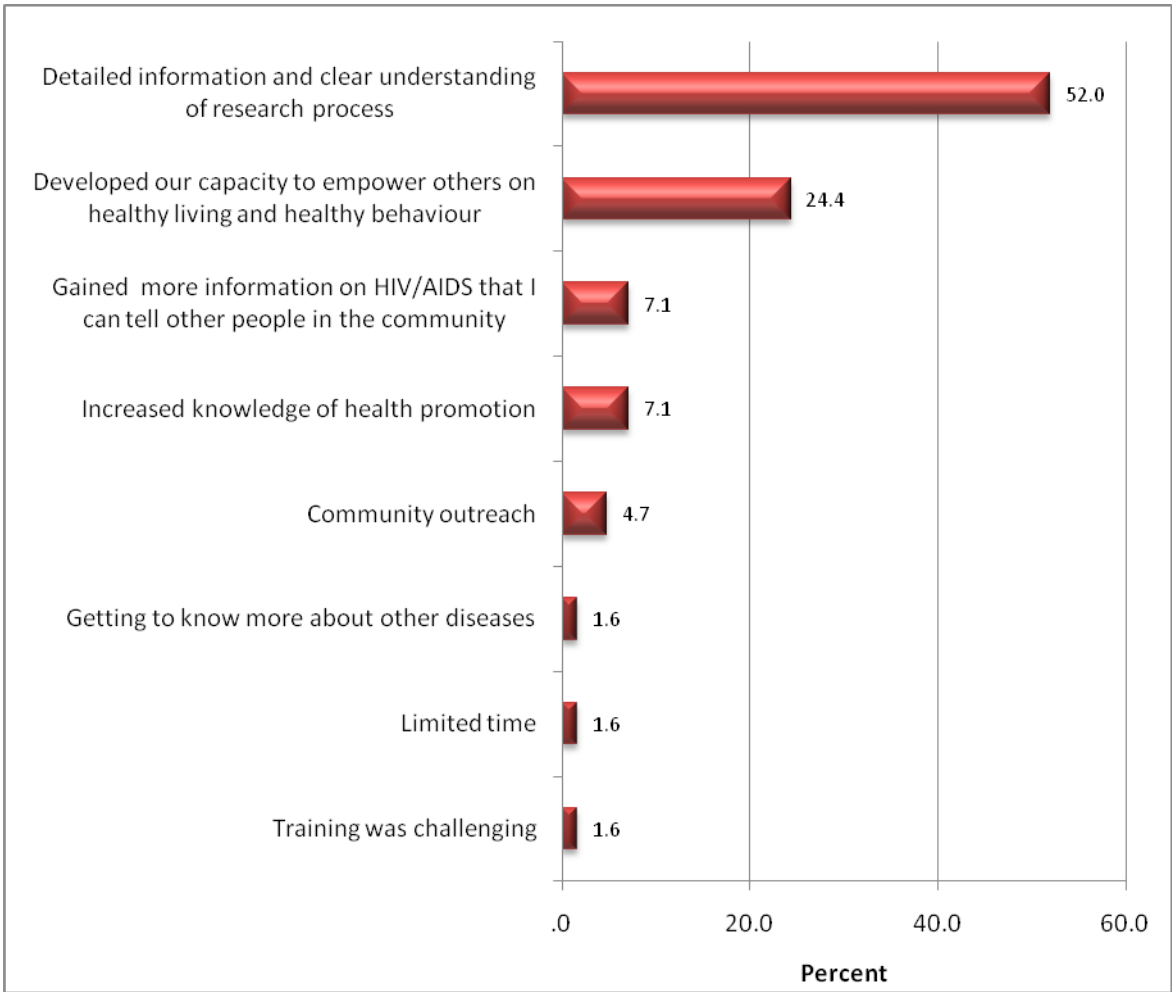
of agreement (96.12%) was for the statement that the facilitator was well prepared for the training. The dissemination of relevant, accurate and reliable information by the facilitators is of paramount importance for successful learning. This was supported in the high response rate for preparation by facilitators. Further, evidence of preparation improves the quality of facilitation, thereby fostering a positive learning environment.

4.4.5 SECTION E: Impact of the MK training programme

This section provides a summary of the responses to the impact of the MK training programme. This section had open-ended questions. The researcher intended to determine if the training had any impact on the respondents and their work.

Figure 4.8 illustrates the responses to the impact of the training on CHW's and their work.

Figure 4.8: Impact of the training on CHW and their work

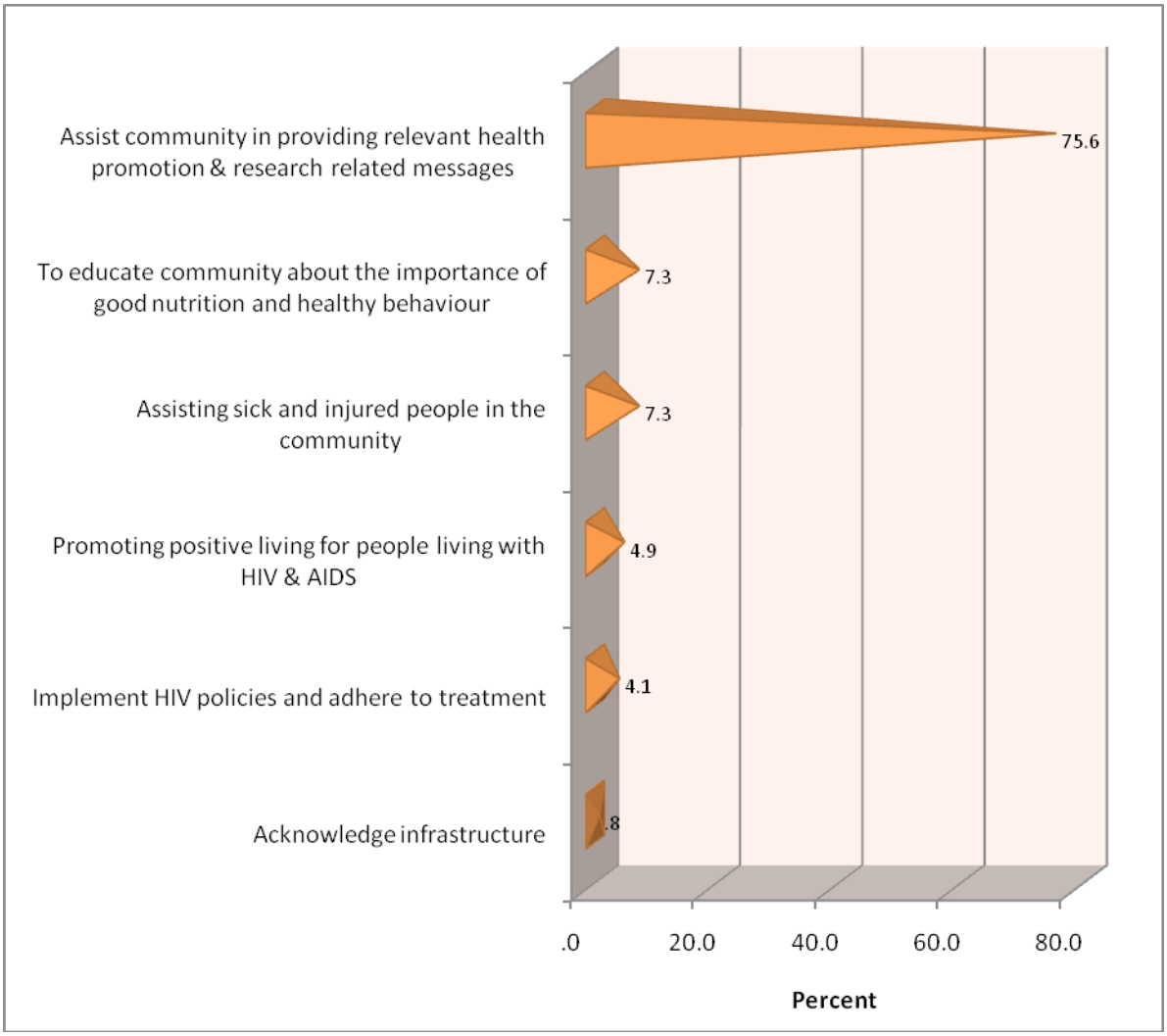


More than half of the respondents agreed that the training provided by Masikhulisane was clear and provided insight into the research process (52%). A total of 24% believed that their capacity had been developed to

empower others in communities on healthy living and healthy behaviour. It is also shown that the majority agreed that the time allocated for training was not limited and neither was the training challenging. This is a favourable finding since the majority of the CHW's have the lowest years of service (one to two years) and do not have post matric education.

