CHALLENGES FACING HOME AND COMMUNITY BASED CARE GIVERS ON HIV/AIDS CARE AND SUPPORT SERVICES IN RATLOU, NORTH WEST PROVINCE

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Challenges facing Home and Community Based care givers on HIV/AIDS care and support services in Ratlou, North West province

By

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A mini-dissertation submitted in partial fulfilment of the requirement for the degree of Master of Public Management (MPM)

University of Venda

School of Management Sciences

Oliver Tambo Institute of Governance and Policy Studies

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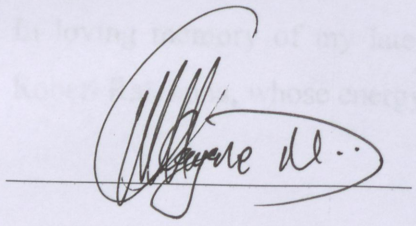
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DECLARATION

I, **Ndivhuho Mangale** hereby declare that the mini-dissertation for the Master in Public Management degree at the University of Venda hereby submitted by me has not previously been submitted for a degree at this or any other university, and that it is my own work in design and in execution and that all referenced material contained therein has been duly acknowledged.



09 / May / 2014

NDIVHUHO MANGALE

Date

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DEDICATION

I dedicate this work to my wife, Nakiseni Themeli-Mangale, and to my children, Pfunzo and Ndamulelo Mangale. Also to my parents Angelina and Mmbengeni Mangale, two Sisters Livhuwani, Azwinyandi, brother Rudzani and Grandmother Nyawasedza Mangale for their understanding and prayers although-out my studies

In loving memory of my late brother Khuliso Michael Tshigoba and my friend Shumani Robert Ralebona, whose energy and love for life inspire me even today.

Philippians 4:13: I can do all things through Christ who gives me strength.

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LIST OF ABBREVIATIONS

The following acronyms and terms are used throughout the thesis. They are listed here for reference and clarity;

AIDS:	Acquired Immunodeficiency Syndrome
ART:	Antiretroviral Treatment
CBO:	Community-Based Organisation
CSW:	Commercial Sex Workers
DOH:	Department of Health
HIV:	Human Immunodeficiency Virus
HSRC:	Human Sciences Research Council
M&E:	Monitoring and evaluation
MRC:	Medical Research Council
MSM:	Men who have Sex with Men
NEPAD:	New Partnership for African Development
NHLS:	National Health Laboratory Services
NSP:	National Strategic Plan (on HIV, AIDS and STIs)
OVC:	Orphans and Vulnerable Children
PEP:	Post-Exposure Prophylaxis
PMTCT:	Prevention of Mother to Child Transmission (of HIV)
PLHIV:	Person/people living with HIV
SABCOHA:	South African Business Coalition against HIV and AIDS
SADC:	Southern African Development Community
SANAC:	South African National AIDS Council
STI:	Sexually Transmitted Infection
TB:	Tuberculosis
VCT:	Voluntary Counselling and Testing
UNAIDS:	Joint United Nations Program on AIDS
UNGASS:	United Nations General Assembly Special Session
WHO:	World Health Organisation
MTCT:	Mother to Child Transmission
ART:	Anti-Retroviral Therapy
HTA:	High Transmission Area
ANC:	Antenatal Clients
CHBC:	Community-Home Based Care

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CBC:	Community Based Care
HBC:	Home Based Care
LED:	Local Economic Development
SPSS:	Statistical Packages for Social Service

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ABSTRACT

The study is about the experiences of Home Community Based care workers when rendering HIV care and support services in the process of PHC re-engineering in Ratlou sub-district in North West province. The purpose of the study was to explore and describe experiences and challenges facing care givers facing Home and Community Based Care workers when they are rendering HIV and AIDS care and support services in Ratlou-Sub district of North West province. The specific objectives of this study were to identify and describe major challenges facing home based care givers when rendering HIV care and support services within the sub-district; to assess sustainability of home community based care projects; to assess Home based care integration with health systems and community; to describe care and support services rendered by care givers; to recommend effective and efficient mechanisms, approaches and methods suitable to improve home community based care organisations.

