EXPERIENCES OF COMMUNITY CARE GIVERS CARING FOR CLIENTS SUFFERING FROM TUBERCULOSIS IN ETHEKWINI DISTRICT, KWAZULU-NATAL

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Declaration

This is to certify that the work is entirely my own and not of any other person, unless explicitly acknowledged (including citation of published and unpublished sources). The work has not previously been submitted in any form to the Durban University of Technology or to any other institution for assessment or for any other purpose.

_____ _____

Signature of student Date

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Abstract

Introduction

Tuberculosis is still a leading cause of deaths in low and middle income countries especially those of Sub-Saharan Africa. The successful implementation of strategies to improve TB outcomes remains critical for South Africa as the country is faced with the burden of many TB related deaths. South Africa has included TB management as a priority programme for the country in its strategies to the achieve millennium development goals. The National Department of Health introduced the CCG programme to assist professional health workers in the control and management of various health conditions including TB. The competent management of the CCGs is central to meeting service delivery objectives.

Aim of the study

The aim of the study was to explore and describe the experiences of community care givers caring for TB clients.

Methodology

A qualitative, exploratory, descriptive design was used to conduct the study. Purposive sampling was used to recruit 24 community care givers that were employed by Department of Health receiving a stipend and had been working as community care givers for at least two years. Data was collected using semi structured interviews and was subsequently analysed using Tesch's method of data analysis

Results

The themes that emerged from the interviews included: accessibility of kits and protective clothing to the CCGs, their safety and security, training and development,

including financing of the CCG programme. The following sub-themes emerged as part of the themes: Insufficient supply of kits, alternative means of making kits available to the CCG's, promotion and supply of uniforms for the CCGs, procurement and supply of protective clothing, alternative ways of getting protective clothes, vaccination against communicable diseases, safety allowance, transparency on criteria for further training and development, age limits regarding the selection of the CCGs, lack of career pathing, stipend received by the CCGs and employment benefits for the CCGs.

Recommendations

Recommendations were made with regards to institutional management and practice, policy development and implementation, and further research. These included establishing processes for: supply of kits, protective clothes and vaccines, pre and periodical medicals, criteria for further training and development, and issuing of stipend. A broader study involving all the CCGs affiliated to all PHC clinics in eThekwini district on the required support and supervision was also recommended.

Dedication

I dedicate this dissertation to:

- My one and only late son Lungelo who left me so early in life;
- My family, especially my four brothers Thoshi, Bonginkosi, Gcina and Thokozani who have been the pillars of my life;
- My six sisters, for their continued emotional, psychological and physical support and
- Most importantly, my loving parents who taught me how to love and respect others.

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Glossary of terms

Tuberculosis: a communicable bacterial disease caused mainly by the *Mycobacterium tuberculosis*, also known as tubercle bacilli or as Acid-Fast Bacilli (AFB), which affects primarily the lungs. AFB may also affect other body organs as extra pulmonary TB (Norgle, Smit and du Toit 2011: 69).

Directly Observed Treatment Support: a programme in which a trained person (family member, CCG, or community member) watches the client swallowing the tablets to ensure that the client takes the right drugs at the right time and for the appropriate duration (Department of Health 2009a: 46).

Community Care Giver: any health worker who performs functions related to health care delivery who is trained in the context of the intervention but has no formal professional certificate or tertiary education (Lewin et al. 2006: 8).

Clinic: a primary health care clinic, community health centre or hospital that provides services to TB or HIV positive clients.

Decentralised care: the care that is moved from a health care clinic into the homes and community.

Primary carers: the main care givers, usually family or community members.

Re-engineering of PHC: an initiative of the Department of Health to address the primary health care needs in the community. A population based approach for delivery of PHC outreach services to the uninsured population of South Africa (Department of Health 2011: 14).

Stipend: the money paid in place of a salary for services in the care giver setting and is often below a living wage.

Treatment supporter: a person nominated by the health worker and the client, who watches the client take his/her medication. His/ her main role is to ensure that

the TB client takes the drugs regularly, while listening and encouraging the client as part of his/her role (Norgle, Smit and du Toit 2011: 69).

Multi-Drug Resistant TB: TB disease caused by strains of *Mycobacterium tuberculosis* that are resistant to both Rifampicin and Isoniazid, with or without resistance to other drugs. MDR-TB is a human-made problem/human error (Department of Health 2009a: 80).

List of Acronyms

Acronym	Full term
AIDS	Acquired immune deficiency syndrome
CCGs	Community Care Givers
CHC	Community Health Centre
DHS	District Health System
DOTS	Directly Observed Treatment Support
EPWP	Expanded Public Works Programme
HIV	Human immunodeficiency virus
KZN	KwaZulu-Natal
MDG	Millennium development goals
MDR	Multi-Drug Resistant
NGO	Non-Governmental Organisation
NHI	National Health Insurance
NPO	Non-Profit Organisation
PHC	Primary Health Care
TB	Tuberculosis
WHO	World Health Organisation
XDR	Extreme-Drug Resistant

CHAPTER 1

OVERVIEW OF THE STUDY

1.1 INTRODUCTION AND BACKGROUND

Tuberculosis (TB) is still a leading cause of deaths in low income and middle income countries especially those of Sub-Saharan Africa, where TB is an epidemic because of the increase susceptibility conferred by HIV infection (Department of Health 2009a: 9). Approximately 70% of adult new cases of TB in South Africa are co-infected with human immunodeficiency virus (HIV). TB is the commonest cause of morbidity and mortality among HIV infected people in South Africa, and it also accelerates HIV disease progression (Department of Health 2010: 2). South Africa is one of 22 high burden countries that contribute about 80% of the total global burden of all TB cases. The World Health Organisation (WHO) has ranked South Africa as the third highest TB burden country (WHO 2010: 39). TB treatment default rates remain high at above 5% of the national target, creating a barrier to achieving the targets for treatment success and cure rates of 85%, thus creating the potential for drug resistant TB (Department of Health 2007-2011: 5).

In 2005 the then Minister of Health, Manto Tshabalala-Msimang, declared TB to be a national crisis and a TB Crisis Management Plan was developed. This plan focused on four health districts with the highest disease burden and poor treatment outcomes, eThekwini District being one of them (Department of Health 2007-2011: 6). In 2006, KwaZulu-Natal (KZN) had the highest total TB caseload accounting for 31% of all TB cases nationally (Department of Health 2009a: 8). The aim of the National TB Crisis Management Plan was to address the four districts with the highest TB burden and to strengthen service delivery systems and processes at community level and community participation so as to increase awareness (Department of Health 2007-2011: 18). TB is curable if

clients take a complete and uninterrupted course of appropriate drug therapy (Department of Health 2009a: 45). Treatment interruption presents a problem for clients, their families and the community, and for the health personnel caring for them. One of the consequences of inadequate and incomplete treatment is the development of Multi-Drug (MDR) or Extreme-Drug Resistant (XDR) TB (Department of Health 2009a: 45).

The National Department of Health introduced the CCG programme to assist professional health workers in the control and management of various health conditions including TB. There are CCGs that get a stipend from the Department of Health and those that work on voluntary basis. The CCGs who obtain the stipend from the Department of Health include those who are affiliated to eThekwini Municipality.

The Directly Observed Treatment Support (DOTS) strategy was adopted by the World Health Organization (WHO) in 1991. According to Norgle, Smit and du Toit (2011: 69) this strategy includes the four key pillars, namely: detection of smear-positive Pulmonary TB in patients using sputum microscopy; directly observed treatment with short course chemotherapy; guaranteed continuous drug supply, and; a case record system. The DOTS strategy is an important element in the WHO recommended policy package for TB control (Department Health 2009a: 46). According to DOTS strategy, a patient is given treatment at home or at the work place on daily basis. One of the aims of the TB programme is to organize TB services so that the patient has treatment as close to home or work as possible. Community DOTS can contribute substantially to any local TB programme because it is more accessible and convenient to clients. The treatment supporter can be an existing CCG trained to provide DOTS (Department of Health 2009a: 47). The CCGs also assist with conveying health information to the community on TB prevention, identifying and referring suspected cases for screening, tracing treatment defaulters and supporting those on TB treatment.

The successful implementation of strategies to improve TB outcomes remains critical for South Africa as the country is faced with the burden of many TB related deaths. South Africa has included TB management as a priority programme for the country in its strategies to the achieve millennium development goals (MDGs) by 2015 (Department of Health 2012: 83). The competent management of CCGs is central to meeting service delivery objectives. CCGs' support elements should include balanced workloads, supervision, community awareness about their existence, their activities and roles as well as assisting them to deal with the emotionally taxing environments in which they may be performing their duties (Department of Health 2009b: 55). The researcher conducted a qualitative study to explore the experiences of CCGs caring for clients on TB treatment in eThekwini district KZN.

1.2 PROBLEM STATEMENT

Tuberculosis (TB) is still a leading cause of deaths in South Africa. The government of South Africa's guidelines on the management of TB included amongst the strategies to strengthen TB management; free TB treatment, DOTS strategy and the introduction of the CCGs (Department of Health 2009:11-14). Despite the availability of free TB drugs, DOTS strategy and the CCGs programme, South Africa has not been able to achieve the national targets which are TB case detection rate of 70%, cure rate of 85%, TB treatment success rate of more than 85% and the default rate of less than 5% (Department of Health 2007-2011: 20). There is robust evidence that CCGs can undertake actions that lead to improved health outcomes, especially in the field of TB management. For CCGs to be able to make an effective contribution, they must be carefully selected, appropriately trained and continuously supported (Lehmann and Sanders 2007: 26). Although South Africa already has about 72 000 CCGs, health outcomes are still sub-optimal especially in the areas of maternal, child health and TB programmes (Department of Health 2011: 3). This may be attributed to inadequate support and supervision, random distribution with poor coverage, no community links with community

based services or services offered by PHC clinics or no targets for coverage to be reached (Department of Health 2011: 3).

1.3 PURPOSE OF THE STUDY

The purpose of the study was to explore and describe the experiences of community care givers caring for TB clients.

1.4 RESEARCH QUESTIONS

1.4.1 Main question

- What were the experiences of CCGs who are caring for TB clients in the community in eThekwini District?

1.4.2 Sub-questions

- How did the experiences of the CCGs influence the management of the TB clients?
- What were the challenges that were being experienced by the CCGs in caring for TB clients in the communities?

1.5 SIGNIFICANCE OF THE STUDY

The results of this study provide evidence-based information on experiences of CCGs caring for clients on TB treatment in their communities and contribute to the existing body of knowledge about the functioning of the CCGs in eThekwini district. The findings assisted the researcher in structuring the recommendations regarding how the functioning of the CCGs could be strengthened and/or improved in order to promote good quality service by this group of health care workers. This could be one of the strategies to facilitate the success of the TB programme in eThekwini district which could also be adopted

by other districts, provinces or countries in a similar situation as eThekwini district. The findings of the study will also be used by other researchers to build on their body of knowledge.

1.6 OUTLINE OF THE DISSERTATION

Chapter 1: Introduction and background to the study.

Chapter 2: Literature review.

Chapter 3: Research methodology.

Chapter 4: Presentation of the results.

Chapter 5: Discussion of results, conclusion, limitations of the study and recommendations.

1.7 CONCLUSION

Management, support and supervision are the key elements which make or break the CCGs programme. CCGs are not a cheap alternative form of PHC labour, but are an integral part of the District Health System (DHS) needed if the goal of health for all is to be achieved. CCG programmes are vulnerable unless they are driven, owned by and firmly embedded in communities themselves. CCGs represent an important health resource whose potential in providing and extending a reasonable level of health care to underserved populations must be fully tapped. This chapter outlined the introduction and background to the study, the problem statement, the purpose, objectives and significance of the study. The structure of the dissertation was also explained. The following chapter focuses on previous studies conducted and available literature on the CCGs, DOTS and TB in order to gain a broader perspective on the topic under study.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter will present the thoughts, views, assumptions and investigations made by various researchers and authors on the work, experiences and the importance of CCGs on health outcome indicators. Literature search was conducted over a period of 12 months, using different scholarly search engines such as PubMed, Cinahl, Summons and Google scholar. The search strategy included using obvious key words related to CCGs, TB management, directly observed treatment strategy, TB treatment success. The World Wide Web including search engines such as Google Scholar was also searched for similar key words which allowed access into a number of scholarly articles. The reference lists of key articles were scrutinized and this identified other relevant articles. In order to provide a complete an overview of available knowledge and resources, peer reviewed and non-peer reviewed journals; materials on the World Wide Web were used. Government policies, guidelines and strategic plans were also reviewed as hard copies and/or electronic documents from the Department of Health web site

2.2 GLOBAL CONTEXT ON THE USE OF CCGs IN TB MANAGEMENT

Estimates are that one third of the global population is infected with TB, and, as a result, at risk of developing active TB. Each year more than eight million people develop TB, and about 1.9 million people die of TB every year (Miller 2007: 11). The shortage of well-trained professional health workers is global, but low and middle-income countries where HIV/AIDS and TB are taking the greatest toll, feel the crisis most acutely. Urgent and drastic action must be taken to tackle the human resource crisis in the face of the epidemic (WHO 2007a: 1). 'Task Shifting' was adopted by the WHO as a means to solve the human resource crisis. Task

shifting is the name given to a process of delegation whereby tasks are moved, where appropriate, to less specialised health workers thereby making more efficient use of the human resources currently available. CCGs can potentially deliver a wide range of HIV/TB services, thus freeing the time of qualified professionals (WHO 2007a: 3).

According to the WHO (1989: 6) CCGs should be members of the communities where they work, selected by the communities, be answerable to the communities for their activities and be supported by the health system but not necessarily a part of its organisation and have a shorter training than professional health workers. The CCG programme originally gained global support at the 1978 Alma Ata conference on PHC, as it was seen as a vital element of the strategy to achieve the WHO's goal, set in 1975, of 'Health for All by the year 2000' (WHO 1978: 5). Many CCG programmes began to emerge in many countries in the developing regions of the world, including South Africa.

In Ethiopia, an estimated 20% of the time of the limited number of professional health workers available is currently spent on counselling and taking blood specimens on people living with HIV/AIDS. Task shifting allows CCGs to perform these tasks and free up that 20% of country's professional health workers for clinical care. This process expands the human resource pool very rapidly and has the added advantage of building bridges between the health clinic and the community (WHO 2007b: 4). In Uganda, task shifting is already the basis for providing HIV/AIDS and TB treatment. Uganda's professional health workers are undertaking a range of tasks that were formerly the responsibility of doctors. In turn, tasks that were conducted by professional health workers have been shifted to CCGs who have training, but not professional qualifications. As a result, Uganda has expanded its human resources for delivering HIV/AIDS and TB services by creating a range of non-professional types of health care workers (WHO 2007b: 5). As Ministries of Health and global stake holders have strengthened health systems toward attaining MDGs 4, 5 and 6, they have seen a

growing role for CCGs. Particularly in low resource environments, remunerated (stipend) and volunteer CCGs possessing basic primary service skills have widened access and filled critical care gaps, enabling progress in a wide range of health outcomes.