Figure 4.9 highlights the use of information during the training.

Figure 4.9: Use of information



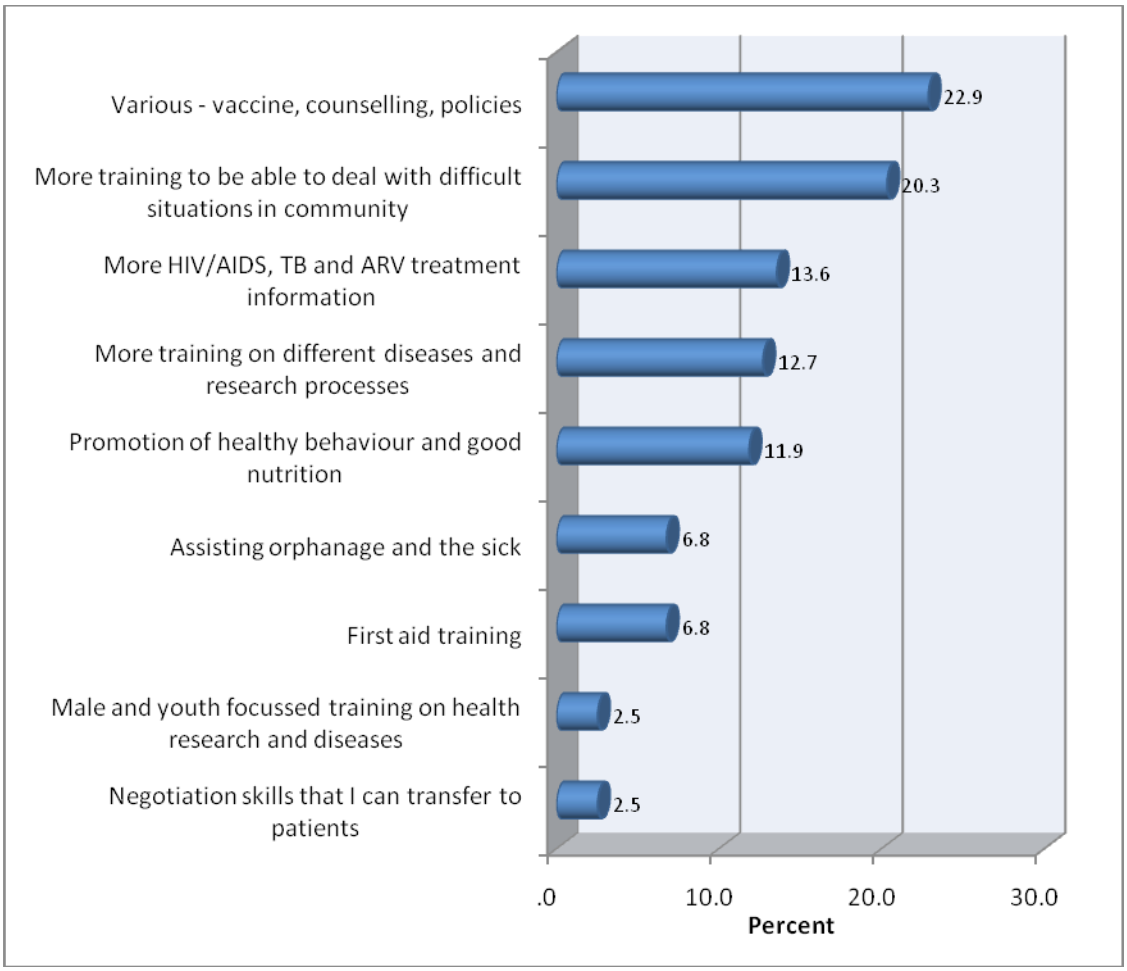
A total of 75.6% of the respondents believed that the training assisted them in providing relevant health promotion and research-related information to communities. Training also helped them in the following areas:

- Education of the community regarding good nutrition and healthy behaviour;
- Assisting the medically ill;
- Promoting positive living for HIV positive people;
- Maintaining treatment schedules; and
- Developing and maintaining infrastructure.

Any training programme endeavours to provide skills, competence and knowledge which trainees can use for their own personal development and to disseminate to relevant stakeholders. The responses clearly indicate that the CHW's are able to use the knowledge gained for different purposes at the PHC level.

Figure 4.10 highlights responses on what further training opportunities are needed.

Figure 4.10: Further training opportunities needed



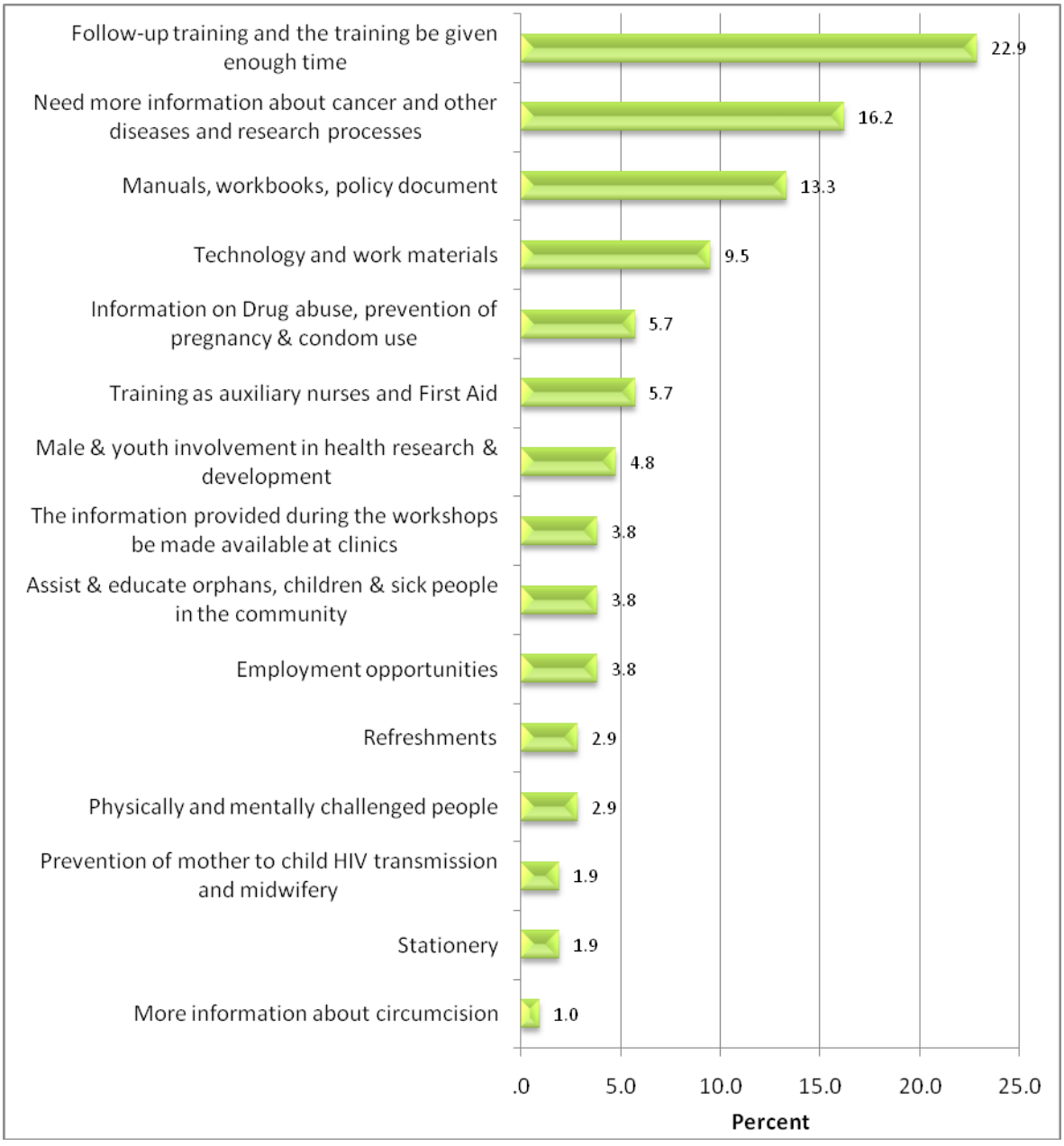
Preferences of respondents rated higher in terms of information relating to diseases and treatment (49.2%), as indicated in the following areas:

- Vaccines - 22.9%;
- More HIV and AIDS, TB and ARV treatment information – 13.6%; and
- More training on different diseases and research process – 12.7%.