The researcher utilised triangulation of both Qualitative and Quantitative research method and descriptive study design was used. The researcher used sample size of 70 respondents based on their knowledge and experience in HIV care and support. In this study Questionnaire was self administered together with 70 respondents purposively selected from population of 290 and a separate interview guide was used to interview 5 (five) home based care project managers purposefully selected based on the years of experiences and services they are rendering from 12 Home based care organization in Ratlou sub-district provided by the department of health.

The study findings show that there is a good relationship between home-based care givers and health care workers.

- Only few home based care projects have sufficient funding from other institutions to can sustain the project and of which less than 50% of the project have the chance of sustaining itself in the absence of funds.
- The results show that services home based care givers are rendering are benefiting the surrounding communities which the project situated.
- Majority of the home based care projects have stakeholders participate on the running of the project.

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- The results show that monitoring and reporting systems such as reporting tools are linked with the department of Health and Social Development systems. Majority of the respondents' indicated that patients are provided with a detailed referral form when referred to clinic.
- The results further reveal that there is still delay on payment of stipend among care givers and payment of stipend among care givers.
- The results further reveal that there is lack of training on care givers in the field of their work. If home based care and health systems can be integrated this can smooth the process of Primary health care (PHC) Re-engineering in South Africa.

It is recommended that all home based care givers should form part of the Primary Health care team and consideration should be given to government employing them.

- Measure to be taken to ensure that home based care project must start poverty and income generating project to ensure sustainability in the absence of funding.
- The government must define the role of the Home based care givers within the context of the PHC re-engineering strategy; and also redefine their scope of practice including for those who are care givers who are not doing PHC re-engineering.
- The researcher further recommends that government must strengthen relations between health services and stakeholders and representatives in the communities.
- There is a need to strengthen referral systems between facilities, traditional health practitioners and other community structures, such as tribal authority and religious support groups.
- There is high demand to train family members about the importance of home based care givers and establish relationship in order to improve attitude towards care givers.
- There should be strong monitoring and evaluation systems in place to track the role and contribution of Home based care givers within the context of the Ward Based PHC Outreach Teams.
- There is a strong need to provide training for Community care givers on identifying patients who require home based care services.
- Payment of stipends should be prioritised, develop a new system to monitor payment of care givers stipends as home based care givers still travel long distances without any means of transport.

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- The department of health and social development should provide continuous education, training, mentorship & supervision to partner organisations.

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CHAPTER ONE: INTRODUCTION AND BACKGROUND OF THE STUDY

1.1 Introduction

The study is about the experiences of Home Community Based care givers when rendering HIV care and support services in the process of Primary Health care (PHC) re-engineering. The purpose of the study is to explore experiences and challenges facing care givers when rendering Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) care and support services, in Ratlou-Sub-District, North West province. This chapter focuses on the introduction and background of the study. It covers the background of the study, major research questions, aims and objectives of the study, motivation and importance of the study, research methodology, delimitation of the study, definitions of concepts and division of the study.

1.2 Background of the study

Provision of Home and Community Based care (HCBC) has grown rapidly over the last five years with increase numbers from 13 organizations funded in 2001 organisations compared to 1823 funded in 2007 and in 2008 financial year. Over 600 community care centres including drop-in-centres developed, this constitute about 70% of the sub-districts in the country with up to 35 000 community care givers trained (South Africa Department of Social Development , 2009:15). Further literature reveal that Development of core indicators for the HCBC and the Orphans and Vulnerable Children (OVC) programs increased number of care givers receiving government stipend (South Africa Department of Social Development, 2009:16). In 2008 there were about 65 Non- Profit Organization (NPOs) in North West province of which two NPOs are providing youth friendly services. In 2009 there were about 5330 Home Based Care givers who were receiving stipend of R850 but which was due to increase to R1000 per month as recommended. About 555 Care givers were trained on HIV and AIDS NQF Level1 and 500 care givers were trained on Auxiliary Training (South Africa Department of Social Development, 2009:166-178).