As countries continue to strengthen their health systems and develop their health workforce to reach beyond the MDGs toward improving quality of care and the scope of access to services, the cadre of CCGs becomes very important (Foster, Tulenko and Broughton 2013: 3). Evidence has shown that engaging CCGs not only promotes better health but saves lives, particularly in the most remote areas. Foster, Tulenko, and Broughton (2013: 3) state that strengthening the capacities of the CCGs and continuing to harmonise and integrate individual CCG programmes across service areas, and within the community and formal health systems will move countries closer to achieving quality health systems that are available, accessible and acceptable. However, despite the growing role of the CCGs, improvements are needed in the process for developing and managing CCG programmes. These authors further argue that although many CCGs are volunteers or receive minimum stipends for their contribution, certain CCG roles have evolved in such a way that formal recognition within the country's health systems would be more appropriate.

Foster, Tulenko and Broughton (2013: 3) suggest that since the CCGs provide important services in delivering health promotion, disease prevention and even curative services, recognising this role as an institutionalised component of the PHC system will be an added advantage. Countries such as Ethiopia, Ghana and Brazil with growing economies and strong governance system have transitioned their CCGs to become permanent members of the formal health team, and are continuing to scale up the numbers and expand the CCGs' scope of practice. This evolution contributes to the strengthening of primary care systems so that they can be more accessible and responsive to a wider range of the population (Foster, Tulenko and Broughton 2013: 4). To align actions with the shared understanding

that CCGs provide a necessary level of extended primary care and public health outreach, both nation states and the broader global community are strongly encouraged to make defined commitments, and take measurable steps to fulfil them. CCGs have become a permanent part of national efforts to reach the MDGs to extend access to basic primary care services and move toward long-term universal coverage of equitable and quality care. Although they are an integral part of the health system, the CCGs have remained informal and unrecognised health providers, with varying levels of training, responsibility and compensation from country to country (Foster, Tulenko and Broughton 2013: 8). The authors conclude that CCGs should be recognised, integrated and supported by international health systems in collaboration with informal community systems so that they contribute optimally to national universal health coverage. Miller (2007: 88), in his study conducted on the perceptions and beliefs of CCGs about TB clients in Auckland, concluded that CCGs are frequently placed in stressful situations and become very involved with family dynamics. He further suggested that they should attend counselling skills programmes to enable them to manage the complex issues they encounter when working with clients.

2.3 INVOLVEMENT OF THE CCGs IN THE MANAGEMENT OF TB IN AFRICAN COUNTRIES

The use of CCGs has been identified as a strategy to address the growing shortage of professional health workers in Africa and worldwide. Brenner et al. (2011: 7) studied the impact of CCGs on child morbidity and the mortality rate in Uganda, and argue that community-based intervention using CCGs to promote health for children under five years has successfully improved child health outcomes and decreased mortality. Factors that promoted success of CCG programmes may have included: attention to local needs and priorities, alignment with local health systems, an established and consistent selection process, training and regular supervision of CCGs. Bello (2010: 6) in a study conducted in Nigeria on challenges of DOTS implementation strategy in the TB treatment concluded that for effective DOTS implementation strategy to

eliminate TB worldwide there is a dire need for a holistic approach reaching all clients with high quality care. Making services available and accessible to all those who need them even in the remotest areas including the poorest and most vulnerable to the disease could enhance effective implementation of DOTS strategy. This could be achieved through the effective use of CCGs. Despite the fact that DOTS short course has recorded significant improvement in the TB disease detection, treatment and control in Nigeria, neither the set target for the TB detection rate nor the cure rate has yet been achieved nationwide.

2.4 INVOLVEMENT OF THE CCGs IN THE MANAGEMENT OF TB IN SOUTH AFRICA

In South Africa, public health services are decentralised from national and provincial levels to district levels. The planning, administration and implementation of health functions are executed at district level. The PHC approach was adopted in South Africa about two decades ago, as an ideal vehicle for the delivery of equitable and quality health care to its population; however, the country continues to perform poorly in health outcomes. (Ogunmefun et al. 2011:14). TB services are integrated with primary health care, resulting in an increase in the overall number of health workers whose mandate includes TB control. The factors contributing to poor outcomes include the combined burden of diseases such as HIV/AIDS and TB and the lack of human resources for the health. Many CCG programmes began to emerge in many countries in the developing regions of the world including South Africa. In the late 1970s and 1980s, various forms of CCG cadres were introduced into health programmes in the communities around South Africa (Ogunmefun et al. 2011: 14).

South Africa is one of the countries where there is a lack of human resource for the health crisis, as there is a shortage of capable and motivated health

professionals due to factors such as high rate of emigration, impact of HIV/AIDS and TB epidemic, high burden of disease and poor funding of the health sector (Ogunmefun et al. 2011: 14). In addition, South Africa continues to be plagued with poor health outcome indicators especially in maternal and child health indicators in comparison with other middle-income countries such as Brazil and Chile (Ogunmefun et al. 2011: 14). As a result of the need to address these factors, there has been a recent shift towards the re-engineering of PHC in South Africa through the provision of community based PHC services by the CCGs to improve the PHC outreach service to the uninsured 84% of the South African population. The guidelines further state that the PHC re-engineering model should include CCGs as part of the formal structure of the health service (Department of Health 2011: 14). Such teams would be composed of one professional health worker as a team leader, health promoter, environmental health officer and six CCGs depending on the size of the population to be served. Included in the roles of the CCGs are: household profiling, health promotion and prevention, performance of basic first aid and provision of health related information. Although there are 72 000 CCGs in South Africa, the country has not managed to generate better health outcomes (Department of Health 2011: 19).

The lack of improved health outcomes could be as a result of several CCG related factors such as: inadequate training, support and supervision; random distribution with poor coverage; no link between the community based services and services offered by fixed health clinics, and; limited or no targets for either coverage or quality to be achieved (Lehman and Sanders 2007: 27). Lehmann and Matwa (2008: 16) state that due to the lack of formal instructions, training and related resources to undertake the responsibility, there is inadequate professional supervision of the CCGs by professional health workers. PHC re-engineering should include CCGs as team members because the above factors can be corrected if CCGs are 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 they are to serve (Department of Health 2011: 3).

The use of CCGs has been identified as one strategy to address the growing shortage of professional health workers, especially in low-income countries (Lehmann and Sanders 2007: v). This initiative would not only be a step towards improving health outcomes, but also achieving MDGs by 2015. Lehmann and Sanders (2007: v) define CCGs as health aides selected, trained, and working in the communities from which they come. It is important for CCGs to respond to local, societal and cultural norms and customs to ensure community acceptance and ownership. There is robust evidence that CCGs can undertake actions that lead to improved health outcomes, especially in the field of TB management.

Although South Africa has a history of people volunteering to help their communities with basic services dating back to the 1950s, the last ten years has seen a greater involvement of individuals and groups supporting government-led programmes (Department of Health 2009b: 10). In part this has been driven by HIV/AIDS and TB which has dramatically impacted on the health and social wellbeing of communities. The impact of HIV/AIDS and TB has meant that there has been a dramatic increase in the number of people requiring care and support. With rising costs of care and hospitals not able to cope with demands for beds, the aim is to decentralise care to the community level, placing the responsibility on the PHC clinics and other stakeholders (Friedman et al. 2007: 167). Ogunmefun et al. (2011: 15) state that by the late 1990s, the impact of the HIV/AIDS and TB epidemic in South Africa began to overwhelm clinic-based health services, as the demand for them started outweighing the supply. Thus home and community-based care provided by the CCGs emerged as a way to provide cost-effective and compassionate care to people affected by the epidemic.

In response to the challenges above, the Department of Health and the Department of Social Development, together with other government departments, increased their support to Non-Profit Organisations (NPOs) as

community partners to address the need for care and support services at a home and community level (Department of Health 2009b:10). The support includes training, management, provision of a stipend and integration of CCGs into social development in line with the 1999 Cabinet mandate, which states that the Departments of Health and Social Development must work closer together and the national rollout of the Expanded Public Works Programme (EPWP) which drove a significant increase in the number of CCGs. The Cabinet mandated the Departments of Health and Social Development to take the lead in the implementation of the CCG programme. The Department of Labour's EPWP is one of the government's short to medium-term programmes aimed at the provision of additional work opportunities coupled with training. EPWP is one of the government's poverty alleviation strategies for the country. The National Department of Health defines CCG in the Community Care Worker Policy Management Framework as any worker or volunteer who delivers services under the auspices of home community-based care and support programmes, both in support of health and social development programmes (Department of Health 2009b: 6).

The term 'community care worker' encompasses and replaces 'community worker' and 'community care giver'. In order to deliver effective PHC services, it is imperative for professional health workers to be well informed about communicable diseases like TB (Van den Berg and Viljoen 1992: ii). They must be able to identify suspected cases, screen, manage and apply control measures. The main role of professional health workers is to prevent and control communicable diseases at primary, secondary and tertiary levels. Treatment of TB is a team effort in which members of the family and the community are involved. Therefore, treatment programmes must be adapted to the needs of the clients, and factors such as distance from the clinic and work place and domestic circumstances must be taken into account. Human, Smith and Tshabalala (2010: 49) in their study on TB clients and compliance conducted at Thembisa in Ekurhuleni, Gauteng, concluded that there are numerous factors to be considered in helping TB clients to complete their

treatment. Therefore, it requires combined efforts of stakeholders such as government, professional health workers, community, clients themselves and CCGs.

In South Africa, public health services are decentralised from national and provincial levels to district levels. The planning, administration and implementation of health functions are executed at district level. TB services are integrated with PHC, resulting in an increase in the number of professional health workers whose mandate includes TB control (Human, Smith and Tshabalala 2010: 49). For many clients, clinic DOTS is inaccessible, inconvenient, and costly and causes loss of income (Department of Health 2009a: 46). According to Van den Berg and Viljoen (1992: 231), the full course of treatment should preferably be taken by the patient under full supervision. The CCG programme was introduced, aiming at helping to trace TB defaulters, household profiling and bringing the report to operation 'Sukuma Sakhe' for resolutions. Dr Aaron Motsoaledi, the Minister of Health in his 2010/2011 Annual Report on the 24 November 2011, said that HIV/AIDS and TB were affecting the life expectancy and maternal and child mortality rates of South Africans in a cruel way, thus creating a crisis. Extraordinary measures were being implemented to combat this crisis, such as implementation of National Health Insurance (NHI), re-engineering of the PHC system and revitalisation of infrastructure through the National Health System's Priorities Ten-Point Plan (2009-2014) which would address the crisis (Department of Health 2012/13-2016/17: 7). The establishment of PHC outreach teams is one of the strategies proposed for the re-engineering of PHC in South Africa. Each team will comprise of an average of one professional nurse and six CCGs (depending on the size of the population). These teams will facilitate community involvement and participation in identifying health threats, vulnerable groups and individuals, and appropriate interventions for addressing these (Department of Health 2011: 15).

As a result of the need to address these factors, there has been a recent shift towards the re-engineering of PHC in South Africa through the provision of community-based PHC services by CCGs. This initiative would not only be a step towards improving health outcomes, but also achieving MDGs by 2015. According to Ogunmefun et al. (2011:16), studies conducted on CCGs in South Africa have shown that they are playing a significant role in the provision of community-based health services in rural, peri-urban and urban communities around South Africa. Even so, there have been some fundamental factors that have led to the failures of the CCG programme. Some of these factors are relating to the lack of proper mechanisms of supervision and support for the CCGs. The Community Care Worker Policy specifies that CCGs should always perform their work under the supervision of an appropriately qualified manager such as a community health worker supervisor (Department of Health 2009:57).

Despite the rights provided for in the Bill of Rights (Right of access to health care services), stigma is still rife within many communities. People living with HIV/AIDS and or TB are often discriminated against and neglected by their families (Department of Health 2007-2011: 167). Thus, in many cases CCGs have become the primary carers, assisting with household chores and even spending their own money to provide food or transport to PHC clinics. The increasing number of children who are orphans as well as those who are HIV positive and TB co-infected has added an extra burden to CCGs (Department of Health 2007-2011: 167).

The CCG programmes in South Africa flourished in the 1980s due to strong support from international donors; however they started floundering from 1994 as a result of lack of support from Department of Health, which indicated its reluctance to support a national CCG programme. In addition many international donors withdrew their support, or redirected their funds through government departments. As a result many CCG programmes in South African provinces collapsed, except for those in KZN because of strong provincial

government support (Department of Health 2009b: 57).

According to Odendaal et al. (2011: 4), establishing and maintaining high morale among CCGs is an important component of ensuring the delivery of quality services, and CCGs are the health care providers with the most intimate knowledge of clients' circumstances and how these impact on treatment and adherence. Provincial guidelines for the implementation of PHC re-engineering highlights that CCGs need to be 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. Lehmann and Sanders (2007: 26) also agreed that for CCGs to be able to make an effective contribution, they must be carefully selected, appropriately trained and continuously supported. CCGs are frontline public health workers who are trusted members of and have unusually close understanding of the community they serve. Such a relationship enables them to serve as a liaison or link between health/social services and the community to facilitate access to services (Department of Health: 2010: 1). Although their roles vary depending on local cultural setting, they mostly work in underprivileged and marginalised communities where people may have limited resources, lack access to quality health care. CCGs play an integral role in helping systems becoming more culturally appropriate and relevant to the people they are to serve.

Odendaal et al. (2011: 4) further argue that the CCGs often become intimately involved in the psycho-social realities of clients and they noted that working with individuals with serious and often stigmatised diseases (TB and HIV/AIDS) is emotionally stressful; therefore, CCG training should include both the bio-medical aspects of TB/HIV/AIDS and psycho-social aspects of living with these diseases. The CCG Policy Framework was launched in 2004 with the vision to formally manage CCGs as valued contributors to the broader delivery of comprehensive health care services as part of the unique partnership between government and non-profit organisations to ensure life for all (Department of

Health 2009b: 18). The policy framework contains service package guidelines for CCGs such as: promotion of adherence to medication, identification of TB defaulters, providing information to people living with person with TB, identification of signs indicative of TB and support the tracing of TB defaulters. The CCGs play a role in supporting home, community based care which goes beyond service delivery to a level of self- empowerment. The CCGs should form part of the service delivery teams within the DHS, promoting PHC and community-based health services' objectives. They should become a formal resource for basic PHC service configurations (Department of Health 2009b: 28). Carers need help and support if they are to continue to carry their roles, and meeting the carer's needs is a complex issue (Ross and Mackenzie 1999: 128-129). People decide to go for testing and counselling, or to seek health/social services, in the context of the community and the household. The community can create an enabling environment that strengthens the capacity of communities to own responses to HIV/AIDS and TB, and promotes and helps people to get into treatment.

2.5 THE CCGs PROGRAMME IN ETHEKWINI DISTRICT

In eThekwini District, each PHC clinic has a group of CCGs affiliated to it depending on the clinic location, because CCGs are supposed to work in the area where they reside. Hermann et al. (2009: 11) state that selection of the CCGs should be based on their motivation to serve the community and belonging to the same community is therefore crucial. Selection and motivation are the essential and basic conditions for all successful CCG programmes. In eThekwini district, CCGs work as a link between the PHC clinics and the communities to enhance service delivery.