Even though the identified sources of information needed for further training are in the current training programme, it appears that respondents prefer greater focus on diseases and treatments. Respondents also requested training in dealing with difficult situations in communities. This request may be indicative of feelings of independency in responding adequately as CHW's in such challenging environments.

Figure 4.11 below highlights what respondents think should be included in the training programme.

Figure 4.11: Additional content in training programme



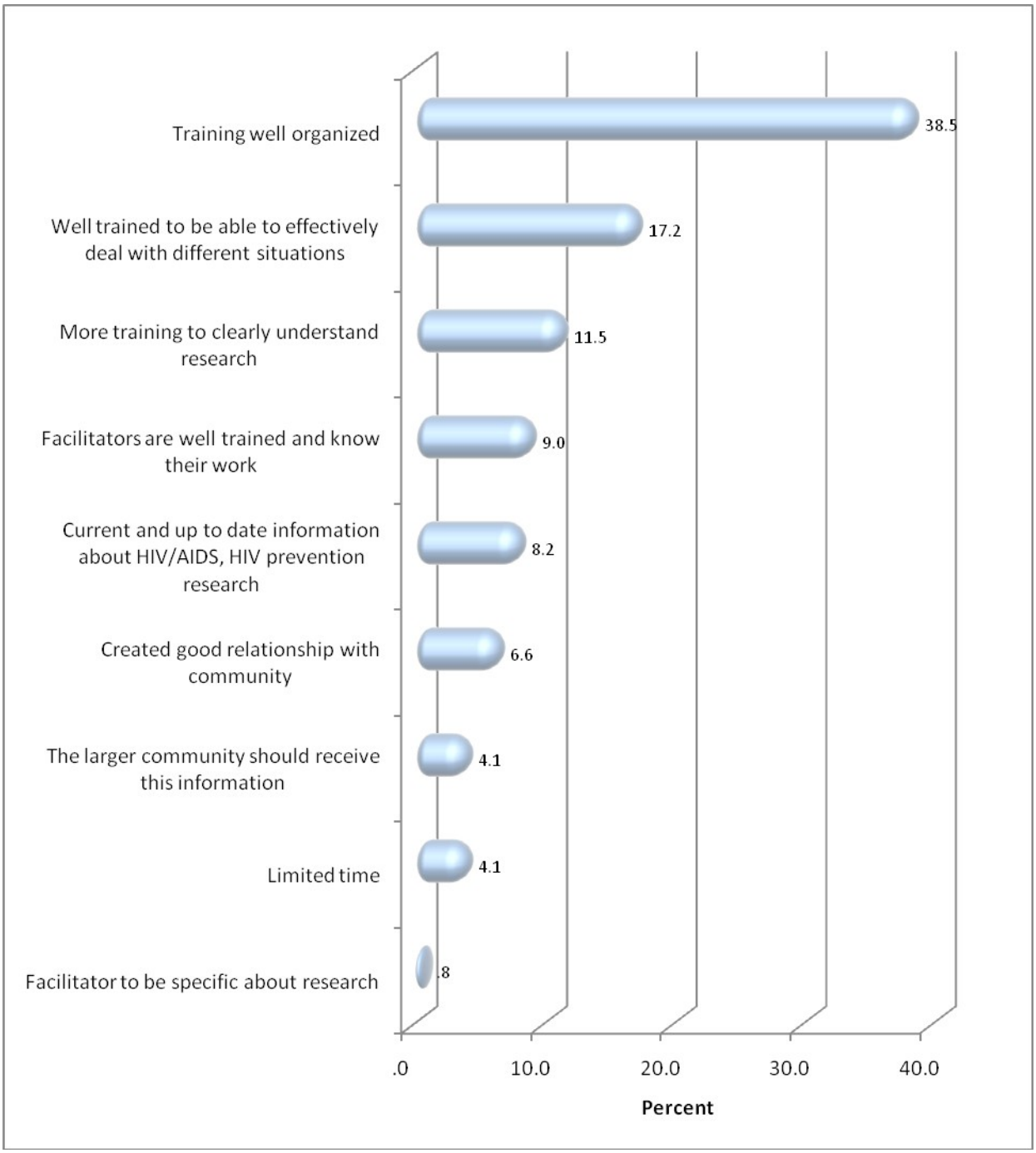
A total of 22.9% of the respondents indicated the need for follow-up training and that training should be expanded to more workshop sessions. Furthermore, the need for manuals (13.3%) and work materials (9.5%) emerged. These findings are indicative of the need for greater access to learning materials as sources of reference.

Access to information by other sectors of the community relating to health issues also emerged as requests in the following areas:

- Availability of information at clinics;
- Male and youth involvement in research; and
- Educate orphans, children and sick people.

Figure 4.12 illustrates general comments made by respondents with regard to their training.

Figure 4.12: General comments



Generally, the respondents indicated that the training was well organised (38.5%), the facilitators were well trained and knowledgeable and able to deal with different situations (26.2%) and the need for more training has been repeatedly made. Some respondents (8.2%) indicated that they received current and up-to-date information about HIV and AIDS, and HIV prevention

research. 6.6% indicated that they acquired skills to create good relationships with the community they serve.

4.5 Hypothesis testing and correlations

4.5.1 Hypothesis testing

The traditional approach to reporting a result requires a statement of statistical significance. A *p-value* is generated from a *test statistic***.** A significant result is indicated with "p < 0.05". These values are highlighted with an *. All values with a p-value more than 0.05, do not have a significant relationship.

The chi square test was performed to determine whether there was a statistically significant relationship between the variables (rows vs columns). The null hypothesis states that there is no association between the two. The alternate hypothesis indicates that there is an association.

Table 4.14 summarises the results of the chi square tests.

Table 4.14: Chi square test

	Group / Area	Gender	1st Language	Age Group	Education	Period of Service
The purpose of the training offered by Masikhulisane was clearly stated	0.229	.002*	.011*	0.255	0.514	0.757
The information provided during the training is necessary for us as community health workers as well as the community we work in	0.199	.000*	0.067	0.812	.000*	0.539
It is important for me to be fully trained on health research, HIV/AIDS, HIV vaccines and microbicides for me to assist others	0.062	.008*	0.576	0.873	.000*	0.416
Training provided by MK provides opportunities for addressing the needs of community health workers	0.23	0.173	.046*	0.672	.000*	0.838
I feel empowered after attending the training offered by MK	0.214	0.412	0.995	0.058	.019*	0.919
During the training I acquired skills that have enabled me to share up to date information on vaccines and microbicides with patients and community members	.027*	.000*	0.945	.010*	0.831	0.428
The learning outcomes were clearly stated at the beginning of the training	0.133	0.163	.004*	0.416	0.448	0.074