In Uganda it is evident that community-based organisations (CBOs) and non-government organisations (NGOs) are crucial for the successful combating of the HIV pandemic. Globally many community organisations are involved in community support programmes of

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various kinds. It is recognised that such community organisations could play an even greater role in HIV prevention, as they are in contact with those people most vulnerable to becoming infected with HIV (Van Wyk, Strebel, Peltzer, and Skinner, 2006: 3).

Since the beginning of the HCBC programme in 2000, several guidelines were developed by the Department of Health and Social Development such as; the National Guidelines for Social Services to children infected and affected by HIV and AIDS; Integrated Home and Community Based Care modes; guidelines of the establishment of Community Based multipurpose care Drop-in Centres; Guidelines for establishing Child Care forums; Guidelines for Establishing support groups and Guidelines for Establishing Home and Community Based care and support (HCBC) programme (South Africa Department of Social Development, 2007: 6).

It has been realised that uniformity has not been achieved in the quality of services provided by the HCBC organizations. This became more evident in the study commissioned by the Department of Social Development to evaluate the cost and process indictors for HCBC programme in 2005. The study has illustrated variability in costs and Quality of services provided due to variations content, frequency and standard of services provided. It is imperative to note that norms and standards are means to ensure the provision of quality of services and that fund are utilised effectively and efficiently to maximise the actual and potential benefits of the HCBC programme (South Africa Department of Social Development, 2007: 6).

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Norms and standards are therefore not meant to be prescriptive however; there should be desire by organizations to exceed minimum expectations. Furthermore monitoring and evaluation of the HCBC programme in the implementation of the norms and standards is crucial, especially in identifying gaps in services rendered and for generating information and lessons learnt that could be used to make evidence-based decisions and policy making process that would improve the capacity and sustainability of HCBC organizations (South Africa Department of Social Development, 2007: 7).

The South Africa National Strategic Plan (NSP) 2007 to 2011 seeks to provide guidance to all government departments and sectors of civil society on addressing HIV and AIDS/STIs, building on work done in the past decade. The national multi-sectoral response to HIV and

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AIDS is managed by different structures at all levels. Provinces, local authorities, the private sector and a range of community-based organisations (CBOs) are the main implementing agencies. Each government department has a focal person and team responsible for planning, budgeting, implementing and monitoring HIV and AIDS interventions. In this plan, communities are envisaged to take more responsibility and to play a more meaningful role in planning and implementing activities (South African National Department of Health and SANAC, 2007: 47).

1.3. Statement of the problem

The operational plan policy for Comprehensive HIV and AIDS Care, Management and Treatment (CCMT) for South Africa of November 2003, provides a detailed framework for the care and treatment of South Africans infected with HIV and AIDS, including the provision of anti-retroviral treatment. The Plan recognises the role of Home and Community Based Care (HCBC) organisations in providing services to people infected with HIV and AIDS. It identifies home-based care as a useful tool for assessing and supporting patient adherence to Antiretroviral treatment (ARV) and other therapies, including locating and reaching out to patients who miss scheduled appointments, and promoting continuity of care and adherence with ARV regimens. The plan also recognises the importance of community-linked prevention strategies carried out and notes that such services can do a great deal to minimise fear and discrimination, providing and reinforcing accurate information to address stigma surrounding HIV infection. The Plan acknowledges the contributions of both paid and volunteer caregivers, noting the risks of burnout from emotional and psychological stress and overwork. It advocates for the provision of time and structured programmes for debriefing and grief management for caregivers (South Africa Department of Health, 2003). This include what was outlined in the HIV/AIDS/STD Strategic Plan for South Africa of 2007-2011 that one of the sub-goals under treatment, care and support is to provide adequate treatment, care and support services in communities, including implementing models of community/home-based care in all provinces and promoting the acceptability of such care.