2.6 THE SCOPE OF PRACTICE AND TRAINING OF THE CCGs

According to the National Department of Health in South Africa, the scope of practice of the CCGs includes the following:

- Promotion of health and prevention of illness.
- Conducting structured household assessment to identify their health needs.
- Provision of psychosocial support to community members.
- Conduct community assessments and mobilise around community needs, identify and manage minor health problems.
- Support continuum of care through service co-ordination with other relevant service providers and
- Support screening and health promotion programmes in schools and early childhood development centres (Department of Health 2011: 19-20).

The following training is required for the CCGs to be able to fulfil their duties in relation to the scope of practice:

- An introduction to the health care system.
- Functions of the PHC Outreach Team
- Core skills on counselling, interpersonal; communication; psychosocial and ethical codes; record keeping (Department of Health 2011: 27).

2.7 THEORETICAL FOUNDATIONS OF THE STUDY

The researcher chose Avis Donabedian's model as a theoretical framework to guide the study. Donabedian's model known as the 'structure, process and outcome model' provides a framework that guides understanding (Naranjo and Kaimal 2011: 33). Donabedian suggests that these three components (structure, process and outcomes) are interdependent in such a way that their relationships impact the next component either positively or negatively (Donabedian (1969:1833). Naranjo and Kaimal (2011: 33) highlight that this model provides a roadmap to improving quality by illustrating that there must be a focus on structures and processes in order to improve outcomes. The model was intended to evaluate and control the quality of care in organized programs of medical care and to evaluate the medical care process at the level of physician-patient interaction. In the model the structure included the entire environment where care is provided and its characteristics where the processes within the structure will lead to a desired outcome Donabedian (1969:1833). The outcome of medical care according to Donabedian is in terms of recovery, restoration of function and of survival (Donabedian 2005:691). The researcher selected this model and adapted it to guide the study regarding the CCGs where similar to the process of provision of health, the CCGs function within the structure. The characteristics of the environment (the structure) where they work and the various processes will determine or influence the outcome of the CCG programme.

2.7.1 Structure

Structure is the first dimension of Donabedian's model. The primary premise of the structure component is that given the right setting, high-quality care will flourish. The structure or setting of an organisation is multi-faceted. It includes material and human resources, leadership and supervision and safety. In the current study the structure include the clinical setting where the CCGs work which is the community level, the PHC clinic that they are affiliated to the material resources and supplies and the knowledge and skill that they require

to execute their duties. Structure will also include their safety and career pathing.

2.7.2 Process

Process is the second dimension of Donabedian's model and refers to both practice and management processes. Process characteristics are considered more proximal indicators of quality outcomes than structural characteristics because they are the actual activities performed by an organisation (Naranjo and Kaimal 2011: 34). In the current study, processes include training and development such as workshops and seminars, implementation of standardised operating procedures and policies guiding work done by the CCGs and their management, as well as insurance coverage, criteria and procedures determining the selection and training of the CCGs.

2.7.3 Outcomes

Outcome is the final dimension of the conceptual model. This is the explicit result that occurs from the antecedents of structure and process. Outcomes reflect the results of achievements or underachievement (Naranjo and Kaimal 2011: 35). Outcomes can help to identify potential areas of risk, non-compliance to policies, set procedures and criteria. They offer data to managers, enabling them to initiate improvement projects or evidence-based practice. In the current study, outcomes include the ability of the CCGs to execute their duties which was the management of TB clients. Sometimes negative outcomes are achieved as a result of flaws in the structure or the processes.

2.8 CONCLUSION

The PHC package on norms and standards and the 2010 PHC re-engineering strategy emphasize the need for strong collaborations between communities, community-based organisations and health clinics, and other government

departments. The new PHC approach expects that professional health workers work closely with CCGs. This chapter was looking at the thoughts, views, assumptions and studies made by different authors and researchers on the experiences of CCGs and available support systems for them when performing their work. The following chapter focuses on the methodology adopted by the researcher, sampling, data collection and analysis.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter will address methods used in the research design, research setting, sampling process, data collection, data analysis and ethical considerations.

3.2 RESEARCH DESIGN

A qualitative, exploratory, descriptive design was used to conduct this study. Qualitative research studies things in their natural settings, attempting to make sense of or interpret phenomena in terms of the meanings people bring to them (LoBondio-Wood and Haber 2011: 91). Qualitative research is discovery oriented, explanatory and descriptive in nature. The researchers assume that one can only understand things if the context in which they take place is considered (LoBondio-Wood and Haber 2011: 86).

3.2.1 Qualitative design

Bowling (2009: 380) defines qualitative research as social research carried out in the field or natural setting and analysed largely in non-statistical ways. Qualitative researchers often collect data in the field at the site where participants experience the problem under study (Polit and Beck 2012: 221). Hennink, Hutter and Bailey (2011: 9) argue that qualitative researchers study people in their natural settings, to identify how their experiences and behaviour are shaped by the context of their lives, such as the social, economic, cultural or physical context in which they live.

The strength of qualitative research lies in the people being studied in their natural setting, with in-depth data about the phenomenon under study gathered; this enables the researcher to gain better insight into the subjective feelings of the participants. Thus, qualitative researchers study phenomena in their natural settings, attempting to make sense of phenomena in terms of the meanings people bring to them.

3.2.2 Exploratory design

Exploratory design explores the dimensions of a phenomenon in order to better understand the context within which an intervention would unfold. Exploratory design sheds light on the various ways in which a phenomenon is manifested and on underlying processes (Polit and Beck 2012: 640). The researcher intends to use exploratory design to better understand the experiences of the CCGs when performing their duties.

3.2.3 Descriptive design

Descriptive design focuses on portrayal of the characteristics of persons, situations or groups (Polit and Beck, 2012: 725). The purpose of qualitative research is to provide a detailed account of the phenomenon under study in order to understand the meaning of an experience (Burns and Grove 2009: 201). Descriptive research provides an in-depth description of participants' experiences in a narrative type description. This design was chosen for this study because new meaning might be discovered which would describe that which already exists and can form the basis for future research. The researcher was thus able to describe the experiences of the CCGs.

3.3 STUDY SETTING

The study was conducted in eThekwini district. The focus areas were the community areas where the CCGs were working. The CCGs work in the community but they are affiliated to the PHC clinics which are either municipal or provincial for control and management purposes. The areas where the CCGs were allocated to work were within the catchment area for the PHC clinics where they were affiliated. Descriptive qualitative studies are often conducted in natural settings (Burns and Grove 2009: 352). Therefore, eThekwini municipality PHC clinics were used as a natural setting to recruit the CCGs and to conduct the interviews.

EThekwini District is one of the eleven districts of KZN, and is the largest of the eleven districts with the population of approximately 3.5 million (33%) of the total population of KZN. EThekwini district is located on the east coast of the Republic of South Africa, in the province of KZN; its society is so diverse that it faces various social, economic, environmental and governance challenges. The people who reside within the district consist of individuals from different ethnic backgrounds. The majority of the population come from the African community (78%); followed by the Indian community (16.6%), White community (6.6%), Coloureds (2.5%) and other (0.4%) EThekwini Municipality 2013/14 Integrated Development Plan [IDP] Review: 8)

The District is divided into four sub-districts: the South, Central, West and the North sub-districts (Figure 3.1). Central is the urban core of the eThekwini Municipality, and is home to approximately 1.3 million people (34%) of the population of eThekwini. The boundaries of the central sub-district extend from UMngeni River in the north, along the coast through to the Umlaas Canal in the south and extend to the escarpment in the west. The next largest sub-district is the North sub-district at 1.5 million people (31%). North boundaries extend from UMngeni River in the south to Tongaat in the north with the coastline in

the east and ILembe District Municipality to the west and north. The South sub-district has 18% of the population and the Outer West region accommodates the least number of the people (16%). The south and the central sub-districts are functionally integrated for the management, control and delivery of the health care services and are together known as south central sub-district.

The greatest population concentration occurs in the Central and the North regions. The largest population concentrations are found at Inanda/KwaMashu (58%); Phoenix (17.5%) and Durban North (7.1%) (EThekwini Municipality 2013/14 IDP Review: 27). In the West sub-district, a large portion (50%) is covered by traditional authorities and has a major portion of the metropolitan open space system. The population here is highly mobile/migrant because this is a highly industrialised area; it is mixed with formal areas, informal settlements and traditional authorities.

According to census 2011 the majority of the unemployed population were Africans (85%), followed by the Indian (11%), Coloured and White population at 2% each. There is high profile, middle and low class people in the district. This situation creates problems in managing TB effectively in the district. The morbidity and mortality profile of the eThekwini municipality area demonstrates how the challenges of the high HIV/AIDS and TB burden, the increased maternal and child mortality, the escalating lifestyle diseases and the high number of accidents have had an impact on decreasing the life expectancy of the citizens in the metro. The mushrooming of informal settlements results in less desirable living conditions, exposing people to health risks (EThekwini Municipality 2013/14 IDP Review: 16).

In 2009 a total of 43 739 TB clients were registered in the eThekwini district, making it one of the districts with the highest number of TB cases.

The provision of PHC services in eThekwini district is the responsibility of both the KZN provincial department of health and eThekwini Municipal Health unit. The PHC clinics are distributed in the three sub-districts, where the CCGs work hand in hand with professional health workers caring for TB clients. There are 100 PHC clinics in eThekwini district, 60% (59 clinics) are managed by the Municipality and the remaining 40% (41 clinics) belong to KZN provincial Department of Health. There are 28 Municipal PHC clinics in the South central sub-district, 18 in the North and 13 in the West sub-district. Out of the 41 PHC clinics belonging to KZN provincial Department of Health, 16 PHC clinics are situated in the South sub-district, 11 are in the North and 14 are in the West sub-district.

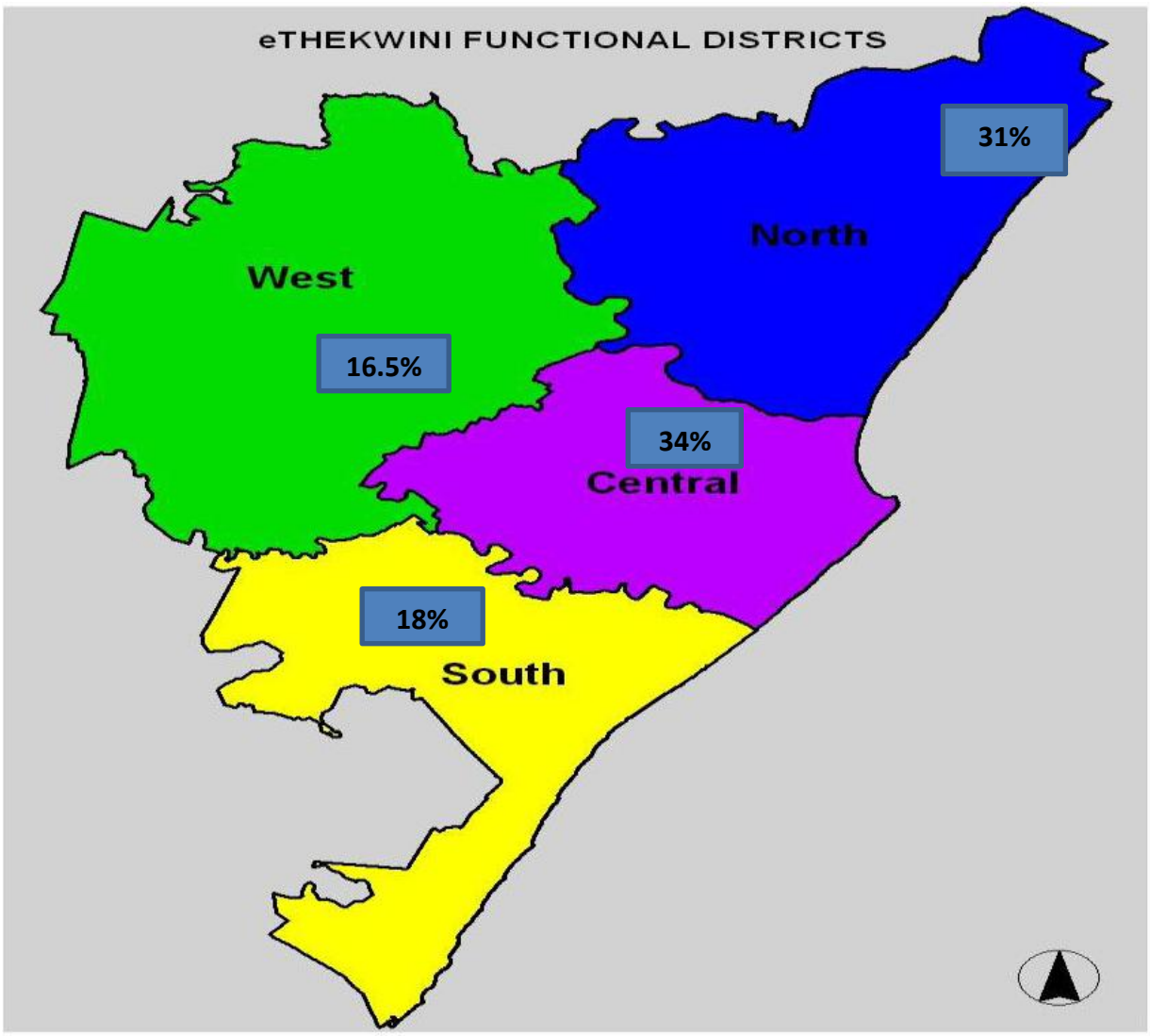

Figure 3.1: Map of eThekwini District indicating population distribution.

3.4 SAMPLING PROCESS

3.4.1 Sampling of community areas from the three sub-districts

Sampling is a process of selecting cases to represent the entire population so that inferences about the population can be made (Polit and Beck 2012: 275). All three sub-districts were included in the study. Purposive sampling method was used to select the community areas that were included in the study. The aim was to include the community areas with high TB prevalence. TB statistics from eThekwini Municipality PHC clinics was used to identify and purposively

select the two PHC with the highest TB case load per sub-district. The catchment areas for the PHC clinics with the highest TB case load were considered as areas with the high prevalence of TB infection and were selected for the study.

Two community areas that were catchment areas for the PHC clinics with a highest TB case load were included in the study. A total of six community areas were included in the study. The aim was to gather the information from the CCGs who were working in areas with high numbers of TB clients.

Inclusion Criteria

- All the three sub-districts were included (South and central included as one)
- Only the Municipal PHC clinics were used to identify the community areas that were included in the study because all the CCGS that were affiliated to the Municipal PHC clinics were receiving the stipend.
- Only the PHC clinics with the highest TB case load were used to identify the community areas in each sub-district because it was considered that the catchment areas that were serviced by these clinics possible had the high prevalence of TB infection.
- Only the community areas with the high TB prevalence were included in the study. The aim was to target the areas that have challenges in meeting the targets for the TB programme. These had mostly been observed in the areas with high TB prevalence rates. There are selected parts of the district that has more TB cases than others. This is mainly due to the differing demographic profiles in the different parts of the district as briefly described in the area of the study above.

Exclusion criteria

- All provincial Department of health PHC clinics were not used to identify the community areas because a mixture of CCGs groups was affiliated to these clinics. These included those that received the stipend from the Department of health, those from the Non-Governmental/Non-Profit Organisations and those who were working on voluntary basis.
- All the Municipal PHC clinics that did not have the highest TB case load were not used to identify the community areas because it was considered that the catchment areas that were serviced by these clinics possible had the low prevalence of TB infection.