Health research related information on HIV/AIDS, HIV vaccines and microbicides is relevant to us as community health workers	.008*	0.143	.047*	0.715	0.104	.025*
New and up to date information on HIV/AIDS, HIV vaccines and microbicides was presented during the training	0.482	0.701	0.143	0.375	0.698	0.309
The information was easy to understand and allowed me to follow during the training	.047*	0.542	0.078	0.964	0.85	0.769
Masikhulisane facilitators are always available for us when we need refresher training courses	0.152	0.614	0.776	0.286	0.822	.011*
The facilitator was well prepared for the training	.011*	.013*	0.968	.001*	0.293	0.837
The training methods were interactive	.040*	0.231	0.954	0.361	0.96	0.458
At the end of the training, an evaluation was conducted to gauge participants understanding of research related information has increased	.008*	0.226	0.23	0.156	0.915	0.248
Adequate time was given for the training	0.075	0.061	.001*	0.293	0.94	0.83
The facilitator's instructions were clear, simple and well explained	.005*	0.063	0.735	0.19	0.791	0.711
The facilitators used participants existing knowledge and experience during the training	.022*	0.074	0.888	0.272	0.67	0.361
The facilitators used different facilitation methods to ensure that learning was effective	.024*	0.347	0.893	0.437	0.451	0.329
There are support mechanisms for participants after attending the training offered by MK	0.322	0.844	0.641	0.728	0.868	0.285
The facilitator was approachable	.011*	0.542	0.13	0.513	0.713	0.398
The facilitator presented new information that was not easily available	.035*	0.484	0.852	0.087	0.847	0.212

The p-value between "gender" and "the purpose of the training offered by Masikhulisane was clearly stated" is 0.002 which is less than the significance value of 0.05. This means that there is a significant relationship between the variables, implying that gender did play a role in terms of how respondents rated the statement "the purpose of the training offered by Masikhulisane was clearly stated". There are also significant relationships between the gender and first language variables with the various statements, thereby indicating the influence of these two variables in the rating by respondents.

The p-value between "gender" and "the information provided during the training is necessary for us as community health workers and the community we work in" is 0.000 which is less than the significant value of 0.05. This

shows that there is a significant relationship between the variables. This also means that gender did play a role on how respondents rated the statement “the information provided during the training is important for us as well as the community we work in”.

The p-value between “language” and “the purpose of the training offered by Masikhulisane was clearly stated” is 0.011 which is less than the significant value of 0.05. This means that there is a significant relationship between the variables, i.e., language did play a role on how the respondents rated the statement “the purpose of the training provided by Masikhulisane was clearly stated”.

The p-values between “education” and “the information provided during the training is necessary for us as community health workers as well as the community we work in”, “it is important for me to be fully trained on health research, HIV and AIDS, HIV vaccines and microbicides for me to assist others” and “training provided by MK provides opportunities for addressing the needs of community health workers” is 0.000, which is less than the significant value of 0.05. This means that there is a significant relationship between the variables, i.e., education did play a role on how respondents rated the three statements mentioned.

Language did play a role on how respondents rated the statement “training provided by MK provides opportunities for addressing the needs of community health workers”. The p-value of “language” is 0.046 which is less than the significant value of 0.05. This means that there is a relationship between the variables.

Language also played a role on how respondents rated the statement “the learning outcomes were clearly stated at the beginning of the training” that has a p-value of 0.004 and the statement “health research related information on HIV and AIDS, HIV vaccines and microbicides is relevant to us as community health workers” whose p-value is 0.047. Both of the p-values are

less than the significant 0.05. This means that a relationship exists between the variables.

The p-value of “education” and the statement “I feel empowered after attending the training offered by MK” is 0.019, which is less than the significant 0.05. This means that a relationship exists between the variables, i.e., education played a role on how respondents rated the statement “I feel empowered after attending the training offered by MK”.

The p-values of “age group” and the statement “during the training I acquired skills that have enabled me to share up to date information on vaccines and microbicides with patients and community members” that has a p-value of 0.010 and the statement “the facilitator was well prepared for the training” that has a p-value of 0.001, which is less than the significant value of 0.05. This means that a relationship exists between the variables, i.e., age group played a role on how respondents rated the two statements mentioned above in this paragraph.

The p-values of “period of service” and the statement “health research related information on HIV and AIDS, HIV vaccines and microbicides is relevant to us as community health workers” that has a p-value of 0.025 and the statement “Masikhulisane facilitators are always available for us when we need refresher training courses” that has a p-value of 0.011, which is less than the significant 0.05. This means that there is a relationship between the variables, i.e., period of service played a role on how respondents rated the two statements in this paragraph.

According to the chi square test, gender seems to have played a role on how respondents rated many statements. All values without an * (or p-values more than 0.05) do not have a significant relationship.

4.5.2 Correlation of values

Bivariate Spearman's correlation was also performed on the ordinal data.

The results indicate the following patterns.
Positive values indicate a directly proportional relationship between the variables and a negative value indicates an inverse relationship.

The correlation values are independent of any of the biographical data.

The correlation value between "The purpose of the training offered by Masikhulisane was clearly stated" and "The information provided during the training is necessary for us as community health workers as well as the community we work in" is 0.587. This is a directly related proportionality. Respondents agree that the information provided met the purpose of the training.

The correlation value between "it is important for me to be fully trained on health research, HIV and AIDS, HIV vaccines and microbicides for me to assist others" and "training provided by MK provides opportunities for addressing the needs of community health workers is 0.424. This is a directly related proportionality. This means that respondents agree that the training provided by MK addresses the needs of the community health workers.

The correlation value between "I feel empowered after attending the training offered by MK" and "during the training I acquired skills that have enabled me to share up to date information on vaccines and microbicides with patients and community members' is 0.472. This is a directly related proportionality. Respondents agree that the information provided empowered and equipped them with skills to share up-to-date information about vaccines and microbicides.

The correlation between "the learning outcomes were clearly stated at the beginning of the training" and "health research related information on HIV and

AIDS, HIV vaccines and microbicides is relevant information to us as community health workers" is 0.348. This is directly related proportionality. Respondents agree that the acquisition of health research related-information on HIV and AIDS, HIV vaccines and microbicides was the outcome of the training.

The correlation value between "Masikhulisane facilitators are always available for us when we need refresher training courses" and "the facilitator was well prepared for the training" is 0.244. This is directly related proportionality. Respondents agree that Masikhulisane facilitators are always prepared and available for the training.

The correlation value between "the training methods" and "at the end of the training, an evaluation was conducted to gauge participants understanding of research related information" is 0.350. This is directly related proportionality. Respondents agree that the participants' understanding of research-related information is the result of the training methods that were interactive.

The correlation value between "the facilitator was approachable" and "the facilitator presented new information that was not easily accessible" is 0.366. This is directly related proportionality. Respondents agree that facilitator was approachable and presented new information that was not easily accessible.

4.6. Document analysis

The following documents were analysed to determine feedback provided on the MK training programme by personnel form SAAVI, who are involved in managing the MK training programme:

- MK workshop activity reports;
- Mk workshop evaluation forms;
- MK facilitator's quarterly reports; and
- SAAVI composite report.

4.6.1 Workshop activity reports

Workshop activity reports (SAAVI, 2011:1) indicate that the majority of the workshop participants (CHW's) in the INK area involved in training in the period from 2010 to 2011 were satisfied that their expectations were met and that adequate time was given for the workshops. Most of the workshop participants indicated that they will be able to educate their communities on the immune system, basic information about HIV and AIDS, science and research, ethical issues in research, legal and human rights and community involvement and participation (SAAVI, 2011:2).

Many workshop participants also indicated that the facilitator was approachable and created a conducive learning environment which enabled participants to actively participate in the learning processes. They further indicated that the facilitator was able to cater for those participants who did not understand English very well by using IsiZulu and that the facilitator used their existing knowledge and information to build new learning.

4.6.2 Workshop evaluation form

The analysis of the workshop evaluation forms (SAAVI, 2011:2) indicate that the majority of participants agreed that facilitators communicated clearly the learning outcomes at the beginning of the workshop and that their communication was clear throughout the workshop, taking into account the learning level of the group. With regard to the information learnt from the workshops, they will be able to use or educate the community on the following topics:

- The immune system;
- Basic knowledge about HIV and AIDS;
- Science and research;
- HIV vaccine research and development;

- Ethical issues;
- Legal and human rights; and
- Community involvement and participation.