The challenge is that among those who practise home-based care are volunteers and there is little knowledge about their experiences relating to the voluntary work they do in rural setting. Research is therefore needed to explore the impact of this new policy on the volunteers and care givers as well as those for whom they care. This knowledge is vital for

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the planning, development and implementation of voluntary programmes related to home-based care. The research findings may also identify aspects of the policy that need to be reconsidered, or indicate areas in which further research is needed. Despite the guidelines and policy provision there are still challenges facing home and community care workers when they are rendering HIV care and support services. Most of the challenges include lack of proper funding, delay in payment of stipends, lack of transport to access patients home and clinics. A national audit on home and community-based care (HCBC) organisations in South Africa showed that most of the organisations were, however, faced with challenges such as lack of access to water, electricity and computer equipment and a formal office space. In addition, some organisations were in need of funds for stipends for their community caregivers (Ogunmefun, Friedman, Mothibe and Mbatha, 2011:2).

The research problem is that, there are challenges which are facing Home Based care workers which are not being addressed; hence there is a need for a fuller understanding of the challenges and contributions of the home community based care workers. Majority of community home based care projects are striving to sustain due to factors such as lack of project management skills, political involvement in the running of projects, bringing service to the people who are living in deep rural areas, to obtain community commitment, illness of volunteers or care givers, lack communication. In the study commissioned by the Department of Social Development in 2006 Management challenges have been recorded under financial, personnel, training and capacity building as well as infrastructure. HCBCs that are not funded by the Departments of Health or Social Development requested funding from either of the government departments and they were not sure how to access funding from these departments. The HCBCs require funding not only for stipends but also to cover basic expenses such as repairs, telephone and transport costs. Some HCBCs do not have the funds to insure their equipment so if anything gets damaged; they often have to wait for financial assistance before being able to repair the items (South Africa Department Social Development, 2006: 65).

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1.4 Aim and objectives of the study

The following are the aim and the specific objectives of the study;

1.4.1 General objective

The overall aim of the study was to explore and describe challenges facing Home and Community Based Care workers when they are rendering HIV and Aids care and support services in the process of PHC re-engineering in Ratlou Sub-district, of North West province.

1.4.2 Specific objectives

The objectives of the study are:

- To describe major challenges facing home based care givers when rendering HIV care and support services within the sub-district
- To assess sustainability of Home community based care projects
- To assess Home based care integration with Health systems and community
- To describe care and support services rendered by care givers
- To recommend effective and efficient mechanisms, approaches and methods suitable to improve home community based care organisations.

1.5. Major research questions

The following research questions are formulated in order to achieve the above set objectives;

- What are the challenges facing Home community care givers when rendering HIV/AIDS care and support services?
- Are care givers provided with relevant skills, training, knowledge and training to caregivers?
- Are the care givers provided with stipends?
- Are project managers able to sustain projects in the absence of Government funding?
- Are the projects having access to funding for sustainability?
- Are the home community based projects relating with the community and stake holders?

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1.6. Significance of the study of the study.

According to De Vos , Strydom,, Fouche and Delport,.(2000:118) in this part of the proposal, one takes the opportunity to convince the reader of the value of the proposed research and to indicate that the results of the study will be relevant for the people in other settings. Convincing the reader that the study is significant and should be conducted, entails building an argument that links the research to larger, important theoretical problems, social policy issues, or concerns of practice. Research conducted It must contribute to the knowledge and useful for practitioners (De Vos , Strydom, Fouche and Delport, 2000:118).

It is crucial for the department of Health and Social Development to assess Home Based Care services in health care facilities, this is particularly important in South African situation where health resources are unevenly distributed, between the rural areas, including distribution of health care providers. After the study results being analysed, the study will assist the Department of Health and Social Development in North West Province through District and sub district and facilities to understand the dynamics associated with the experience of Home Community Based Care workers and further develop insight into factors that affects Home Community Based projects. The study will assist other funders, policy makers and policy implementers within Department of Health to introduce measures and reinforce existing policies on Home Community Based Care to develop strategy and models to make an informed decision that can be used to strengthen treatment, care and support services in the province.