3.4.2 **Sampling of the CCGs**

In purposive sampling, the researcher selects participants based on personal judgement about which participant will most benefit the study (Polit and Beck 2012: 517). Subjects were selected conveniently, but with a purpose and the researcher targeted the individuals with a particular kind of knowledge (Holzemer 2010: 87). The researcher selected the participants that were currently supporting TB patients, because they would have the current information required by the researcher.

The number of participants in a qualitative study is adequate only when saturation of information is achieved in the study area (LoBondio-Wood and Haber 2011: 91). Therefore, the sample size for the CCGs was guided by data saturation. Data saturation is when themes in the data become repetitive and redundant, such that no new information can be gleaned by further data collection (Polit and Beck 2012: 516). When additional sampling provides no new information, only redundancy of the previous information, the researcher will know that data saturation has been achieved. The researcher interviewed all consenting CCGs in the selected clinics who were currently supporting TB

clients and had been employed as CCGs for two years or more. Data analysis was performed simultaneously with data collection in order to monitor and guide against data saturation. Data saturation was reached after interviewing ten participants from two community areas belonging to two sub-districts, (five from each community area). Two extra participants were interviewed from one of the two community areas to confirm data saturation. Two to four participants were interviewed in each of the remainder of the four community areas. It was important that these interviews were done to confirm that no new information emerged between community areas and between sub-districts. A total of 24 interviews were conducted for the entire study.

Inclusion criteria

- All CCGs who had been working for the past two years. This group of CCGs were considered to have been in the system for long enough to have experienced as much as possible about the CCG programme.
- Only CCGs that received a stipend from the Department of Health and were affiliated to eThekwini Municipality PHC clinics in the three sub-Districts were included. The CCGs that receive the stipend have a contractual agreement with the Department of Health that they must abide to, unlike the CCGs who work on voluntary basis.

Exclusion criteria

- All the CCGs employed by Non-Governmental/Non-Profit Organisations were excluded because they performing their duties on voluntary basis.
- All CCGs who were not receiving a stipend from the Department of Health were excluded because these CCGs perform their duties on voluntary basis and are not compelled to abide by some of the rules and regulation by the Department of Health.

- All CCGs that had been working as care givers for less than two years were also excluded. This group was considered to have not had enough exposure to the CCG programme and working conditions.
- All CCGs who were not currently supporting TB clients were excluded because they fell outside the area of focus for the current study.

3.4.3 Recruitment process

Participants were recruited by the researcher at the CCG meetings that were held in the PHC clinics. The researcher addressed the CCGs at these meetings giving them information about the study and information letters to read on their own at home. Almost all the consenting CCGs signed the consent forms during the information giving session and the interview was scheduled for the date and time that was convenient for the CCGs. Other CCGs returned the signed consent forms after reading the information letter. These consent forms were given to the researcher on the days when she came to conduct the interviews for the CCGs who had consented earlier. The number of CCGs that participated in the study ranged from two to seven per community area. There were 7-5 interviews conducted in each PHC clinic before data saturation was reached. With the remainder of clinics, 2-4 interviews were conducted per PHC clinic to confirm data saturation.

3.5 DATA COLLECTION

Data collection took place from March 2014 to April 2014. Interviews took place in the six PHC clinics identified in the North, South-central and West sub-districts. Data was collected by conducting semi structured interviews with the participants. Interviews allowed the researcher to investigate issues from the perspectives of the CCGs involved. The interviews were conducted using an interview guide (Appendices 6a and 6b) to remember topics to be covered in the interview (Hansen 2006: 99). All interviews were scheduled at a time and

place convenient for the CCGs. All CCGS preferred to have the interview at the PHC clinics where they were affiliated. The researcher was able to get a private room where to conduct the interview in each of the PHC clinic in order to ensure privacy. The interviews were conducted by the researcher herself. The interviewing skill that the researcher has learnt and developed in her experience as a professional nurse which involves interviewing clients and relatives assisted the researcher to conduct the interviews in a professional manner. The interviews were conducted using the language of choice by the participants. All the participants chose IsiZulu. Individual interviews were carried out with each participant that allowed the participant to talk freely with the interviewer. Interviews began with a broad descriptive question which was followed with probing questions to elicit further details on a specific subject to uncover or draw attention to what was not mentioned. Semi-structured interviews were conducted with all participants, which typically ran for 30-45 minutes. Participants were asked to describe their experiences in caring for clients on TB treatment in their communities. This was used as a main question; other questions were also used as probing to facilitate discussions. Interviews were conducted by the researcher herself who is an isiZulu-speaking person, and isiZulu was used without an interpreter. All interviews were conducted in isiZulu and recorded using a voice recorder. They were transcribed verbatim and translated into English by the interviewer and subsequently transferred from IsiZulu back to English in order to ensure that no meaning was lost during translation. Both translated documents were counter checked by the supervisors who are both Zulu speaking.

Field notes were also used to substantiate the recorded information and also to highlight points of emphasis, issues that one would refer to later in the interview, mood, tone and facial expression noted during the interview (Hansen 2006: 108). Data was kept with the researcher at all times until it was secured to maintain confidentiality. All data forms/tapes were labelled with an identification number and the date they were collected. Participants were verbally thanked in acknowledgement of their contribution. Being mindful that

the interview process could be stressful or even raise false hopes, the interviewer debriefed the participants.

3.6 PRE-TESTING OF THE DATA COLLECTION TOOL

Data collection tool was pre-tested so to assess whether the research questions were realistic and understood by the participants. The pre-test was done in February 2014 by the researcher. One PHC clinic was randomly selected from the three sub-districts out of the PHC clinics that had the highest number of clients who were on TB treatment and a community area serviced by the selected clinic was used as a pre-test site. This was done to ensure that the community area had similar characteristics with those included in the study. A PHC clinic in the North sub- district was selected. Semi- structured interviews were conducted with three CCGs who were affiliated to the selected PHC clinic and working in the selected community area. Data collected was analysed but was not included in the main study. No amendments were made to the interview questions. The community area, PHC clinic and the CCGs that were used for the pre-test were not included in the main study.

3.7 DATA ANALYSIS

Data analysis was done concurrently with data collection where all information collected in one day was analysed before the next interviews were done. This was done in order to monitor data saturation. Tesch's method of data analysis was used to analyse data. Tesch's method involves the researcher listening to audiotapes and reading and re-reading all the transcriptions to get a sense of the full data, jotting down ideas as they emerge (Tesch 1992: 141). At the end of each interview the researcher listened to the recorded responses from the participants several times, in order to gain a clear understanding of the data collected. In this study, data was organised into categories which were further arranged into themes and sub-themes. The researcher also read and re-read the recorded notes, comparing these with the recorded information. One

transcript of the interview was picked up at a time and re-read; the underlying meaning of the data sorted out and jotted down. The categories were predetermined based on Donabedian's structure process and outcome in order to assist the researcher to base discussion on and be guided by this model Data was organised into categories which were further arranged into themes and sub-themes (Polit and Beck 2012: 562). The researcher thereafter identified and organise data into themes and sub-themes. Data was analysed and systematically explored to generate meanings. Verbatim reporting was done where data reporting was substantiated by direct quotes from the participants.

3.8 TRUSTWORTHINESS

Trustworthiness refers to the extent to which a research study is worth paying attention to, worth taking note of and the extent to which others are convinced that the findings are to be trusted (Babbie and Mouton, 2001: 276). Lincoln and Guba (1985: 289) suggest four criteria for developing the trustworthiness of a qualitative inquiry namely credibility, dependability, confirmability and transferability.

3.8.1 Credibility

Credibility refers to the confidence in the truth of the data and interpretation of them (Lincoln and Guba 1985: 321). The researcher ensured credibility of data by investing or spending more time in the field. A sense of trust was developed with the participants by the manner in which the researcher presented herself during all the contact sessions with the participants, how the information giving sessions were conducted and by not giving false information and false promises to the participants. A triangulation process was used whereby more than one source of information (the researcher used different CCGs) was used to collect data, which led to the same conclusions. The researcher used in vivo coding when presenting research findings**.**

3.8.2 Dependability

Lincoln and Guba (1985: 320) describe dependability as stability of data over time and over conditions. The researcher used the same main question for all CCGs interviewed on different dates. The sub-questions were also not changed. This helped the researcher to establish that the measure was stable when used on the different participants, because participants gave similar or almost similar responses. This ensured dependability of data.

3.8.3 Confirmability

Confirmability is the potential for congruence between two or more independent people about the accuracy of data, relevance and meaning (Lincoln and Guba 1985: 320). The researcher developed and maintained an audit trail to ensure confirmability of data by reporting and describing the entire research process and ensuring that data is securely stored for availability should the need arise. There was on-going documentation regarding the researcher's decisions about data analysis and collection process. Documentation from the audit trail included the recorded information on the tape recorder and the field notes about the process of data collection. This was achieved by including large amounts of data in the written report, to show objectivity and neutrality of the data.

3.8.4 Transferability

Lincoln and Guba (1985: 321) refer to transferability as generalizability of data, as the extent to which the findings can be transferred to have applicability in other settings or group. Although the researcher attempted to ensure transferability of the results for this study by providing the description of the research setting and research processes, several issues such as area where the study was conducted which was one district only, participants included which included only the CCGs that were affiliated to eThekwini Municipality PHC clinics and demographics of the CCGs who were Africans mainly working

with African clients in informal settlements, makes it difficult to generalize the study findings to CCGs working in other parts of the country. However, providing the description of the research setting and research processes confirms the authenticity of the study and makes it possible to build on these findings when performing further research.

3.9 ETHICAL CONSIDERATIONS

Procedures to ensure that the researcher complied with the fundamental principles for protecting the study participants which according Burns and Grove (2009: 188) include beneficence; human dignity and justice were ensured. The researcher is a Clinical Nurse Specialist in one of the PHC facilities where data was not collected. Nevertheless, the nature of the study did not carry any risk to harm the participants; the researcher ensured that she constantly kept in her mind that as stated by Polit and Beck (2012: 170), the need for sensitivity is usually greater in qualitative studies because these often involve in-depth exploration into highly personal areas. Dignity of the participants was ensured by conducting the interviews in a safe, comfortable and private environment and also by a professional and courteous attitude that the researcher ensured whenever she was approaching the participants. The selection of the study participants was based on research requirements inorder to ensure that there was fair selection and treatment to all the participant and that participants had equal chances to be selected (Polit and Beck 2012: 173). The researcher only started after the study design and procedures were approved by the DUT Faculty Research Committee and Ethical clearance certificate issued (Appendix 1). Data collection only commenced after the eThekwini Municipality Health Research Unit and Provincial Health Department had approved that the study be conducted using their employees (CCGs) and the interviews be conducted in their PHC clinics (Appendices 2b, 3b, 4b). Information sessions/briefing of the participants about the research and written information was issued by the researcher; thereafter all participants were required to sign the consent form (Appendices 5a and 5b). Giving the

participants the information letter was important because it allowed them ample time to review the information about the study before signing the consent (Polit and Beck 2012:177). The participants were made to choose between having the interviews conducted either in IsiZulu or in English because isiZulu is the main local language in eThekwini District. Right to self-determination was ensured by given the choice to participate or not without any coercion and also to withdraw from the study at any point if they wished to do so (Burns and Grove 2009: 190). Data collection tools were identified by numbers so that there would be no link between the participants' identity, the community area, the PHC clinic and information collected. This ensured confidentiality and respect to human right to privacy (Polit and Beck 2012: 174). Trust was developed between the researcher and the participant by the manner in which the researcher presented herself during all the contact sessions with the participants, how the information giving sessions were conducted and by not giving false information and false promises to the participants. Completed data collection tools will be kept under lock and key for a minimum of five years, and thereafter will be destroyed by shredding. Electronic data were stored in a computer and secured with a personal secret password only known to the researcher. The data will be wiped off after five years.

3.10 CONCLUSION

This chapter described the entire research design and methods. It highlights how the study was carried out and how data was collected and analysed and also gives explanation regarding how it was ensured that the study was scientific and authentic by describing ethical consideration and trustworthiness. The sample chosen was appropriate for the data to be collected as it targeted people the CCGs who were caring for clients on TB treatment which was in line with the problem identified.

CHAPTER 4

PRESENTATION OF THE FINDINGS

4.1 INTRODUCTION

In the previous chapter, research methodology was discussed. This chapter presents the findings of data analysis. As described in Chapter 3, semi-structured interviews were conducted with CCGs. The presentation of the study results is based on Donabedian's theoretical framework.

4.2 SAMPLE REALIZATION

A total of 24 interviews were conducted for the entire study. The number of interviews in each community area was guided by data saturation. The number of CCGs interviewed from each community area ranged between two to seven. Table 4.1 below presents the number of interviews conducted in each community area.

Table 4.1: Number of interviews conducted

Sub-District	Code for the Community Areas	Code for the PHC clinics used as interview venues	Number of Interviews conducted
West	Area 1	PHC 1	3
	Area 2	PHC 2	2
North	Area 1	PHC 1	5
	Area 2	PHC 2	3
South central	Area 1	PHC 1	4
	Area 2	PHC 2	7
Total	**Total areas: 6**	**Total PHC clinics: 6**	**24**

4.3 PRESENTATION OF FINDINGS

4.3.1 Community areas included in the study

All the community areas included in the study were either black Township, rural or semi-urban. All the areas that were semi- urban either consisted of informal settlements or government subsidised low cost houses.

4.3.2 Demographic information of the participants

The ages of the CCGs that participated in the study ranged from 21 years to 56 years. The participants were all African females and spoke isiZulu. All the participants except five; three from South Central, two from the West and one from the North sub-district had standard ten as the level of basic education. The other participants had standard eight as the highest level of basic education. One participant from South Central had a qualification as a nursing assistant but had been working as a CCG for the past 15 years. All the other participants did not have any post basic education qualification. The participants had the work experience of between two and 20 years.

4.4 CATEGORIES, MAJOR THEMES AND SUB-THEMES

4.4.1 Categories

The three elements of Donabedian's model were used as categories on which to organise data. These included structure process and outcome. The intention was to facilitate discussion of the results based on this model as a model that was guiding the study.

4.4.2 Major themes that emerged from the interviews

Six major themes emerged from the interviews:

- Accessibility of kits used by the CCGs.
- Accessibility of protective clothing.
- Training and development of the CCG's.
- Financing of the community giver programme by the Department of Health.
- Safety and security of the CCGs.
- Insufficient supply of kits.

The major themes were grouped according to the three categories which were the structure, process and outcome.as specified in Donabedian's model that was guiding the study. The first three major themes were in relation to the structure, the fourth and fifth were in relation to the processes and the sixth was in relation to the outcome.

4.4.3 Sub-themes that emerged from the interviews

Several sub-themes emerged from the interview in line with the six major themes. The categories, major themes and sub-themes are presented in Table 4.2 below.