The analysis of the workshop evaluation form (SAAVI, 2011:2) also indicated that there was a general feeling from the participants to have more follow-up workshops to ensure that they clearly understand research-related information and to identify weaknesses and strengths in terms of how they disseminated the information to the communities. They also felt that sharing their experiences in post-workshop sessions will be helpful in enhancing the quality of their work. Participants indicated that the information provided is important for them as CHW's and for the communities they work in. Some of the participants indicated that it is also important that the communities receive accurate, reliable and up-to-date research-related information. Participants indicated that they would like to have more information on other diseases like diabetes, malaria fever, cancer, tuberculosis and new information on HIV and AIDS (SAAVI, 2010:3).

4.6.3 SAAVI annual report

According to SAAVI's report (2011:26), the MK training programme has been implemented according to plans. The analysis of the workshop evaluation forms conducted by MK facilitators indicated a need to contextualise within health. This decision had already been taken by MK in their staff meeting in 2012, looking at the majority of workshop participants who would like to see the training programme incorporating other health issues and diseases. The process of developing a learning programme that incorporates other diseases and health issues is underway. The MK facilitators have, however, started incorporating other health issues in their planning, although the final document has not been finalised. This has benefited workshop participants in acquiring current, reliable and up-to-date information on other diseases and health issues. This learning programme is being developed to specifically meet the need to provide knowledge and skills in the diverse areas pertaining

to community-based home care, community health work and spiritual and social support for the afflicted communities (SAAVI, 2011:26). The development of a revised curriculum is based on the following:

- The availability of resources within SAAVI;
- Networking with other organizations and providers;
- Identified needs of CCG's, CHW's, CDW's, and Volunteers; and
- Need for on-going training for CCG's, CHW's and CDW's among others.

According to the report (SAAVI, 2011:32), the aim of the evaluation was to gauge the extent to which the training programme was received by participants, in terms of its acceptability and relevance. The analysis of the documents indicated that the training was well received and that the training was acceptable to the target group and its relevance was established as the participants agreed that the training is important for them as CHW's and the community they work in. However, there is a need to include specific areas relating to particular diseases and management thereof.

4.7 Conclusion

To address the objectives of this study, data was obtained via both quantitative and qualitative approaches using a questionnaire.

Questionnaires were administered to groups of CHW's at different venues. Respondents were drawn from 6 different areas in similar proportions. Two groups were drawn from KwaMashu, two groups from Ntuzuma and two groups from Inanda. The aim was to ensure that the study uses the same number of respondents in each area.

The perceptions of the respondents in this chapter reflect factors that mainly contribute to the content of the MK training programme, its provision and the facilitation of the training programme.

Furthermore, this chapter answered the following questions: the impact respondents think the training provided has had on them as CHW's and on their work, identifying situations in which they will be able to use the information gained during the training, further training opportunities they think are needed and what they think should be included in the existing training programme.

Overall, there is a strong level of agreement with each statement in this section on the provision of the MK training programme, showing of an average 95.11%. A high level of agreement at 92% average was shown for the section on the content of the MK training programme. There is also a high level of agreement (89%) in the section concerning the facilitation of the MK training programme.

More than half of the respondents (52%) thought that the training provided by Masikhulisane was clear and provided insight into the research process. The predominant area for the application of the training received was in assisting the community in providing relevant health promotion and research-related information (75.6%). The ranking in terms of preferences for training opportunities shows that 43.1% of the respondents would like to have training relating to policies, treatment and how to handle difficult situations in the community.

The ranking of preferences with regard to what respondents think should be included in the training programme shows that 52.4% of the respondents feel that there is a need for follow-up training and that the training should be extended to more sessions. More information about cancer and other diseases, including health research processes, were considered as important inclusions in the training programme. More than a third of the respondents (38.5%) indicated that the training had been well organised and that actual learning did take place. A total of 17.2% indicated that they were well trained and that they be able to deal with situations.

The next chapter focuses on the conclusions and recommendations of this study.

CHAPTER FIVE

Conclusions and recommendations

5.1 Introduction

Training is considered vital for the development of human resource skills, competencies and knowledge. By developing the capacity of CHW's, they will be empowered to not only educate communities, but also provide health care at PHC level.

Based on the above imperatives, the researcher explored the nature of the training provided by MK with the objective of determining its usefulness and ways of enhancing training provided by SAAVI.

5.2 Conclusions

The use of community health workers has been identified as one strategy to address the growing shortage of health workers, particularly in low-income countries. Using community members to render certain basic health services to the communities they come from is an approach that has been employed in various countries. There have been innumerable experiences throughout the world with programmes ranging from large-scale, national programmes to small-scale, community-based initiatives to provide health care at community level.

Currently, in South Africa, the CHW programme remains disease-focussed, particularly toward HIV and AIDS and TB care treatment and support. There is no policy that governs the CHW programme and there is also no standardized training to be followed when training this cadre. As a result, different organizations develop and train a particular group of CHW's according to the mandate that they are supposed to fulfil for a particular project in which they may be engaged in at the time (Magingxa, 2011: 4).

The researcher, therefore, undertook the research to investigate the perceptions of CHW's in the INK area on the training services provided by MK. Data was obtained through conducting a case study using both qualitative and quantitative techniques. Quantitative data was obtained through a questionnaire. Qualitative data was obtained through Section E of the questionnaire which was composed of open-ended questions and undertaking a document analysis.

The analysis of data in chapter four and the accompanying conclusions aimed to address the following objectives:

Questionnaire

- **To determine the nature of the training provided to CHW's**.

In addressing the above objective, the researcher asked the question on what respondents thought about the provision of the MK training programme.
The outcome was:

CHW's were able to relate the information provided in the training to their work and identified existing gaps in which they can use the information. CHW's recognized the need to be fully trained on health research, HIV and AIDS, HIV vaccines and microbicides to be able to assist others.

The information provided in the MK training programme should form part of the accredited standardized training programme for CHW's that is now SAQA approved in South Africa. CHW's view the content of the training programme provided by MK as critical for them as well as for community members.

The formalization of the MK training programme will enable CHW's to identify opportunities in addressing the needs of their communities. Hence, the

training equips CHW's with skills that enable them to share up-to-date information on vaccines and microbicides with patients and communities.

Research-related information needs to be part of the standardized training, since it provides a form of empowerment to CHW's in fulfilling their roles in the community.

- **To examine the perceived relevance of the training provided by MK to CHW's and their work.**

This objective was addressed by establishing the perceptions of CHW's about the content of the MK training programme. Although CHW's receive training relating to the nature of their work, research-related information does not feature in such detail as provided in the MK training programme.

It was established from respondents' responses that a high percentage of CHW's are of the opinion that the information provided in the MK training programme should be disseminated to people in the communities to ensure that people live a healthier life. Places like clinics should have handouts which the community can use for their own knowledge development.

CHW's support the use of up-to-date information on HIV and AIDS, HIV vaccines, microbicides and other diseases when they provide health promotion and education in their communities.

- **To identify perceived barriers to effective training of CHW's.**

In addressing the above-mentioned objective, the analysis aimed to elicit information about how the MK training programme is facilitated.

It was established that ensuring learner centredness is tantamount to effective learning. CHW's were able to draw from their experiences to build new learning. The training programme is focussed on providing skills that will

enable CHW's to successfully promote health and educate communities about health research.

It was established that the training is planned and prepared according to the needs of the target group before the actual training takes place. The training would not have been successful if the facilitators did not use interactive, participatory and collaborative methods of facilitation. Facilitators should continue to ensure planning and preparation before training.

From the responses, it was established that there is not enough support for the CHW's by MK after attending the training. There should be continuous interaction between the trained group and facilitators to ensure that the information disseminated to the communities is correct.

- **To determine the impact of training on CHW's and their work**.

In addressing this objective, various questions were asked to ascertain the impact of the MK training programme like explaining the impact the training has had on the participants, identifying situations in which participants will be able to use the information gained during the training, what further opportunities are needed and what participants think should be included in the existing training programme.