The study will contribute to the already existing body of knowledge on the experience of Home Community Based Care services. The study results will provide the information to Home Community Based Care projects regarding the knowledge and exposure of care workers. The study will enable the ministry of health to effectively utilize resources, infrastructures and to strengthen care and support services. Home Community Based Care projects can use the information gained to improve their client cantered services. The study importance as care workers who are not trained will be sent for relevant trainings to improve their skills in order to run sustainable Home based Care projects. Communities will be motivated to involve itself and to participate in planning and implementing home community

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based care projects. Projects will able to sustain themselves without depending on other sources of funding.

1.7 Relevance of the study

This study is relevant to public administration and management profession as evidenced in the following observations: public policy and intervention evaluation is one of public administration that directs public service delivery at community level. The government sets policies and instructions which direct community intervention. Public institutions including Nongovernmental organizations and not for profit organizations are regulated by policy statement such as legislations and regulation issued to serve as guidelines. Institutions are spending money through social investments and they receive feedback through monitoring how their resources are being spent. This study is relevant to evaluate public services delivery to measure access to services and public participation and accountability.

1.8 Limitations of the study.

Time constraint was included as possible limitation of the study for interviewing and subsequent data analysis as the study area is very scattered which were not easily accessible The absence of control group can also be considered as limitation as there won't be comparison of the participant's response and findings. Lack of funding in this project was considered as a limitation of study as travelling to home based care that is situated in a long distance rural setting was a challenge and most project are in distance roads which are easy accessible. Sensitivity to some of the questions about sustainability of funds may results in respondents not answering some of the question correctly as they think donors or funds can be stopped and to avoid bridging confidentiality of patients' information.

1.9 Delimitation of the study.

The study was conducted in Ratlou Sub-District Municipality and can be generalised to neighbouring municipality in similar situations. The study was focusing only on home base care givers. The researcher did not consider gender, age and ethnic group of respondents

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when selecting the sample size. The study focus on the experiences and challenges facing home based care givers within Ratlou Sub-district.

1.10 Definition of key terms

For the purpose of this study, the following concepts are defined in accordance with the research:

- **Project-**According to Van Der Waldt and Knipe (1998: 220) a project is a one-time effort to accomplish an explicit objective by a specific time, like the individual activity, the project has a district start and a finish and a time frame for completion, each activity in the project will be monitored and controlled to determine its impact on other activities and project.

- **Project Management-** According to Spinner(1992: 2) Project Management in the business and industry field is defined as managing and directing time, material, personnel, costs, to complete a particular project in an orderly, economical manner, and to meet established objectives in times, dollars, and technical results

- **Development Management-** According to Van Der Waldt and Knipe (1998:130) development management is a process whereby a person, community or a state manages development activities in order to achieve an objective, and continuously takes account of the environmental influences on the process.

- **Community Development-** Community Development refers to the process and a method aimed at enhancing the capacity of communities to respond to their own needs, and at improving their capacity for development, through community mobilization, strength-based approaches and empowerment programmes (South Africa Department of Social Development guide 2007: 18).

- **Sustainable Livelihoods-** According to South Africa Department of Social Development guide (2007: 18) Sustainable Livelihoods is rooted approaches rooted in

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particular people in a specific places making decisions about sustaining themselves and their families.

- **Community Capacity Building-** It is the process and means through which national Governments and Local Communities develop the necessary skills and expertise to manage their environment and natural resources in a sustainable manner within their daily activities (South Africa Department of Social Development guide, 2007: 24)

- **Sustainable Development-** It is a parallel paradigm emerging out of the environmental sector, within enormous significance for community development, it focuses on integrating strategies for economic growth, social development and environmental protection into a new paradigm for development, it is intended to provide a framework for global, national and local development strategies (South Africa Department of Social Development guide, 2007: 25).