Table 4.2: Overview of categories, major themes and sub-themes

CATEGORIES	MAJOR THEMES	SUB-THEMES
1 Structure	1 Accessibility of kits used by the CCG's.	1.1 Supply of kits. 1.2 Alternative means of making kits available to the CCG's.
2 Structure	2 Accessibility of uniforms and protective clothing.	2.1 Promotion and supply of uniforms for the CCGs. 2.2 Procurement and supply of protective clothing.
3 Structure	3.Safety and security of the CCGs.	3.11 Vaccination against communicable diseases. 3.12 Safety allowance.
4 Process	4 Training and development of the CCGs.	4.1 Transparency on criteria on further training and development. 4.2 Age limits regarding the selection of the CCGs. 4.3 Lack of career pathing of the CCGs.
5 Process	5 Financing of CCG Programme by the Department of Health.	5.1 Stipend received by the CCGs. 5.2 Employment benefits for the CCGs.
6 Outcome	6 Insufficient supply of kits	5.3 Exposure to infection and other health hazards 5.4 Unsafe practices

4.5 STRUCTURE

In the current study the structure included three themes; accessibility of kits by the CCGs, accessibility of protective clothing as well as safety and security of the CCGs.

4.5.1 Major theme 1: Accessibility of kits used by the CCGs

The CCGs stated that there were problems in accessing kits that to use in performing their duties. The eThekwini district office procure, store, supply and deliver kits to all CCGs working in eThekwini district including those that are affiliated to eThekwini Municipality PHC clinics. The kit includes gloves, adult nappies, soaps, mask, hand rub, jiks, linen savers and bandages.

4.5.1.1 Sub-theme 1.1: Supply of kits

Most of the CCGs were caring for bedridden clients that require adult nappies, linen savers and gloves to use while working with them. CCGs are expected to share kits among themselves which interferes with their work, because each of them ends up getting either gloves or nappies. The CCGs complained that although reports were always written on the state and number of the clients who needed kits, but when supplies were given the number and state of the clients were not considered, hence the available kits had to be shared.

Other participants verbalised that chances were not given to order kits according to the clients' needs. Kits are given to the CCGs only when they were available. In most cases these kits are not enough; hence had to be shared among equally between CCGs without considering the number of clients that each had. The participants also reiterated that the number of clients and individual needs were not considered when giving out kits by district office. This was evident in the following statements by the participants:

''…..Well, I think the last time I saw the kits was in 2010 when one of the NGO's gave us. We were told that kits are available at the District office but there is no car to deliver them " (West: Participant 4).

"…..We were told by our supervisor to share the kits because they are not enough. This disturbs our work because we need everything in those boxes to care for our clients" (South: Participant 1).

"…..We are never given enough kits., I take kit even if it is incomplete, there is nothing that I can do because we are told that these people are getting government grants; why they do not buy their own things" (South: Participant 1).

"…..We are never given complete kit; the kits are either incomplete or not enough. I do not remember seeing masks in the kits we receive, only nurses at

the clinic are given masks not CCGs yet we are equally exposed to diseases" (North: 4 Participant).

During the interviews, the participants also emphasised that there is a challenge in collecting kits from the district office. The participants were expected to collect kits for on their own using public transport. Some verbalised that sometimes the community health facilitators from eThekwini municipality assisted with the collection although most often the community health facilitators sometimes were given kits because the district office needed proof that CCGs have bedridden clients that need kits which the community health facilitators could not provide. This was highlighted in the following statements:

"…..Even if the kits are available at the district, the problem is with delivering them to us. We have to contribute money from our pockets so that we can send someone from us to collect them which also does not work very work because, it causes a lot of delay, and also the one person is usually unable to carry the kits enough for all of us and will usually come back with very limited stock. " (North: Participant 2).

"…..We are expected to help inside the clinic with things like blood pressure checks, sugar testing, HIV testing; it is fine for them but when we request to use the clinic car to collect kits we are told we cannot. They will tell us they can't give us we cannot use the clinic car because the car belongs to the Municipality and we belong to Province. Yet in other clinics, under eThekwini municipality their supervisors sometimes ask the community facilitators to collect kits using the clinic car" (South: Participant 6).

"…..Well, before we get kit the district want to come and check if we are really having bedridden clients, which means they do not trust us yet we submit stats every month and this causes delays in them issuing us the kits " (South: Participant 4).

Other participants verbalised that the PHC clinics where they were affiliated work with were prepared to store and control kits for them. Therefore the would not be a problem to store and control the kits if these were supplied and delivered in large quantities which will make working much easier. The participants further stated that this would give better access to kits as all CCGs sign on at the clinics every day before going to the communities.

This was highlighted on the following statements:

"…..Well, the clinic manager allows us to store our kits in the clinic store room. We collect items as we will need on daily basis after signing on'' (South: Participant 5).

"…..Yes, the clinic supervisor gives us room to keep our kits, it is just that we do not have supplies from the district office" (West: 2 Participant).

4.5.1.2 Sub-theme 1.2: Alternative means of making kits available to the CCGs

The participants stated that there was a problem with the alternative supply of kits as PHC clinics were not supplying them due to limited stocks available at PHC clinics. Some CCGs confirmed that there were given very few items such as linen savers, gloves and masks by clinics. Others ended up buying domestic gloves to use saying that this type of gloves were more durable.

This was evident in the following statements by the participants:

"…..The alternative means to get kits is to borrow it from the clinics; and although the sister at the clinic gives us some gloves but she does not give us enough, she always tell us that gloves are only limited to clinic staff because stocks are limited'' (North: Participant 3).

"…..The clinics expect us to work for them in exchange of them giving us kits from the clinic stocks. Yes, we help inside the clinic with things like Blood Pressure checks, sugar testing and HIV testing, we do almost all things but

when we ask for gloves linen savers or masks, they do not agree to give us , we are told that we are not staff members " (South: Participant 2).

4.5.2 Major theme 2: Accessibility of uniforms and protective clothing

The participants verbalised concerns about not getting uniforms and protective clothing. The protective clothing included; face masks, safety shoes, raincoats and hats or umbrellas. The participants felt that the CCGs were subjected to contracting infectious diseases especially because they also traced TB defaulters including MDR/XDR-TB clients. The other concern was that CCGs were also exposed to extreme weathers when doing home visits tracing defaulters or profiling households. The participants also felt the CCGs needed to have a uniform that will make them to be identifiable in the community and representable instead of wearing private clothes. This would make the CCGs safer. Several sub-themes emerged from this major theme. These include uniform supply, procuring and supply of protective clothes.

4.5.2.1 Sub-theme 2.1: Promotion and supply of uniforms for the CCGs

The participants raised concerns that they were using their own clothes when caring for clients in their communities, as a result they were not recognised and respected by the communities as they appeared as any other community member. The Managers at the District Office also expected them to work as from 08h00-16h00 daily for five days a week, yet they used their own clothes. The participants were also concerned that they carried infections home; their shoes got torn easily especially during rainy seasons when they walked in the mud. One group of participants reported that they bought T-shirts with their own stipends. Each T-shirt cost R150.00. They were concerned that it was too expensive. They were also dissatisfied that they did not have name tags from the Department of Health that confirmed them as appointed CCGs in their

communities. They reported that in other sub-districts, CCGs were issued with name tags as a means of identification.

This was evident in the following statements:

"…..We start work from 08:00-16:00 every day for five days a week yet we do not get uniforms or allowances. It is so hard, sometimes I do not know what to wear because I must be presentable" (North: Participant 4).

"…..Only name tags were given to us by the District office, no uniforms. We are using our own clothes and shoes even when it is raining. We feel we need uniforms. We tried to buy navy skirts for us but the supervisor refused us to wear it saying two different uniforms are not allowed at the clinic because nurses were wearing different colour uniforms. At the same time she also refused us buying same uniforms as nurses, she said we are only CCGs , We cannot wear the same uniform as the nurses" (North: Participant 3).

"…..The only identification thing that we have is the name tags. These name tag were designed and paid for by ourselves. The District office promised to give us name tags five years ago, but until today we never received them. Let alone the uniform nothing is being said about it " (West: Participant 2).

"…..To tell the truth we are given yellow jackets only, these jackets are the same as that use by road constructors. They can be used by anybody who claims to be a CCG because there are no names written there that identify us as CCGs. We cannot call them uniforms. These jackets are also very hot especially in summer" (North: Participant 4).

"…..Preferably, if we can get uniforms, hats, raincoats, safety shoes, bags and winter jackets including our name tags so that we will look identical and be recognised by the community we are serving and mostly to get protected when we are working" (North: Participant 5).

4.5.2.2 Sub-theme 2.2: Procurement and supply of protective clothing

The CCGs raised concerns that the Department of Health was not supplying them with protective clothes such as face masks, gloves, safety shoes and raincoats or winter jackets. They emphasized that since they also traced TB defaulters as well as MDR/XDR TB, they needed protective clothing. Concerns were also raised that when doing household profiling, they spent more time exposing themselves even with clients with infectious diseases as this was not disclosed by clients that they defaulted treatment.

This was identified in the following comments by the CCGs:

"…..It is important that we must wear protective devices like face masks. Some clients refuse to open windows or doors when we visit them. We end up getting their diseases like TB, because most of these clients are TB defaulters" (South: Participant 2).

"…..I wish the Department of Health can always supply us with protective clothing at least the face masks especially because when we are doing house hold profiling, we spend many hours in one house or shack to fill the complicated profiling form. This exposes us even more to infectious TB defaulters" (South: Participant 5).

4.5.3 Major theme 3: Safety and security of the CCGs

The CCGs expressed their concern on their safety while performing duties. They reported that they travelled long distances in an unsafe environment when doing home visits. Being females and subjected to homes where the clients were only males posed the risks of being sexually abused. They also verbalised financial insecurity because the stipend they received was far below cost of living. They were also worried that they may get infectious diseases since they were excluded from vaccinations given to other health workers.

4.5.3.1 Sub-theme 3.1: Vaccination against communicable diseases

The participants reported that they did not get vaccinated for communicable diseases like swine flu and hepatitis B as it was only for permanent government employees at the clinic. They strongly felt that their lives were in real danger as they also work with sick people including defaulters.

This was identified in the following statements:

"…..I always hear that nurses get injections to protect them against infections as they nurse the clients, why we are not given as CCGs because we also work with sick people" (South: Participant 6).

"…..Surely, our lives are not safe in the communities we are working, they may rape us and we get infections and diseases. We work in the shacks and most boys there are on drugs and I do not feel safe at all. I do this work because I do not have another option. I feel the department must give us injections or vaccines to protect us from the infections instead of giving us the lot of treatment after we already have been raped and the damage is done" (South: Participant 4).

"…..I think we are highly exposed to infectious diseases because most of these clients we trace are TB defaulters including MDR-TB. I think it is only fair that we also get vaccinated against diseases" (South: Participant 3).

4.5.3.2 Sub-theme 3.2: Safety allowance for the CCGs

The participants expressed concerns on being exposed to risks while doing their work. Dangers included things like: dog bites, snake bites, sexual abuse and contracting infectious diseases like MDR/ XDR-TB. They verbalised that since they did not receive facial masks, they mostly got exposed. It was even worse when doing house hold profiling because they spent more time with each family. The feeling was that they needed to be compensated through monetary incentives.

This was shown in the following statements:

"…..I wish the government can give us danger allowance on top of our stipend because we work under very dangerous conditions" (North: Participant 3).

"…..Actually, we are exposed to dog and snake bites, even if we have to get rabies vaccines we are referred to Prince Mshiyeni Memorial Hospital; no transport is arranged for us. Sometimes we do not even have money to go there and we have to borrow it. They must just pay us the allowance every month so that you know when you need to go to hospital, it is your responsibility" (South: Participant 5).

"…..Well, I think danger allowance will help us to buy our own gloves because most of the time we do not get them with the kits, hence we use bare hands to care for the bedridden" (West: Participant 1).

4.6 PROCESS

Process includes themes such as training and development and financing of the CCG programme by the Department of Health.

4.6.1 Major theme 4: Training and development of the CCGs

Training and development in the current study was regarded as the process because it did not include knowledge and skills of the CCGs but rather the concerns were with regard to the processes of making training and development available to them. The CCGs expressed concerns on processes and procedures followed on their training and development. They strongly felt that there was no clarity as to what trainings and developments planned for CCGs to empower them since the majority of them are still young with matric certificates. They also raised concerns that they were trained on health related issues mostly, yet they were expected to work with other government initiatives like in 'Operation Sukuma Sakhe'.

4.6.1.1 Sub-theme 4.1: Transparency on criteria for further training and development

The participants verbalised their concerns and dissatisfaction on the selection criteria which were followed by the Department of Health for further training and development. They further stated that there were no clear or transparent procedures as to who qualified for other developments outside community care giver programme. Development included: nursing courses, nutrition advisers, social work assistants and office administration. They highlighted that they did all the work especially during campaigns as equals, but when developing them certain individuals were selected.

This was picked up in the following comments:

"…..Truly, I do not know how the Department of Health select people for training. I heard that they need to have matric to be selected, but there are many CCGs with matric who are not taken" (North: Participant 1).

*"…..Well, when we ask about these trainings we were told that it is our choice to be CCGs, we were not forced so we can go if we want to, there are so many people out there who wants to volunteer" (*South: Participant 3).

"…..Actually, we need to be informed in time about available trainings so that we can also apply. I think that will give us a chance to be considered equally for development" (North: Participant 2).

"…..Well, I think all the CCGs that have matric should be trained as nurses because we know most of the nursing things, some of us know the clients more than nurses do" (North: Participant 1).

"…..Well, I think the last time the person was taken for further training was in 2011/2012, and we do not know how she was chosen. Until now no one was ever taken for such training" (South: Participant 4).

4.6.1.2 Sub-theme 4.2: Age limits regarding the selection of the CCGs

The participants expressed their dissatisfaction on the age limit for the selection of the CCGs who were selected for training and development. They verbalised that the district told them that the age limit was thirty five years, and they strongly felt that at that age some of them were still upgrading their matric symbols.

This was picked up in the following comments:

"…….Well, I think the Department of Health must consider changing the age limit for training and development. Thirty five years is very early because most of us are still improving our matric results" (North: Participant 3).

"…..Yes, even the MEC for health Dr S. Dhlomo appreciates the work we do, he even mentioned that there is a programme for CCG development through leanerships like nutrition advisors and nursing, but he did not specify age limits" (South: Participant 6).

4.6.1.3 Sub-theme 4.3: Lack of career pathing of the CCGs

The CCGs expressed their concerns regarding access to other advertised posts at the PHC clinics. They felt that they needed to be prioritised when positions are available because they had work experience compared to the general public. They verbalised that sometimes they were not even made aware of such positions. Being affiliated to Municipality PHC clinics made them felt they would be considered for positions like data capturers, clerks or even general assistants, yet it is not happening.

"…..But we are not recognised as employees. We are still expected to apply for posts inside the department" (South: Participant 2).

"…..Oh, how I wish the district can recognise the work we do and consider us when the permanent positions come, not to give posts to people that never even volunteered" (South: Participant 4).

4.6.2 Major theme 5: Financing of the CCG programme by the Department of Health

The CCGs stated that they were funded by the government to perform their duties. They verbalised concerns on several issues regarding their pay and conditions of service. All those who received the stipend had persal numbers. A stipend is an amount of money given to CCGs that is below a salary. They emphasised that in order for them to receive a stipend they needed to renew their contract each year.