It was established that the training provided by MK was clear and provided insight into health research and health promotion. This means that the content in the MK training programme appeals to the CHW's.

The MK training seeks to provide knowledge and skills which CHW's can use for their health promotion activities and their development. Further, development on the MK should focus on building the skills that CHW's have to enable them to deal effectively with varying conditions in their communities.

It was established that CHW's prefer greater focus on different diseases and treatment. Furthermore, there is a need for manuals and work materials to be used by CHW's in their work. This means that CHW's recognized the worthiness of the information gained during the training and realised that, for them to educate and disseminate the information successfully, they need to have relevant materials and manuals.

It was also established that there is a need for MK to ensure that the training is extended to reach information clinic staff, community health committees, ward committees and various other stakeholders in health service delivery at community level. MK uses a sectoral approach that incorporates most of the stakeholders mentioned above.

Document analysis

In the analysis of the organizational documentation, it was evident that there is clear directedness in terms of what MK aims to achieve in providing the training. MK adopts a sectoral approach that targets various sectors to create broader awareness of health research, HIV vaccine research and microbicide research.

In the beginning, the MK training programme provided only research-related information. It has, however, evolved to incorporate health promotion encompassing primary health care. In this way, it has become a training programme that directly addresses the needs of CHW's, considering their role in the communities as well as various other stakeholders in communities.

The training programme in its current form has not lost its primary focus of creating research literacy to facilitate meaningful community involvement and participation in health research. The researcher is of the opinion that the MK training programme, being the training programme of its kind in the country, should further extend to cover schools, thereby increasing its reach to children

in schools. This may well provide an opportunity to revisit the content with a view to ensure its appropriateness for school-going children.

The succesful implementation of the MK training programme is dependent on the establishment, coordination and maintenance of relationships with various stakeholders. It is important that the programme gets buy-in from relevant stakeholders. Furthermore, this will ensure that further development of the training programme will take into consideration needs of the targeted groups or sectors encompassing the following:

- Greater access to learning manuals and materials as sources of reference;
- Access to information relating to health and health by other sectors of the community;
- Making the information available in places like clinics for community members own knowledge development; and
- Reviewing the content to make it appropriate for children in schools.

5.3 Recommendations

Considering the current status and provision of the MK training programme, many factors contribute to the successful implementation of the training programme. Based on the quantitative and qualitative analyses, the following recommendations are suggested:

- Accreditation

Evidence from chapter four illustrates that CHW's view the MK training as a legitimate and relevant training programme that should form part of their formal training for CHW's. Evidence further illustrates that the MK training is

viewed as seeking to provide knowledge and skills which CHW's can use for their health promotion activities and their development. According to Akintola (2010:54), volunteering involves committing time and energy to provide a service that benefits someone, society or the community without expecting financial or material rewards. Volunteering is a core element of community participation in primary health care, which has been seen as the key strategy for achieving Health for All (Alma Ata Declaration 1978; Walt 1988). Therefore, MK needs to ensure that the training gets accredited with SAQA as part of Ancillary Health Care qualification and ensure continued form of support for this cadre after attending the MK training programme to ensure that the information provided during the workshops is cascaded to people in communities.

- Broadening the sectoral approach

Another recommendation is the broadening of the MK sectoral approach to increase reach and uptake. The Alma Ata Declaration (1978:4) calls for a reorientation and broadening of the skills of health personnel to enable them to respond to the challenges of implementing PHC and to work in teams as well as with other sector professionals and communities, particularly to work more closely with communities and with other sectors and to function in a decentralised health system (Lehman, 2008:5).

The researcher is of the opinion that if the sectoral approach extends to incorporate other sectors that have not yet been reached, more people will benefit from the training programme. Furthermore, this will ensure meaningful community involvement and participation in health research. This can have benefits for CHW's as well as their communities and MK. Eventually, people will be empowered by developing their knowledge and skills to take action on health issues or health needs. This will move communities higher up the ladder of participation on issues concerning development in their community through networking with others in the community and outside it and to discuss specific issues or concerns or to get assistance (SAAVI, 2011:22).

- Revisiting the content

Another recommendation is revisiting the content to ensure acceptability and appropriateness for targeted sectors in health service delivery. The programme should be designed to provide participants with a broad understanding of the organization, financing and delivery of health services at the national, provincial and local levels to strengthen their ability to analyze, interpret and respond to current issues in health policy, and to provide a basic understanding of how to evaluate current programmes and policies.

The researcher is of the opinion that the content of the training programme, should begin with a brief overview of the basic principles of public health and a discussion of the determinants of health. In addition, it should include an overview of the organization and delivery of health care in this country, highlighting critical issues related to access, cost and quality. The following additions should be made to the MK training programme:

- A module that addresses the key concepts of primary health care, where primary care is defined and conceptualized, including specific techniques for its measurement and evaluation. Socio-economic disparities in health care provision; and
- A module that focuses on health policy and its application in health care service delivery to provide a broad understanding of health, health policy and primary health care. The role that health workers and communities play in health policy formulation and implementation should also form part of this module.

Upon completing the training programme, participants will:

- Understand the societal factors that either promote or impede the attainment of health among community members, and recognize the political factors that shape health and social policy and the role of health services and primary health care;
- Learn new strategies for evaluating and measuring primary health care and health status of their communities;

- Gain a broad understanding of the organization and delivery of health services nationally, provincially and locally;
- Apply knowledge and skills gained during the provision of the MK training programme to address issues in health policy; and
- Gain familiarity with cutting-edge research findings in the fields of primary health care, health policy and health research.

- Follow-up training sessions

Another recommendation is conducting follow-up training sessions. This will provide an opportunity for workshop participants who attended the initial workshops to get clarity on issues that they need to be clarified. The researcher is of the opinion that when CHW's are confronted with questions from community when they do their work, they may not be able to provide answers to those questions. According to Lehman (2008:169), the national human resource plan, finalised in 2006, echoes a strong focus on training and continuing development of human resources. Therefore, follow-up sessions will provide an opportunity to discuss challenges that CHW's face in their attempt to disseminate information. Furthermore, it is a way of ensuring that CHW's disseminate accurate, relevant and up-to-date information to the communities. The Health Research Policy in South Africa (South Africa, 2001:14) state that, public understanding of research and science should be an integral part of health promotion campaigns. Therefore, it is imperative that CHW's receive follow up training.

- Increasing the number of days for the initial workshops

Another recommendation is to increase the number of days for the initial workshop to three days. The researcher is of the opinion that research-related information has scientific concepts that are not easily translated into African languages. Facilitators struggle to get messages across in low literacy settings. Increasing the number of initial workshop days will provide an opportunity for facilitators to explain in detail concepts which are important for workshop participants to know. These concepts will also be revisited during follow-up sessions to facilitate clear understanding of the concepts of PHC and health research. This will ensure meaningful community involvement and

participation in health research in that community members will make informed decisions on whether to participate in health research or not after having received sufficient information about health research.

According to International AIDS Vaccine Initiative (2005:17), community members who form part of the catchment area for research, are targeted to be invited to participate in HIV prevention research involving microbicides, diaphragms, and HIV vaccines. Trial communities hosting HIV vaccine research often experience benefits through development of research infrastructure, training and other skills development which may include increased knowledge around HIV, HIV vaccine development and issues associated with HIV vaccine clinical trials, increased clinical trials and laboratory capacity. Therefore, it is important that CHW's provide accurate information to communities.

5.4 Recommendations for further research

According to Johnson and Khanna (2004:25), understanding the reasons why community members become involved in, and remain committed to, community health work is important for ensuring that realistic human resource policies are in place to promote the long-term sustainability of community health work programmes. Motivations for becoming involved in community health work appear similar across settings, with community members often driven by a desire to help their community to cope with the burden of HIV, and other diseases, while opportunities to receive training or income also appear to play important roles in attracting volunteers (Johnson and Khanna 2004;25). The researcher recommends that similar studies should be conducted in other provinces as this study collected data from CHW's that were trained by MK in three Durban townships i.e., Inanda, Ntuzuma and KwaMashu.