- **Local Economic Development-** It is an essential process in which local; governments and/ or community based groups manage their existing resources and enter into partnership arrangements with private sectors, or with each other, to create new jobs and stimulate economic activity in an area (South Africa Department of Social Development guide, 2007: 26)

- **Community Participation-** According to Van Der Waldt and Knipe (1998: 142) Community participation is an active process in which the clients, or those who will benefit, influence the direction and improvement of a development project aimed at improving the welfare of the people in terms of income, personal growth, independence and other Values regarded as valuable.

- **A Community-** In chapter 4 of the municipal system Act, 2000 (Act no 32 of 2000), a community is defined as the body of persons comprising the residents of the municipality, the residents of the municipality, the ratepayers of the municipality, the civic organization and non-governmental, private sectors or labour organizations involved in local affairs and visitors who make use of facilities and services within a municipality.

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- **Home Community-Based Care (HCBC)** services- is defined in this study as the provision of comprehensive services which include health and social services by formal and informal care givers in the home or close to home, including institutional care with an out-reach programme (South Africa Department of Social Development, 2010: 7).

- **Home Community Care worker-** provides care for people who are still living in their own homes either after hospitalisation (South Africa Department of Social Development, 2010: 7).

- **Volunteer-** is an individual who offers their time to perform services for their community without remuneration though a recognised community Based Organization (South Africa Department of Social Development, 2010: IV).

1.11 Organization of the study

This study is divided into five chapters which are as follows:

- **Chapter 1: Introduction and Background of the Study**

This chapter focuses on the introduction and background of the study. It covers the background of the study, major research questions, aims and objectives of the study, motivation and importance of the study, research methodology, delimitation of the study, definitions of concepts and division of the study.

- **Chapter 2: Literature Review.**

This chapter explores the theoretical and historical framework relevant to Home and Community Based Care programme. It will also reveal the views of the various authors and researches concerning the Home based care workers.

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- **Chapter 3: Research Design and Methodology**

The chapter outlines research methods that will be used in the study. The natures of the study and research design are also explored. It also indicates the instruments that the researcher is going to use to collect data, the sampling procedure and its technique.

- **Chapter 4: Data Presentation, Analysis and Interpretation**

The chapter will present all information collected from the respondents according the type of the instruments used. The data will be presented in a meaningful way. The data will be presented and interpreted in narrative manner.

- **Chapter 5: Findings, Conclusion and Recommendations**

This chapter will focus on a discussion of the study results and recommendations, which include overview of the study, limitations of the study, recommendations of the study, implications of the study findings and a conclusion or summary.

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CHAPTER TWO: LITERATURE REVIEW

2.1. Introduction

This is the second chapter of the research project. This chapter reviews the existing literature of the research topic. The Researcher outlines the views of other authors and researchers about the issue related to challenges and experiences of Home and Community Care workers (HCBCW). The theoretical framework of the study is based on Home and Community Based Care literature has been outlined. The type of literature consulted for this review is generally articles from journals and reports produced by government departments and/or partners providing aid relief in HIV and AIDS programmes. This chapter includes the literature review on health care workers experiences in implementing Home and Community Base programme (HCBC). The following aspects are reviewed: Global and national responses to HCBC of HIV and AIDS care and support. Challenges facing HCBC implementation and barriers on the implementation of HCBC programmes, this include situation of HCBC in South Africa including various Conceptual framework that can be used to improve HCBC.

2.2. Policy and legislative framework review on Home Based Care in South Africa

This section briefly highlights the policy and legislative framework pertaining to HCBC programmes in South Africa. As a result of the need for appropriate services for people with chronic illness and those infected and affected by HIV and AIDS in South Africa, some of the earliest principles, policies and recommendations on home and community care strategies were outlines in the 1997 White paper for Social Welfare (South Africa Department of Social Development, 2010: 20).