4.6.2.1 Sub-theme 5.1: Stipend received by the CCGs

The CCGs expressed their concern on the amount of stipend (R1500) given to them, despite the years of experience and workloads. They further stated that they had persal numbers as government employees yet they were constantly reminded that they were not employed; hence they were receiving a stipend. They reported that the stipend was a fixed amount that did not increase or decrease despite the years of experience. Concerns were also raised that they travelled using the same stipend as sometimes they had to take transport to do home visits since walking alone was no longer safe.

This was evident in the following statements:

"…..Actually, we are expected to work from 08:00 – 16:00 for five days a week. We are not allowed to do extra work elsewhere because the District tells us that we will pay back the stipend. The stipend is too little to for us to live on" (North: Participant 3).

"…..Actually, I do not understand why the stipend is not increasing because the work load is ever increasing. We run all the campaigns, trace all defaulters and care for the bedridden but nobody seems to worry about our welfare" (West: Participant 2).

"…..Yes, we once reported that the stipend is not enough, but we were told that it is our choice that we are CCGs nobody is forced, any way there are many people out there who wish to get this stipend" (South: Participant 3).

"…..Well, I am not happy about our stipend, it is too little because the work we do is very heavy and risky. I wish the department can give us more money" (South: Participant 4).

"…..Surely, social grants increase every year, but the stipend does not increase. This shows that the department of health does not care about us, as long as the work is done and stats are submitted" (South: Participant 2).

"…..Actually, they must allow us to do other jobs elsewhere so that we can complement the stipend because cost of living is very high, this money they give us is like nothing" (South: Participant 1).

"…..Well, I will suggest that stipend of the CCGs that have longer service be different from those who are newly contracted. I think it would be fair like that because some of us have more than ten years' experience, yet they get same stipend like the new ones" (South: Participant 5).

"…..Actually, we were not told that we were signing for the stipend that would not increase. I am a CCG for fourteen years now, but I am still getting R1 500 as stipend same like the new CCGs" (West: Participant 4).

4.6.2.2 Sub-theme 5.2: Employment benefits for the CCGs

CCGs expressed their dissatisfaction on the fact that they were not considered as employed because they could not enjoy employment benefits. Employment benefits included such things as; pension funds, retirement or death benefits, unemployment insurance fund, performance or annual bonuses, various types of leaves and medical aids.

This was evident in the following comments:

"…..Well, I wish the government can consider us as full time employees so that we can access employment benefits" (North: Participant 2).

"…..Yes, if a community care giver dies, the family suffers because no money that is given to the family as a death benefit. The children suffer because most of us are single parents" (South: Participant 3).

"…..Truly, I wish the government may start taking care of us as well, because as a CCG I also stay in a very bad shack with four big boys who are smokers. I cannot afford to build my shack, yet if can be employed I will be able afford my own room" (North: Participant 3).

"….. Well, nobody wants to address our concerns and issues as CCGs because even if we report them at the District office, they tell us that we are employed by Province at Pietermaritzburg, so it is the province that wants us to remain as contract volunteers" (South: Participant 5).

4.7 OUTCOMES

4.7.1 Major theme 6: Insufficient supply of kits

Several negative outcomes were evident in the statements by the participants. A major theme identified from these comments was insufficient supply of kits which was the outcome of poor structure and processes with regards to ordering and supplies including the absence or failing of alternative means of making the kits available. Two sub-themes emerged as outcomes linked to these major themes and these were exposure of the participants to infection and other health hazards and unsafe practices by the participants

4.7.1.1 Sub-theme 6.1: Exposure to infection and other health hazards

"…..Yes, we enter shacks that do not have windows and doors are always closed; most of the time we're not aware that the client has MDR-TB defaulter. We may end up getting the same type of TB if we do not have protective clothing" (South: Participant 3).

"…..Sometimes we are forced to even escort clients to hospital because most of these clients are neglected by their families. We seat with them at the back of the ambulance with closed windows. This exposes us continuously to their diseases if we do not have masks" (South: Participant 5).

4.7.1.2 Sub-theme 6.2: Unsafe practices

The absence of protective clothing resulted in the participants performing unsafe practices such as working with bare hands instead of wearing gloves or buying their own kits. The participants regarded this as unsafe practice because there was no guarantee that the items that were not bought through the correct processes by the department of health met the specification by the department of health. These were evident in the following statements by the participants:

"…..We need gloves to work but, I have never received gloves, I try and buy the gloves on my own I buy the strong yellow gloves for myself, and at least they last me longer and I can use them more than once and wash them" (West: Participant 2).

"…..Sometimes I do not use gloves to bath the client because in most cases we get very few gloves , they also get finished very fast and they get torn quickly, we are forced to use more than one pair for one client. I know that I might get diseases but what else can I do; I just take it as I am helping another human being" (North: Participant 3).

"…..what makes things worse is that it is not only that the kit is not enough, but even the packs that we are given are incomplete, sometimes we get adult

nappies only without gloves and we are forced to use bread plastics to protect our hands, can you imagine!. ” (South: Participant 3).

“…..We need gloves to work but, I have never received gloves, I try and buy the gloves on my own I buy the strong yellow gloves for myself, and at least they last me longer and I can use them more than once and wash them’’ (West: Participant 2).

4.8 SUMMARY OF DATA

The findings showed that there were several issues of dissatisfaction among the CCGs in executing their work. Issues ranged from processes, procedures and policies guiding their duties. In almost all five major themes and sub-themes that emerged, the CCGs were verbalising dissatisfaction regarding: CCG management and supervision, training and development, financial incentives and their safety and security while doing their work. Only a few CCGs were appreciative of the incentive they received as a stipend. It was evident.

With regard to question one which was to explore and discuss the experiences of the CCGs in caring for TB clients in the community, the overall findings were that the CCGs experienced difficulties in accessing kits for them to perform their duties. Most of them were caring for bedridden clients without kits. CCGs used their own clothes five days a week and eight hours a day, because they were not entitled to uniform supplies or allowances. The strongly felt that stipend of R1 500 across the board was not fair and was not tallying the amount of work they were doing. Regarding safety and security issues they strongly felt that their lives were highly exposed to infectious diseases like MDR/XDR-TB since they were also tracing TB defaulters without being provided with facial masks. CCGs were dissatisfied and disappointed on the procedures and processes followed to select people for further training and

development. The criteria and requirements were not known by them as to who qualified for selection. They were so discouraged and verbalising that only people who were favoured by the district office got chosen.

With regard to the support given to them by clinics and the district office so that they could carry out their work was verbalised as zero by all of them. They highlighted that support in the form of supplies, financial incentives, supervision and guidance were very minimal and caused lot of challenges. They verbalised that in other instances they had to sign on duty while standing outside clinics because they were not recognised as part of staff. They recommended that if clinic staff members could respect and recognise them as valuable members who could contribute much in the health system, this would be appreciated. The feeling was the district office was not supportive the them since they were not regarded as valuable health workers, but only known when there were campaigns to be conducted.

Regarding the third question on the challenges faced by the CCGs as they performed their duties indicated that almost everything was a challenge. Challenges ranged from unsafety situations in the communities, transport issues, supplies, support and supervision. CCGs mainly worked in informal settlements, with high crime rates in South Africa they felt that they are subjected to robbery and sexual assaults by community members during home visits.

4.9 CONCLUSION

In this chapter the results of data analysis were presented. There was dissatisfaction among the CCGs in various issues. These findings will be dealt with in the next chapter where the results will be presented and supported with

relevant recommendations that will help to improve the support of CCGs will be identified.

CHAPTER 5

DISCUSSION OF THE FINDINGS

5.1 INTRODUCTION

The discussion of the results is guided by the research questions described in the first chapter and Donabedian's theoretical framework of structure, process and outcomes as well as by the themes that emerged from the analysis of the interviews.

5.2 OVERVIEW OF THE RESEARCH DISCUSSIONS

The aim of this study was to explore and describe the experiences of CCGs caring for clients, and to identify the support system available for them. In this study, five major themes were identified, namely:

- Theme 1: Accessibility of kits used by the CCGs.
- Theme 2: Accessibility of protective clothing.
- Theme 3: Training and development of the CCGs.
- Theme 4: Financing of the CCG Programme by the Department of Health.
- Theme 5: Safety and security of the CCGs.

These themes and their sub-themes are interpreted below and validated using relevant literature and Donabedian's structure, process and outcomes model to support the interpretation of the findings.

5.3 STRUCTURE

In the current study, the structure included themes such as: accessibility of kits used by the CCGs, accessibility of protective clothing, safety and security of CCGs. According to Donabedian's model, structure also includes leadership, support and supervision, level of training and career pathing in human resources.

5.3.1 Insufficient supply of kits

It was evident in the interviews that CCGs were concerned about insufficient and irregular supply of kits to execute their work. They were expected to share the kits among themselves, which interfered with their work and service delivery to their clients. Kits were not supplied according to their client's needs despite the reports written about the state of clients they cared for. EThekwini district office procure, store, supply and deliver kits to all CCGs working in the district. Kits included items such as; gloves face masks, adult nappies, soaps hand rub, linen savers and bandages.

Uwimana et al. (2012: 495) in their study conducted on training of CCGs concluded that inconsistency of supplies and commodities such as kits need to be resolved to increase uptake of services. For the CCGs to be able to make an effective contribution to health services, they must be appropriately trained and continuously supported. Support in this instance meant to be issued with work supplies such as kits (Lehmann and Sanders 2007: 26). The CCGs noted in the interviews that even the health clinics that they are affiliated to do not support them with supplies, yet the clients in the communities belonged to the clinics.

Carers need help and support to carry out their roles. Factors such as support from health services staff and adequate supplies play a vital role in the

motivation of carers (Ross and Mackenzie 1996: 128-129). The Community Care Giver Policy Framework contains service package guidelines for CCGs such as rendering home or community based-care which indicate that for them to care for bedridden clients, they need work kits every time they visit those clients (Department of Health 2009b: 18).

From the interviews it was evident that the majority of the CCGs were very discouraged in performing their work without adequate supply of kits. Some even verbalised that they were omitting to visit their bedridden clients. Odendaal et Al. (2011:4) states that establishing and maintaining high morale among the CCGs is an important component of ensuring the delivery of quality services. Despite their potential for expanding PHC beyond health clinic fences and addressing the human resource for health crisis, in most settings CCGs are under-utilised. Therefore, it is crucial to maximise their involvement and support them through adequate supply of work equipment so that the work is done properly (Zachariah, Ford, and Philips 2009: 549-558). According to Hermann et al. (2009: 3), the CCG Management Policy specifies that access to equipment and physical requirements such as care kits should be provided by provincial departments of health and replenished by the provincial departments through local clinics. The use of care kits should be monitored as part of supervision, therefore the CCGs need to access care kits without difficulty (Department of Health 2009b: 65). Supervision and other forms of support such as supplies are crucial for the continued quality service provision by the CCGs. Good supervision together with adequate material support through the formal health system will enable the CCGs to function better.

5.3.2 Non availability of protective clothing

According to the current study, structure also includes accessibility of protective clothing by the CCGs. The CCGs were concerned that the Department of Health was not supplying them with protective clothes. Protective clothing includes such things as uniforms, safety shoes, raincoats; winter jackets umbrellas, facial masks and gloves. They reported that sometimes kits would

come with gloves and masks, but in most cases they were not included. The participants in this study verbalised their concerns regarding carrying infection home via their clothes and that they were highly exposed to infectious diseases like MDR/XDR-TB since they were also tracing TB defaulters. Schneider and Lehmann (2009: 61) state that community-based services are an established and growing part of district health system budgets, and there is no PHC clinic in South Africa without its complementary CCGs, either providing clinic or home-based care within its catchment area. Although the South African government has become the main driver and funder of the CCGs, they remained outside of the formal health system. Building a sustained and effective CCG presence in the South African health system would among other things; improving the conditions and basic entitlements (such as leave and uniform allowance) of CCGs beyond the provision of stipend and creating formal sector mid-level categories such as counsellors into which CCGs with skills and experience can progress. That would ensure fairness in the distribution of opportunities for entry into the formal health sector (Schneider, Hlophe and van Rensburg 2008: 185).

5.3.3 Support and supervision

The CCGs verbalised that there is no support given to them by clinics they are affiliated to or eThekwini district office. The precarious location on the margins of the formal health system of the CCGs resulted in the failure to recognise them as health system's employees entitled to employment benefits like uniform allowances or supply (Schneider and Lehmann 2009: 61). They need to be supported through a purposeful programme that is oriented to their total wellness. Failure to provide support services is considered a serious failure in managing the CCG programme (Department of Health 2009b: 79).

The guidelines on the PHC re-engineering include CCGs as part of the formal structure of the health service, and each team will have six CCGs depending on

the size of the ward (Department of Health 2011 14). This would mean that CCGs would be included on the official Department of Health human resources system. Ogunmefun et.al (2011:10) discovered that CCGs were performing below the level expected by the PHC re-engineering strategy in terms of the ratio of CCGs to households. These authors recommended that the Department of Health should provide the necessary support, training and incentives such as uniforms and transport to enable the CCGs to expand their services from the current ratio of 1:17 to 1:250. They further suggested that the Department of Health should put in place a proper remunerative system for the CCG programme that will enable them to be contracted by districts so that they have job descriptions, performance agreements, uniform reimbursements as well as stable and dependable income through stipends.

5.3.4 Unsafe working conditions

Structure in the current study also included safety and security of the CCGs. From the interviews it was evident that CCGs were concerned about their safety and security while doing their work. Study findings indicated that CCGs are working mainly in informal settlements, subjecting their lives to dangerous situations. Part of their duties was to trace TB defaulters in most cases not using facial masks. As a result, they felt highly exposed to communicable diseases. Safety included such things as vaccinations for swine flu and Hepatitis B and the use of masks for protection.

The Occupational Health and Safety Act (Act no. 85 of 1993) section 8, as amended in 2012, states that an employer has a duty to provide and maintain a working environment that is safe and without risk to the health of his/her employees and to provide personal protective equipment. CCGs are effectively a large and flexible state-generated and supported labour force on the margins of the health system. They do not have the employment rights like other health workers while being expected to work regular hours (Schneider, Hlophe and

van Rensburg 2008: 185). Their status was considered inferior by themselves and other health workers. As a result, they were excluded from any vaccination given to formal health workers. Hermann et al. (2009: 3) further state that professional health care workers saw CCGs as lowly aides and failed to understand the potential value of their contribution resulting in strained relationships which negatively affect the CCG performance.

Lehmann and Sanders (2007: v) point out that CCGs are a good investment but they are neither the panacea for a weak health system nor a cheap option to provide access to health care for underserved populations. CCGs provide their services under difficult conditions that could lead to burnout and disillusionment with their work. This may threaten their wellbeing and the sustainability of their services, hence they need to be supported through a purposeful programme that is oriented to their total wellness (Department of Health 2009b: 79). Interview results indicated that CCGs were also exposed to snake and dog bites, sexual abuse and even exposure to MDR/XDR TB while on duty. Such exposure threatened their lives and sustainability of their services. The competent management of CCGs is central to meeting service delivery objectives. Their support elements should include balanced workloads, supervision as well as assisting them to deal with the emotionally taxing environments in which they may be performing their duties (Department of Health 2009b:55). Odendaal et.al (2011: 4) state that establishing and maintaining high morale among the CCGs is an important component of ensuring the delivery of quality services.