5.5 Conclusion

Progress in health in South Africa has been affected by serious failures in leadership. Health workers, researchers, citizens, and the new government

administration needs to work with each other with renewed commitment to the progressive realization of the right to health for all citizens. More focus on health promotion and training and development of human capital within health are key for improved national health status. Leadership and stewardship on the national, provincial, and district levels are crucial solutions for a better health system. Intersectoral collaboration is also key to the achievement for health for all in South Africa. In closing the 13th International AIDS Conference, the former President of the Republic of South Africa, Nelson Rholihlahla Mandela, stated:

"In the face of the grave threat posed by HIV/Aids, we have to rise above our differences and combine our efforts to save our people. The challenge is to move from rhetoric to action, and action at an unprecedented intensity and scale. There is a need for us to focus on what we know works" (South Africa, 2000).

The findings of this study will be used to make evidence-based improvements in the provision, content and the facilitation of the MK training programme.

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Annexure A

Letter granting permission to conduct research

SOUTH AFRICAN MEDICAL RESEARCH COUNCIL

South African Aids Vaccine Initiative

SAAVI SOUTH AFRICAN AIDS VACCINE INITIATIVE

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29 August 2011

To Whom it may concern

Dear Sir/Madam

PERMISSION GRANTED FOR RESEARCH TO BE CONDUCTED BY DUMISANI SOSIBO

This serves to confirm permission for Mr Dumisani Sosibo an employee [Community Educator] at the South African AIDS Vaccine Initiative [SAAVI], Masikhulisane the Community Involvement Programme of SAAVI, at the Medical Research Council.

The permission granted is to allow Mr Sosibo to conduct research through the Research Title: " The **perceptions of community health workers on the training services offered by SAAVI Maskhulisane in three Durban Townships";** in furthering his studies towards achievement of the degree: Masters in Public Management, at the Durban University of Technology.

We wish Mr Sosibo well in the pursuance of his Masters Degree.

Kind regards.

E. H. Levendal

Elise Levendal
Interim Director: SAAVI
021 938 0552
082 454 4901

SAAVI is supported by:

Department of Health

Cooperazione Italiana allo Sviluppo
Ministero Affari Esteri

Istituto Superiore di Sanità

Annexure B

Letter to the respondents (English)

02 September2011

Dear Participant

I, Dumisani Patrick Sosibo, am currently studying for a Masters Degree in Public Management and undertaking a research project that investigates the "***Community Health Workers' Perceptions on the Training Services Offered By Masikhulisane"***. A case study will be pursued on the above topic in Inanda, Ntuzuma and KwaMashu.

The aim of the study is to investigate the impact of the training services offered by Masikhulisane on the community health workers in the INK area. Your contribution to this study is extremely important to ensure the success of the project.

I kindly request your assistance in completing the attached questionnaire. The questionnaire has been structured in such a way that it facilitates quick and easy completion. Your task is to work through the questionnaire as quickly as you can, and answer the questions as accurately and honestly as possible. It should take approximately 40 minutes to complete the questionnaire. Full details are provided on how to complete the questionnaire.

The questionnaire consists of the following sections:

- Section 1 – Demographic information
- Section 2 – Provision of MK training programme
- Section 3- Content of the MK training programme
- Section 4 – Facilitation of the MK training programme
- Section 5 – Impact of the MK training programme

Instructions on how to complete the questionnaire;

Read all questions thoroughly and answer all the questions

- Read all the instructions on how to answer each question carefully
- Use a black pen
- Do not ask for help from other participants
- Indicate the extent to which you agree or disagree with the statements by putting an X in the appropriate column shown below the statement.

_____

Student: Dumisani Patrick Sosibo

_____

Supervisor: Prof N. Dorasamy

_____

Co-supervisor: Dr R. Rampersad

Annexure C

Letter to the respondents (IsiZulu)

02 September 2011

Kozibandakanyawo

Mina ngingu Dumisani P. Sosibo, ngingumfundi owenza izifundo zeMasters Degree in Public Management esikhungweni sezemfundo ephakeme iDurban University of Technology. Ngenza ucwaningo olumayelana nokuhlola ***Izinvo zonompilo mayelana ngoqeqesho Olunikezelwa uMasikhulisane*.** Ucwaningo kulesihloko luyoqhutshwa endaweni yaseNanda, Ntuzuma kanye naKwaMashu.

Inhloso yalolucwaningo ukuhlola umthelela woqeqesho olunikezelwa uMasikhulisane konompilo kwaINK. Ukunikela kwakho kulolucwaningo kubalulekile empumelelweni yalomsebenzi.
Nginxusa usizo lwakho ekuphenduleni imibuzo esephepheni elihambisana nalencwadi. Imibuzo ihlelwe ngendlela eyenza kubalula ukuyiphendula. Owakho umsebenzi ukuphendula imibuzo ngokushehsa ngendlela ongazama ngayo, nokuphendula imibuzo ngendlela nangokuthembeka. Kungakuthatha imizuzu engu 40 ukphendula imibuzo. Imininingwane egcwele inikiwe ephepheni lemibuzo.

Iphepha lemibuzo linalezigaba ezilandelayo:

- Isigaba 1 – Ulwazi mayelana nokwakheka konompilo
- Isigaba 2 – Ukunikezelwa koqeqesho luka MK
- Isigaba 3 – Okuqukethwe uqeqesho luka MK
- Isigaba 4 – Ukunikezelwa koqeqesho luka MK
- Isigaba 5 – Umthelela woqeqesho luka MK

Imiyalelo yokuphendula imibuzo

- Fundisisa bese uphendula yonke imibuszo
- Funda yonke imiyalelo yokuphendula imibuzo bese uphendula imibuzo ngokuqikelela
- Sebenzisa ipeni elimnyama
- Ungaluceli usizo komunye eceleni kwakho
- Bonisa indlela ophikisana noma ovumelana ngayo nezitatimende ngokubeka uphawu luka X esikhaleni esifanele esibekiwe ngezansi kwesitatimende.

Student: Dumisani Sosibo

Supervisor: Prof N. Dorasamy

Co-supervisor: Dr R. Rampersad

Annexure D

Questionnaire

Research Questions

Imibuzo Yocwaningo

Section A

Isigaba A

Demographic information

Ulwazi Mayelana nokwakheka konompilo

Please complete the table below by putting an X in the space next to the relevant box.

Gcwalisa ngokubeka uphawu X esikhaleni esiseceleni kwebhokisi eliqondene.

Gender		**1st Language**		**Age Group**		**Education**		**Period of Service**	
Male		IsiZulu		Below 16 yrs		Some Primary school		1 – 2 yrs	
Female		IsiXhosa		16 – 25 yrs		Primary school completed		2 – 3 yrs	
		Sesotho		26 – 29 yrs		Some high school		3 – 4 yrs	
		English		30 – 39 yrs		High school completed		4 – 5 yrs	
		Afrikaans		40 – 49 yrs				5 – 6 yrs	
		Other		50 yrs & above				6 - 7 yrs	
								7 & above	

Section B

Isigaba B

Provision of the MK training programme

Ukunikezelwa koqeqesho luka MK

Please indicate the extent to which you agree or disagree with statement by placing an X in the space provided below the statement.

Khombisa indlela ovumelana ngayo nesitatimemnde ngokubeka uphawu luka X esikhaleni esibekiwe ngezansi kwesitatimende.

1. The purpose of the training offered by Masikhulisane was clearly stated.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

Inhloso yoqeqesho yabekwa ngokucacile

Ngiyaphikisana okwempela	Ngiyaphikisana	Ngiphakathi nendawo	Ngiyavumelana	Ngivumelana okwempela

2. The information provided during the training is necessary for us as community health workers as well as the community we work in.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

Ulwazi olwanikezwa oqeqeshweni lubalulekile kuthina njengonompilo kanye nasemiphakathini esisebenza kuwo.