According to the White paper people with chronic illness including HIV and AIDS should be treated within the health systems, but once discharged from hospitals, the department of welfare, welfare organizations, religious organizations and community networks should be called upon to provide social support. Home Based, family oriented and community care strategies must be developed to support individuals and their families in the communities most affected by the chronic illness (including HIV and AIDS). Home based, family oriented and community care strategies were seen as the preferred options for coping with the need for care and social consequences of HIV and AIDS. Community care givers community Care

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Givers (CCGs) were to be given emotional and financial support in order to better care for families. They were to be trained in home nursing and skills such as accessing the services of the organizations providing complementary services, such as psychosocial and spiritual counselling. Consultations were to be held with the Department of Health to facilitate the programmes to support CCGs (South Africa Department of Social Development, 2010: 20).

Since 1997 there has been a shift, spearheaded by the Department of Health and National Department of Social Development, towards implementation of these policies, strategies and recommendations as proposed in the 1997 White Paper for Social welfare. Consequently, the HCBC and support programme become a well-established approach adopted by the government to mitigate the socio-economic impact of HIV and AIDS and other conditions at community level (South Africa Department of Social Development, 2010: 20). The National strategic plan for HIV and AIDS and STIs for 2007 to 2011 has once again reaffirmed the role of both departments in jointly taking responsibility for execution and attainment of the goals of the National plan, primarily in reducing the impact of the epidemic in communities. In addition to the above, both DSD and DOH have adopted a large range of policies and guidelines for the implementation of HCBC programmes in South Africa (South Africa Department of Social Development, 2010: 20).

2.2.1 National Strategic Plan (NSP) for HIV/AIDS/STD South Africa, 2007-2011

The HIV/AIDS and STD Strategic Plan (NSP) is the overarching framework that guides all responses to HIV and AIDS in South Africa. The Plan's primary goals are to reduce the number of new HIV infections and to reduce the impact of HIV and AIDS upon individuals, families and communities. The Strategic Plan is multi-sectorial in orientation, foreseeing roles for government, civil society and the private sector within its broad parameters.

The Plan was structured into four key areas of intervention:

- HIV prevention;
- treatment, care and support;
- research, monitoring and surveillance;
- Legal and human rights.

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One of the sub-goals under treatment, care and support is to provide adequate treatment, care and support services in communities, including implementing models of community/home-based care in all provinces and promoting the acceptability of such care. Among the strategies to be used are the development of implementation guidelines, the establishment of inter-sectorial teams at community level to develop HCBC activity, and use of the media to explore and promote the role of HCBC organisations. The lead agencies for these activities include the Department of Health, the Department of Welfare, NGOs and the media (South Africa Department of Social Development, 2010: 20).

The principles upon which the NSP 2007-2011 is premised are; all government Department and civil society sectors shall be involved in the fight against HIV and AIDS. There shall be meaningful involvement of People living with HIV and AIDS (PLHIV) at all levels of the national response. Social mobilization and national movement on moral regeneration and values promotion shall be strengthened to support sustainable behaviour change. Strengthening the National health and social systems as well as the systems of Non Governmental organizations (NGOs), Faith and community based organizations (FBO) and the private sector is central to effective implementation. All interventions shall be subjected to monitoring and evaluation though a formal framework (South Africa Department of Social Development, 2010: 20).

2.2.2 Comprehensive HIV and AIDS Care, Management and Treatment

The Operational Plan provides a detailed framework for the care and treatment of South Africans infected with HIV and AIDS, including the provision of anti-retroviral treatment. The Plan recognises the role of HCBC organisations in providing services to people infected with HIV and AIDS. It identifies home-based care as a useful tool for assessing and supporting patient adherence to Antiretroviral Treatment (ARV) and other therapies, including locating and reaching out to patients who miss scheduled appointments, and promoting continuity of care and adherence with ARV regimens (South Africa Department of Health, 2003:57).