5.4 PROCESS

Process is the second dimension of Donabedian's model. In the current study, process includes themes such as process of training and development, procedures and policies involved, financing procedures and standardised work flow.

5.4.1 Training and career pathing

Study findings revealed that CCGs were concerned about processes and procedures followed regarding training and development. They reported that there were no clear set criteria and requirements communicated to them on how people were selected for further training. As a result, they were of the opinion that they were not considered for career pathing. Training in the current study meant further training that would enable the CCGs to explore other work opportunities such as nutrition advisors, nurses and assistant social workers.

The Department of Labour's Expanded Public Works Programme (EPWP) is one the government's short medium-term programmes aimed at the provision of additional work opportunities and training, and is one of the government's poverty alleviation strategies for the country (Department of Social Development 2005: 3). The broad aim of the EPWP is to create temporary work opportunities for the unemployed and aims to ensure that all work opportunities generated by the EPWP are combined with training, education or skills development thus enabling people to earn an income. Ogunmefun et.al. (2011: 10) recommended that the Department of Health should facilitate the process of providing formal training to more CCGs especially for those with matric or grade 12. CCGs with no training should be provided with adequate training that is standardized to capacitate them with skills. Odendaal et al. (2011: 33) also concluded that sustained monitoring and evaluation of the CCGs and paying attention to their training needs were necessary to ensure that clients receive quality care.

For CCGs to be able to make an effective contribution, they must be carefully selected, appropriately trained and continuously supported. The policy on the management of CCGs specifies that CCGs provide their services under difficult conditions; this may threaten their wellbeing and the sustainability of their services.

5.4.2 Insufficient stipend

The CCGs verbalised dissatisfaction about the amount of stipend given to them. The stipend is standardised to be R1 500 across the board per month. . Stipend is the amount of money that is below a salary. Years of service and experience are not considered. The CCG programme is currently funded by the Department of Health and for the CCG to be entitled to the stipends; they must have a current contract with the Department of Health and have a persal number. Contracts are renewable on a yearly basis. Stipends continued to be perceived by the CCGs as low for the amount of work involved. Their years of experience were not considered, and there were no increments applicable on the stipend. Odendaal et al. (2011: 33) recommended that the stipends be increased to recognise their valuable contribution to health service delivery. Ogunmefun et.al (2011: 10) in their study highlighted that non-payment of stipends to CCGs resulted in poor performance and lack of commitment. These findings concurred with those from other studies (Lehmann and Sanders, 2007; Friedman et al. 2010). Therefore, it is imperative for the Department of Health to address the issue of payment of stipends for all CCGs, in view of the implementation of the PHC outreach team programme.

Friedman et al. (2007: 5) noted that most CCGs were single unemployed women, with no matric or other qualifications, aged 20-40 years who were desperately in need of a living wage. Their stipend ranged from R1 500 to R3 000. The Policy on CCG management recommends that at least R500 be the

stipend in the first NQF level, but increase to a R1 000 as they move to levels two and three, possibly even higher once they are fully qualified as a CCG in their fourth year of training (Department of Health 2009b: 49).

5.10 OUTCOME

5.10.2 Unsafe practices

Insufficient or incomplete kits supplied for the CCGs to care for their clients resulted in unsafe practices by the CCGs. Unsafe practices included re-use of domestic gloves from one client to another which promoted cross-infection. Clients with infectious diseases were given bed bath barehanded because of limited number of disposable gloves supplied and the CCGs were at risk of contracting the diseases. CCGs were tracing and visiting TB treatment defaulters that were highly infectious. These clients were also interviewed by the CCGs which exposed them to possible MDR/XDR TB because no face masks were available in the kits. According to Occupational Health and Safety Act (Act No. 85 of 1993) section 8, as amended in 2012, an employer has a duty to provide and maintain a working environment that is safe and without risk to the health of employees and to provide personal protective equipment.

Some of the CCGs did not do TB defaulter tracing stating that they would only trace defaulters after getting face masks, which affected service delivery to the community. Uwimana et al. (2012: 495) concluded that inconsistency of supplies and commodities such as kits need to be resolved to increase uptake of services.

5.10.3 Unsafe working conditions

The use of personal clothes and shoes by the CCGs when performing their duties constituted health hazards. The risk of carrying infection from one

household to another and even to their homes was noticed because other CCGs verbalised that, they only changed clothes after two-three days of using them. CCGs were exposed to extreme weathers of all seasons, because they work in the community and only given yellow plastic jackets throughout the seasons. Department of Health (2009b:79) states that CCGs provide their services under difficult conditions that could lead to burnout and disillusionment with their work. This may threaten their wellbeing and the sustainability of their services.

5.11 LIMITATIONS OF THE STUDY

This study was conducted in eThekwini District and, as such, is not transferable to other districts. Only CCGs affiliated to eThekwini Municipality PHC clinics were interviewed, so it is therefore difficult to generalize the study findings to CCGs working with KZN Provincial PHC clinics. All study participants were Africans mainly working with African clients in informal settlements, and as such, the results cannot be generalized to other race groups in formal houses.

5.12 CONCLUSION

In this study, the experiences of the CCGs in eThekwini District were explored and described. In all the five themes identified, the CCGs verbalized dissatisfaction on issues such as insufficient supplies of kits, protective clothing not considered for them yet they worked as employees. Procedures and criteria for selection of people for further training were not clear; their safety was not considered as important by the employer. Issues of support and supervision from the PHC clinics and the district were also not receiving the attention they deserved. CCGs were dissatisfied and discouraged and only working because they did not have any other means to survive.

5.13 RECOMMENDATIONS

5.13.2 Institutional management and practice

It is recommended that eThekwini District Office continues to procure, supply and deliver kits for the CCGs, but storage is to be negotiated with relevant PHC clinics that work with the CCGs for easy accessibility. The ordering and control of kits should be the responsibility of the PHC clinic manager.

From the interviews it was evident that the CCGs work eight hours a day, five days a week. It is recommended that incentives in the form of uniforms and protective clothes be considered. Protective clothes to include safety shoes, face masks, hats and or umbrella. This will be in accordance with infection prevention and control policy for health workers. Uniform supply to all community health workers is recommended than financial incentives, so that all of them use the same uniform.

It is recommended that the CCGs be given Hepatitis B vaccines on signing the contract for the first time and be followed up as are other permanent health workers. Pre-employment medicals and periodicals are recommended so that the CCGs are not subjected to working conditions that may aggravate their state of health.

It is recommended that there should be set criteria in place for further training and development for the CCGs. The criteria should include years of experience as a CCG, age and educational levels of the CCGs. The communicated criteria should also consider those elderly CCGs that have sacrifice their lives doing the work without formal education.

5.13.3 Policy development and implementation

It is recommended that the stipend should increase according to the years of experience for individual CCGs. According to the guidelines of PHC re-engineering, the outreach teams shall consist of CCGs and the draft contract specifies that the stipend shall be R2500 per month. It is also recommended that stipend increase should be revisited.

5.13.4 Further research

A broader study involving all the CCGs affiliated to all PHC clinics in eThekwini district on the required support and supervision is recommended

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Appendix 1: University ethics clearance certificate

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25 February 2014

IREC Reference Number: **REC 85/13**

Ms N N Mazibuko
5 Grandale Place
Newlands West
4037

Dear Ms Mazibuko

Experiences of community care givers caring for clients suffering from Tuberculosis in eThekwini District, KwaZulu-Natal

I am pleased to inform you that Full Approval has been granted to your proposal REC 85/13.

The Proposal has been allocated the following Ethical Clearance number IREC 013/14. Please use this number in all communication with this office.

Approval has been granted for a period of one year, before the expiry of which you are required to apply for safety monitoring and annual recertification. Please use the Safety Monitoring and Annual Recertification Report form which can be found in the Standard Operating Procedures [SOP's] of the IREC. This form must be submitted to the IREC at least 3 months before the ethics approval for the study expires.

Any adverse events [serious or minor] which occur in connection with this study and/or which may alter its ethical consideration must be reported to the IREC according to the IREC SOP's. In addition, you will be responsible to ensure gatekeeper permission.

Please note that any deviations from the approved proposal require the approval of the IREC as outlined in the IREC SOP's.

Yours Sincerely

Prof J K Adam
Chairperson: IREC

Appendix 2a: Permission letter to the KZN Department of Health

05 Grandale Place
Newlands West
4037

The Health Research and Knowledge Management Component
KwaZulu-Natal Department of Health
Private Bag X9051
Pietermaritzburg
3201

Dear Madam

Re: REQUEST FOR A PERMISSION TO CONDUCT A STUDY

I am presently registered for a Master's Degree at the Durban University of Technology in the Department of Nursing. The proposed title of my research project is **"Experiences of community care givers caring for clients suffering from Tuberculosis in eThekwini District, KwaZulu Natal".** The aim of the study is to explore and describe the experiences of community care givers caring for TB clients inorder to make recommendations regarding how the CCGs can be supported in executing their duties. Data will be collected by conducting interviews with the CCGs who are affiliated to eThekwini Municipal clinics, receive a stipend from the KZN Department of Health and have been working for the past two years.. Two clinics with the highest TB case load will be selected from each sub-district namely, South, West and the North sub-districts.

I hereby request your permission to conduct a research project using the CCGs who are under your employment but placed at eThekwini Municipality Health Institutions as the study participants. My research proposal has been attached for your perusal.

Your support and permission to conduct the study using the CCGs as the study participants will be appreciated.

Sincerely

……..
Ms NN Mazibuko (Student)
Telephone: 082 838 5649
Email: norahntombifuthi@yahoo.com

……
Dr MN Sibiya (Supervisor)
Telephone: 031-373 2606
Email: nokuthulas@dut.ac.za

……
Ms TSP Ngxongo
Telephone: 031-373 2609
Email: thembelihlen@dut.ac.za

Appendix 2b: Letter of approval from the KZN Department of Health

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

Health Research & Knowledge Management sub-component
10 – 103 Natalia Building, 330 Langalibalele Street
Private Bag x9051
Pietermaritzburg
3200
Tel.: 033 – 3953189
Fax.: 033 – 394 3782
Email.: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

Reference : HRKM 50/14
Enquiries : Mr X Xaba
Tel : 033 – 395 2805

Dear Ms NN Mazibuko

Subject: Approval of a Research Proposal

1. The research proposal titled **'The experience of community care givers (CCG) caring for clients suffering from Tuberculosis in eThekwini District, KwaZulu Natal'** was reviewed by the KwaZulu-Natal Department of Health.

   The proposal is hereby **approved** for research to be undertaken at KwaMashu B, Verulam, Illovu, Lamontville, Pinetown and Tshelimnyama clinics.

2. You are requested to take note of the following:
   a. Make the necessary arrangement with the identified facility before commencing with your research project.
   b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.

3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Mr X. Xaba on 033-395 2805.

Yours Sincerely

[redacted]

Dr E Lutge
Chairperson, Health Research Committee
Date: 23/04/14

Appendix 3a: Permission letter to the District Manager of eThekwini District

05 Grandale Place
Newlands West
4037

EThekwini District Office
Durban

Dear Madam

Re: REQUEST FOR A PERMISSION TO CONDUCT A STUDY

I am presently registered for a Master's Degree at the Durban University of Technology in the Department of Nursing. The proposed title of my research project is **"Experiences of community care givers caring for clients suffering from Tuberculosis in eThekwini District, KwaZulu Natal".** The aim of the study is to explore and describe the experiences of community care givers caring for TB clients in order to make recommendations regarding how the CCGs can be supported in executing their duties. Data will be collected by conducting interviews with the CCGs who are affiliated to eThekwini Municipal clinics, receive a stipend from the KZN Department of Health and have been working for the past two years.. Two clinics with the highest TB case load will be selected from each sub-district namely, South, West and the North sub-districts.

I hereby request your permission to conduct a research project using the CCGs who are under your employment but placed at eThekwini Municipality Health Institutions as the study participants. My research proposal has been attached for your perusal.

Your support and permission to conduct the study using the CCGs as the study participants will be appreciated.

Sincerely

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Ms NN Mazibuko (Student)
Telephone: 082 838 5649
Email: norahntombifuthi@yahoo.com

……
Dr MN Sibiya (Supervisor)
Telephone: 031-373 2606
Email: nokuthulas@dut.ac.za

Ms TSP Ngxongo
Telephone: 031-373 2609
Email: thembelihlen@dut.ac.za

Appendix 3b: Letter of approval from the Manager of eThekwini District

Appendix 4a: Permission letter to the Head of Health of eThekwini Municipality

05 Grandale Place

Newlands West

4037

The Head of Health Unit

EThekwini Municipality

9 Archie Gumede Place

Durban

4000

Dear Sir/ Madam

Re: REQUEST FOR A PERMISSION TO CONDUCT A STUDY

I am presently registered for a Master's Degree at the Durban University of Technology in the Department of Nursing. The proposed title of my research project is "Experiences of community care givers caring for clients suffering from Tuberculosis in eThekwini District, KwaZulu Natal". The aim of the study is to explore and describe the experiences of community care givers caring for TB clients inorder to make recommendations regarding how the CCGs can be supported in executing their duties. Data will be collected by conducting interviews with the CCGs who are affiliated to eThekwini Municipal clinics, receive a stipend from the KZN Department of Health and have been working for the past two years.. Two clinics with the highest TB case load will be selected from each sub-district namely, South, West and the North sub-districts.

I hereby request your permission to conduct a research project at your institute. My research proposal has been attached for your perusal.

Your support and permission to conduct the study in your clinic will be appreciated.

Sincerely

……..