Ngiyaphikisana okwempela	Ngiyaphikisana	Ngiphakathi nendawo	Ngiyavumelana	Ngivumelana okwempela

3. It is important for me to be fully trained on health research, HIV/AIDS, HIV vaccines and microbicides for me to assist others.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

Kubalulekile kimina ukuba ngiqeqesheke ngokugcwele mayelana nocwaningo lwezempilo, igciwane lesandulela nesandulela ngculazi, umgomo wesandulela ngculazi kanye nemicrobicide ukuze ngikwazi ukusiza abanye.

Ngiyaphikisana Okwempela	Ngiyaphikisana	Ngiphakathi nendawo	Ngiyavumelana	Ngivumelana okwempela

4. Training provided by MK provides opportunities for addressing the needs of community health workers.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

Uqeqesho olunikelwa uMK lunikeza ithuba lokubhekana nezidingo zonompilo.

Ngiyaphikisana Okwempela	Ngiyaphikisana	Ngiphakathi nendawo	Ngiyavumelana	Ngivumelana okwempela

5. I feel empowered after attending the training offered by MK.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

Ngizizwa ngingothuthukile emuva kokuya oqeqeshweni lukaMK.

Ngiyaphikisana okwempela	Ngiyaphikisana	Ngiphakathi nendawo	Ngiyavumelana	Ngivumelana okwempela

6. During the training I acquired skills that have enabled me to share up to date information on vaccines and microbicides with patients and community members.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

Ngesikhathi soqeqesho ngathola ikhono_elangenza ngakwazi ukwabelana neziguli zami kanye nomphakathi ngolwazi olusha olumayelana nemigomo kanye nemicrobicide igel

Ngiyaphikisana okwempela	Ngiyaphikisana	Ngiphakathi nendawo	Ngiyavumelana	Ngivumelana okwempela

Section C

Isigaba C

Content of the MK training programme

Okuqukethwe uqeqesho lukaMK

7. The learning outcomes were clearly stated at the beginning of the training.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

Imiphumela eqondiwe ngoqeqesho yabekwa yacaca ekuqaleni koqeqesho.

Ngiyaphikisana okwempela	Ngiyaphikisana	Ngiphakathi nendawo	Ngiyavumelana	Ngivumelana okwempela

8. Health research related information on HIV/AIDS, HIV vaccines and microbicides is relevant to us as community health workers.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

Ulwazi locwaningo lwezempilo olumayelana negciwane lesandulela kanye nengculazi, umgomo wesandulela kanye nemicrobicide igel luyadingeka kuthina njengonompilo.

Ngiyaphikisana okwempela	Ngiyaphikisana	Ngiphakathi nendawo	Ngiyavumelana	Ngivumelana okwempela

9. New and up to date information on HIV/AIDS, HIV vaccines and microbicides was presented during the training.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

Ulwazi olusha mayelana nemigomo, igciwane lesandulela ngculazi kanye nengculazi, nemicrobicide igel lwanikezelwa oqeqeshweni.

Ngiyaphikisana okwempela	Ngiyaphikisana	Ngiphakathi nendawo	Ngiyavumelana	Ngivumelana okwempela

10. The information was easy to understand and allowed me to follow during the training.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

Ulwazi olwanikezwa oqeqeshweni kwakulula ukuluqonda okwenza kwabalula_ukulandela ngesikhathi kuqeqeshwa.

Ngiyaphikisana okwempela	Ngiyaphikisana	Ngiphakathi nendawo	Ngiyavumelana	Ngivumelana okwempela
			Ngiyavumelana	

Section D

Isigaba D

Facilitation of the MK training programme.

Ukwenziwa koqeqesho luka MK.

11. Masikhulisane facilitators are always available for us when we need refresher training courses.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

Abenzi boqeqesho bayatholakala uma sidinga_ ukuqeqeshwa kabusha.

Ngiyaphikisana okwempela	Ngiyaphikisana	Ngiphakathi nendawo	Ngiyavumelana	Ngivumelana okwempela

12. The facilitator was well prepared for the training.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

Umenzi woqeqesho wayezilungiselele kahle ukwenza uqeqesho.

Ngiyaphikisana okwempela	Ngiyaphikisana	Ngiphakathi nendawo	Ngiyavumelana	Ngivumelana okwempela

13. The training methods were interactive.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

Izindlela ezazisetshenziswa uma kuqeqeshwa zazisibandakanya

Ngiyaphikisana okwempela	Ngiyaphikisana	Ngiphakathi nendawo	Ngiyavumelana	Ngivumelana okwempela

14. At the end of the training, an evaluation was conducted to gauge participants' understanding of research related information has increased.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

Ekupheleni koqeqesho kwanikezwa isivivinyo ukuhlola ukuthi ulwazi mayelana nocwaningo lwabazimbandakanye oqeqeshweni lwandile yini.

Ngiyaphikisana okwempela	Ngiyaphikisana	Ngiphakathi nendawo	Ngiyavumelana	Ngivumelana okwempela

15. Adequate time was given for the training.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

Kwanikezwa isikhathi esanele ukuqeqesha.

Ngiyaphikisana okwempela	Ngiyaphikisana	Ngiphakathi nendawo	Ngiyavumelana	Ngivumelana okwempela

16. The facilitator's instructions were clear, simple and well explained.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

Imiyalelo yomenzi woqeqesho yayicacile, ilula ichazwe kahle.

Ngiyaphikisana okwempela	Ngiyaphikisana	Ngiphakathi nendawo	Ngiyavumelana	Ngivumelana okwempela

17. The facilitators used participants' existing knowledge and experience during the training.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

Abenzi boqeqesho basebenzisa ulwazi abavele benalo labo abazibandakanye oqeqeshweni.

Ngiyaphikisana okwempela	Ngiyaphikisana	Ngiphakathi nendawo	Ngiyavumelana	Ngivumelana okwempela

18. The facilitators used different facilitation methods to ensure that learning was effective.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

Abaqeqeshi basebenzisa izindlela eziningi zokwenza uqeqesho ukuqinisekisa ukuthi abazibandakanye oqeqeshweni bafundile kahle futhi bazwisisile.

Ngiyaphikisana okwempela	Ngiyaphikisana	Ngiphakathi nendawo	Ngiyavumelana	Ngivumelana okwempela

19. There are support mechanisms for participants after attending the training offered by MK.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

Zikhona izinhlelo zokulekelela labo ababezibandakanye oqeqeshweni olunikezelwa uMK.

Ngiyaphikisana okwempela	Ngiyaphikisana	Ngiphakathi nendawo	Ngiyavumelana	Ngivumelana okwempela

20. The following statements best suit the facilitator.
Lezitatimende ezilandelayo zihambelana ngokugcwele nomenzi woqeqesho.

a. The facilitator was approachable.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

Bekufinyeleleka kumqeqeshi.

Ngiyaphikisana okwempela	Ngiyaphikisana	Ngiphakathi nendawo	Ngiyavumelana	Ngivumelana okwempela

b. The facilitator presented new information that was not easily available.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

Umqeqeshi unikezele ngolwazi olusha obekungelula ukuluthola.

Ngiyaphikisana okwempela	Ngiyaphikisana	Ngiphakathi nendawo	Ngiyavumelana	Ngivumelana okwempela

Section E

Isigaba E

Impact of the MK training programme

Umthelela woqeqesho luka MK

21. Explain the impact you think the training provided by Masikhulisane has had on you and your work.

Chaza ngomthelela ocabanga ukuthi uqeqesho luka MK lube nawo kuwe nasemsebenzini wakho.

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22. Identify situations in which you will be able to use the information gained during the training.

Yisho_izimo lapho uyokwazi ukusebenzisa ulwazi oluthole oqeqeshweni.

---

23. What further training opportunities do you think are needed?

Imaphi amathuba oqeqesho oluyaphambili ocabanga ukuthi ayadingeka?

---

24. What do you think should be included in the training programme?

Yikuphi okunye ocabanga ukuthi kungafakwa oqeqeshweni?

---

25. General Comments.

Ukuphawula

Thank you

Siyabonga

ENJOY THE REST OF YOUR DAY

ULUJABULELE USUKU LWAKHO