Ms NN Mazibuko (Student)

Telephone: 082 838 5649

Email: norahntombifuthi@yahoo.com

……

Dr MN Sibiya (Supervisor)

Telephone: 031-373 2606

Email: nokuthulas@dut.ac.za

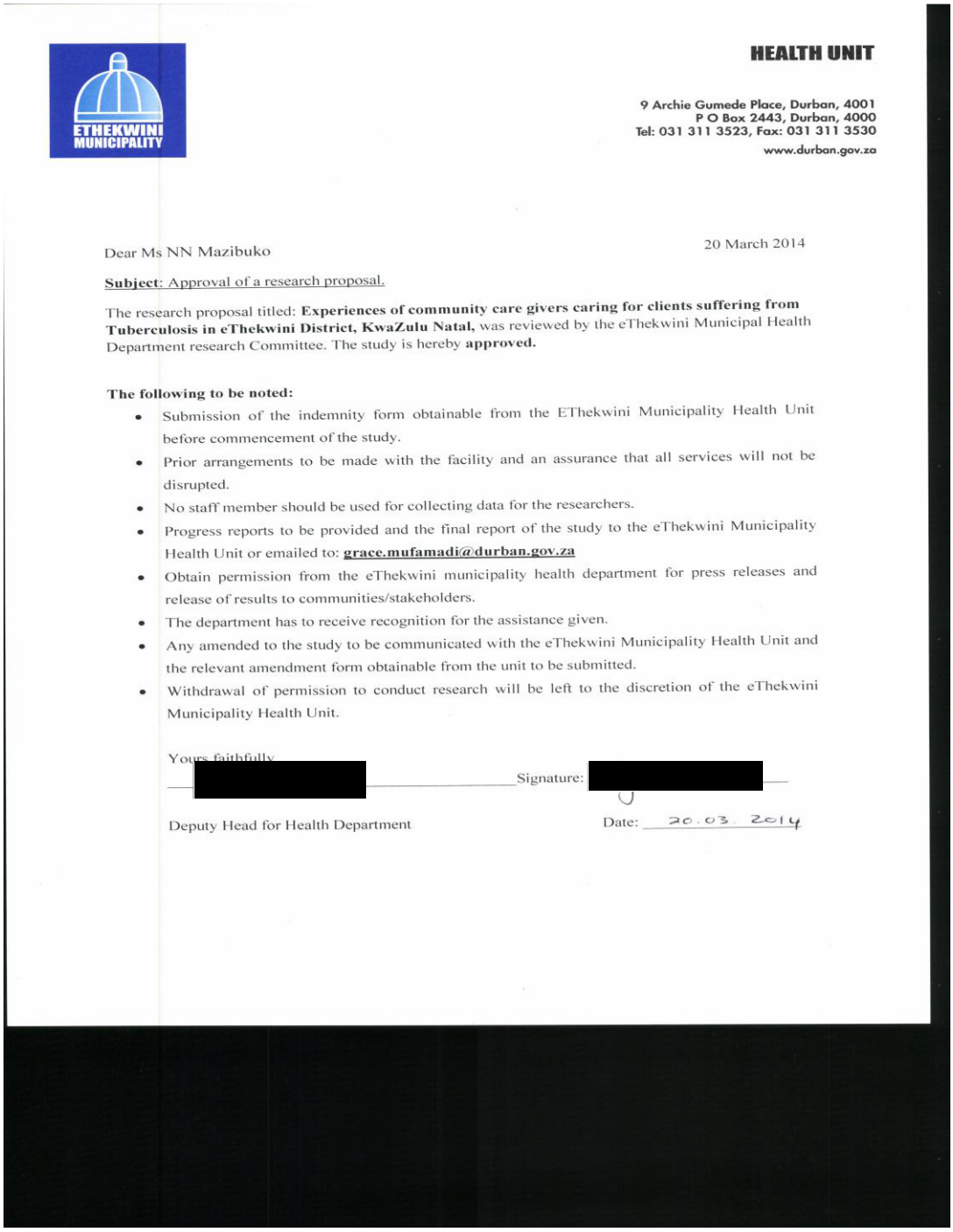
……

Ms TSP Ngxongo

Telephone: 031-373 2609

Email: thembelihlen@dut.ac.za

Appendix 4b: Approval letter from the Head of Health of eThekwini Municipality



HEALTH UNIT

9 Archie Gumede Place, Durban, 4001
P O Box 2443, Durban, 4000
Tel: 031 311 3523, Fax: 031 311 3530
www.durban.gov.za

Dear Ms NN Mazibuko

20 March 2014

Subject: Approval of a research proposal.

The research proposal titled: **Experiences of community care givers caring for clients suffering from Tuberculosis in eThekwini District, KwaZulu Natal,** was reviewed by the eThekwini Municipal Health Department research Committee. The study is hereby **approved.**

The following to be noted:

- Submission of the indemnity form obtainable from the EThekwini Municipality Health Unit before commencement of the study.
- Prior arrangements to be made with the facility and an assurance that all services will not be disrupted.
- No staff member should be used for collecting data for the researchers.
- Progress reports to be provided and the final report of the study to the eThekwini Municipality Health Unit or emailed to: **grace.mufamadi@durban.gov.za**
- Obtain permission from the eThekwini municipality health department for press releases and release of results to communities/stakeholders.
- The department has to receive recognition for the assistance given.
- Any amended to the study to be communicated with the eThekwini Municipality Health Unit and the relevant amendment form obtainable from the unit to be submitted.
- Withdrawal of permission to conduct research will be left to the discretion of the eThekwini Municipality Health Unit.

Yours faithfully

[redacted] Signature: [redacted]

Deputy Head for Health Department

Date: 20.03.2014

Appendix 4c: Indemnity cover from eThekwini Municipality

No. M.1/1/2

Director : Health
Box 2443
DURBAN
4000

Researcher- Name: _____
Institution- Name: _____
Institution- Address: _____
_____
_____
Research Subject: _____

Dear Sir/Madam

RESEARCH SITE : ETHEKWINI MUNICIPALITY HEALTH DEPARTMENT

I, the undersigned, hereby wish to apply for permission to attend the eThekwini Health Department to undertake research on Council property.

I understand that any permission granted to me will be subject to:
(a) there being no additional cost to the Council; and
(b) the exigencies of the eThekwini Health Department, and provided that no interference with its programme will ensue.

In consideration of the facilities given and to be given to me by the eThekwini City Council, as aforesaid, I hereby indemnify the said Council and its officers and hold it and them harmless against and hereby waive, renounce and abandon any claim for damages or compensation arising from injury or loss which I may sustain whilst on Council property or transport or on the way to or from any Council property or place of research or which I may sustain in any way whatsoever whilst conducting research.

I further indemnify the eThekwini Council and its officers against any claim whatsoever which may in any way result from the facilities afforded to me and be brought against the said Council or its officers.

Date: _____ _____
Researcher's Signature

Witness: _____

_____
Researchers Name (in capital letters)

Permanent Address:

_____

_____

Period
From: _____ to _____

Appendix 5a: Letter of information and consent to participants (English)

LETTER OF INFORMATION

Thank you for agreeing to participate in this study. The details of the study are outlined below.

Title of the Research Study: Experiences of community care givers caring for clients suffering from Tuberculosis in eThekwini District, KwaZulu Natal.

Principal Investigator/s/researcher: Ms NN Mazibuko (M Tech Candidate)

Co-Investigator/s/supervisor/s: Dr MN Sibiya (D Tech: Nursing) and Ms. TSP Ngxongo (M Tech: Nursing)

Brief Introduction and Purpose of the Study: I will be conducting the study about your experiences in caring for TB clients in eThekwini. I am interested in learning about two things (1) your experiences as a community care giver, (2) the support system that is available for the community care givers. I will use the information to make recommendations regarding how you can be supported in order to execute your duties as required.

Outline of the Procedures: I will ask you few questions on your experiences as a community care giver. The interview will last between 20-30 minutes. Follow up interviews will be done and these will take place at the clinics where you report at the time that is convenient for you.

Risks or Discomforts to the Participant: None.

Benefits: The information from the interviews will be used to make recommendations regarding how you can be supported in order to execute your duties as required.

Reason/s why the Participant May Be Withdrawn from the Study: You are free to withdraw from the study at any time and there is no penalty that will be imposed on you.

Remuneration: There is no remuneration for participating in the study.

Costs of the Study: You will not bear any costs by participating in this study.

Confidentiality: All the information gathered during the study will be kept in private. The paper based information will be kept in a locked cabinet and the electronic information will be secured with a private code that will only be known to the research. Your name will not be written on data collection sheets and the information that you give will be used for this study only

Research-related Injury: There are no anticipated research-related injuries.

Persons to Contact in the Event of Any Problems or Queries:

Please contact the researcher, Ms NN Mazibuko (Tel no 082 838 5649), my supervisor, Dr MN Sibiya (Tel no 031-373 2606), my co-supervisor, Ms TSP Ngxongo (Tel no 031-373 2609), or the Institutional Research Ethics administrator on 031-373 2900. Complaints can be reported to the DVC: TIP, Prof F. Otieno on 031 373 2382 or dvctip@dut.ac.za.

CONSENT

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, Ms Ntombifuthi Mazibuko (name of researcher), about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number: _____,
- I have also received, read and understood the above written information (Participant Letter of Information) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerised system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

_____	_____	_____	_____
Full Name of Participant	**Date**	**Time**	**Signature / Right Thumbprint**

I, _____ (name of researcher) herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

_____	_____	_____
Full Name of Researcher	**Date**	**Signature**

_____	_____	_____
Full Name of Witness (If applicable)	**Date**	**Signature**

_____	_____	_____
Full Name of Legal Guardian (If applicable)	**Date**	**Signature**

Appendix 5b: Letter of information and consent to participants (IsiZulu)

Incwadi yolwazi

Siyabonga ukuba uvume ukuba yingxenye yalolucwaaningo. Imininingwane mayelana nocwaningo ingenzansi.

Isihloko socwaningo: Izimo ono-Mpilo abahlangabezana nazo uma benakekela iziguli eziphethwe u-Fuba eThekwini District.

Uncwaningi omkhulu: Ms N.N. Mazibuko (umfundi weMastazi).

Abambekile: Udokotela MN Sibiya (D Tech: Nursing) kanye noNkosikazi TSP Ngxongo (D Tech: Nursing).

Isingeniso esifishane kanye nenhloso yocwaningo: Ngizobe ngenza ucwaningo ngezimo enihlangabezana nazo uma ninakekela iziguli ezino-Fuba eThekwini District. Ngifisa ukwazi ngezinto ezimbili (1) Izimo ohlangabezana nazo njengo noMpilo. (2) Usizo/uxhaso olutholayo njengono-Mpilo. Ulwazi engizoluthola ngizolusebenzisa ukwenza izincomo ngendlela eningasizwa/nixhaswe ngayo ekwenzeni umsebenzi ngendlela.

Inqubo yohlelo: Ngizokubuza Imibuzo embalwa ngezimo ohlangana nazo njengo no-Mpilo. Imibuzo izothatha imizuzu ewu 20-30. Kuyobakhona nomhlangano olandelayo oyokwenzeka khona emtholampilo osebenzisana nawo ngesikhathi esiyovumelana nawe.

Ukungaphatheki kahle kwabangenele ucwaningo: Abukho ubungozi nokungaphatheki kahle kwabangenele lolucwaningo.

Inzuzo: Lolucwaningo luzosiza ekutheni kwenziwe izincomo ngendlela eningasizwa/nixhaswe ngayo ekwenzeni umsebenzi ngendlela.

Izizathu ezingenza labo abayinxenye yocwaningo bengabe besaqhubeka nocwaningo: Uvumelekile noma yinini ukuphuma ungabi yingxenye yocwaningo uma ufisa ukwenza njalo.

Inkokhelo: Ayikho inkokhelo etholakalayo ngokuba yingxenye yocwaningo, kanjalo nalabo abayinxenye yocwaningo akulindelekile ukuthi bakhokhe ukuze babe yingxenye.

Ukugcinwa kwemfihlo: Yonke Imininingwane iyogcinwa iyimfihlo, Wonke amaphepha aqukethe imininingwano ngocwaningo ayogcinwa ebhokisaneni elikhiyiwe bese kuthi konke okuwuhlelo lwamakhomputha kuvikelwe ngekhodi eyimfihlo eyokwaziwa kuphele ngumcwaningi. igama lakho angeke libhalwe ezimpendulweni ozinikile, lezimpendulo ziyosetshenziselwa lolucwaningo kuphela.

Ukulimala okungenzeka ngenxa yocwaningo: Akukho ukulimala okungenzeka kuloluhlobo locwaningo.

Ongabathinta uma unemibuzo noma ofuna ukuchazelwa ngakho mayelana nalolucwaningo:

Thinta umcwaningi, Ms NN Mazibuko (Tel no 082 838 5649), umbhekeleli Dr. MN Sibiya (Tel no 031-373 2606), osizana naye, Ms TSP Ngxongo (Tel no 031-373 2609), or the Institutional Research Ethics administrator on 031-373 2900. Izikhalazo zingabikwa ku DVC: TIP, Prof F. Otieno on 031-373 2382 or dvctip@dut.ac.za.

IMVUME

Isitatimende sesivumelwano sokuba yingxenye yocwaningo:

- Mina ngiyaqiniseka ukuthi ngitsheliwe futhi ngachazelwa lapho ngingaqondi khona ngakolucwaningo u Ms N.N. Mazibuko (igama lomcwaningi). Ngiyaqiniseka ukuthi ngichazelwe ngohlobo locwaningo, usizo lwalo nokuthi abukho ubungozi engingabulindela ngalo. (name of researcher), - Research Ethics Clearance Number: _____,
- Nginikiwe incwajana emayelana nalolucwaningo, ngayifunda futhi ngachazelwa ngayo.
- Ngiyaqonda ukuthi imiphumela yalolucwaaningo uma isishicilelwa angeke kufakwe Imininingwane yami, ubulili, Iminyaka Usuku lokuzalwa noma isifo sami.
- Ngiyavuma ukuthi ulwazi oluzotholwa kimi luhlelwe ngohlelo lwama computer.
- Ngivumelekile noma yinini uma ngifisa ukungaqhubeki nocwaningo ukwenza njalo ngaphandle kokuthi kube nemiphumela emibi.
- Ngibenesikhathi esanele sokubuza futhi ngachazeleka kahle. Ngaleyondlela ngiyavuma ukuba yingxenye yalolucwaaningo.
- Ngiyaqonda ukuthi izinto ezibalulekile eziqhamukayo ngokuqhubeka kocwaningo ezithinta mina ngiyokwaziswa ngazo.

_____	_____	_____	_____
Igama lomcwaningi	**Usuku**	**Isikhathi**	**Isiginisha/ Isithupha sakhe**

Mina _____ (igama lomcwaningi) ngiyaqinisa ukuthi lo ocwaningwayo utsheliwe kabanzi

Ngocwaningo, nokuthi azikho izimo ezingaba yingozi kuye ngesikhathi socwaningo.

_____	_____	_____
Igama lomcwaningi	**Usuku**	**Sayina**
_____	_____	_____
Igama likafakazi (uma kunesidingo)	**Usuku**	**Sayina**
_____	_____	_____
Igama lombekeleil (uma kunesidingo)	**Usuku**	**Sayina**

Appendix 6a: Interview guide (English)

Interview Guide for the community care givers

Date---------- Clinic no. Participant no.

Demographic data

Age---------- Gender ----------

Race---------- Years of experience---------

Grand tour question

- What are your experiences in caring for TB clients in the community where you work?

Guided tour questions

- Describe the support system that you are getting performing your duties.
- What challenges are you experiencing in caring for TB patients in their communities?
- What would be your recommendations regarding solutions to these challenges?

NB: The questions will be guided and supported by probing where necessary so that the researcher can get clarity on information given.

Appendix 6b: Interview guide (IsiZulu)

Uhlelo lokuqondisa umhlangano no-Nompilo

Usuku----------Inombolo yomtholampilo Inombolo yongenele ucwaningo

Imininingwane yongenele ucwaningo

Iminyaka---------- Ubulili----------

Ubuzwe---------- Iminyaka yolwazi----------

Umbuzo omkhulu womhlangano

- Chaza ngamazwi akho izimo ohlangabezana nazo uma unakekela iziguli ezinesifo so-Fuba endaweni osebenza kuyo.

Imibuzo yokusekela umhlangano

- Chaza usizo/uxhaso oluthola uma wenza umsebenzi wakho.
- Iziphi izingqinamba ohlangabezana nazo emphakathini ngokunakekela leziguli?
- Iziphi iziphakamiso ongazenza ukuxazulula lezingqinamba?

Qaphela: Lemibuzo engenhla iyonanelwa eminye Imibuzo engacacisa kahle uma kunesidingo ukuze umcwaningi athole kahle okushiwo ocwaningwayo.