The Plan also recognises the importance of community-linked prevention strategies carried out through organisations such as FBOs, workplace programmes, traditional health practitioners, and PLWHA and notes that such services can do a great deal to minimise fear

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and discrimination, providing and reinforcing accurate information to address stigma surrounding HIV infection. The Plan acknowledges the contributions of both paid and volunteer caregivers, noting the risks of burnout from emotional and psychological stress and overwork. It advocates for the provision of time and structured programmes for debriefing and grief management for caregivers (South Africa Department of Health, 2003:28).

2.2.3 Guidelines for Home Community-Based Care and Support

These guidelines, developed by the Department of Social Development, are intended to assist individuals or groups wishing to establish HCBC projects. The document takes readers through a sequence of technical steps, such as performing community needs assessments, calling for volunteers, and establishing management committees. The guidelines do not directly address any organisational capacity issues, but recognise the need for HCBC management committees to be trained on project management, fund-raising and resource mobilisation, financial management, networking and relationship building, accounting and reporting to donor agencies, governance, people management and drafting operational plans.

2.2.4 Non-Profit Organisations Act No. 71 of 1997

The Non-profit Organisations (NPO) Act No. 71 of 1997 was established to create an environment conducive for the functioning of NPOs. It establishes an administrative and regulatory framework for the operation of NPOs to conduct their affairs and encourages NPOs to maintain adequate standards of governance, transparency and accountability. The Chief Directorate for NPOs is tasked with carrying out the provisions of the Act, including determining and implementing programs to help NPOs register and helping NPOs maintain and improve their governance systems.

The Non-profit Organisations (NPO) Act No. 71 of 1997 suggest that to be registered as an NPO, the Act requires a group to submit a properly completed application form and two copies of the group's constitution. To maintain its registration status an NPO must provide a narrative report of its activities; financial statements; and an accounting officer's report certifying that the group's financial statements are consistent with its accounting records and that it has complied with the Act and its own constitution. NPO registration is a requirement

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for tax exemption and is often a requirement for receiving donor funding. Compliance with the NPO Act (eg. maintaining registration) requires annual narrative and financial reporting.

2.2.5 Public Finance Management Act (PFMA) No. 1 of 1999

The purpose of public finance management Act (PFMA) No. 1 of 1999 is to regulate financial management in the national and provincial governments; to ensure that all revenue, expenditure, assets and liabilities of those governments are managed efficiently and effectively; and to outline the responsibilities of persons entrusted with financial management in those governments Conditional grant funds for the HCBC programme flow to provinces via both the Department of Health (DoH) and Department of Social Development (DSD), and each province is responsible to comply with the PMFA for funds distributed to services providers. By implication, CBOs and NGOs in receipt of public funds are also called upon to comply with the Act and Guidelines.

The proper implementation of the PFMA will increase the speed and efficiency with which funds are distributed to service providers in the provinces and improve the transparency and feedback systems of the budgeting process. However, some of the standards outlined in PFMA, and the financial management processes that are required to meet them, may not be readily understandable or achievable by emerging community organisations without substantial and on-going assistance.

2.2.6 Expanded Public Works Programme social sector plan 2004/2005 to 2008/2009

The Expanded Public Works Programme (EPWP) social sector plan for 2004/2005 to 2008/2009, adopted by Cabinet in November 2003, is one part of an overall government strategy to reduce poverty by providing work experience and short-term employment to unemployed South Africans. The programme is focused on unemployed, under-skilled and under-qualified persons and aims to draw significant numbers of the unemployed into productive work. This will enable them to earn an income; provide unemployed people with education and skills; ensure those participants in the EPWP are able to translate the experience and either enabled to set up their own business/service or become employed; and

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to utilise public sector budgets to reduce and alleviate unemployment. Opportunities for implementing the EPWP have been identified in the infrastructure, environmental, social and economic sectors. The social sector Department of Social Development, Health, and Education has two initial plan which has the following focus areas: Early Childhood Development and HCBC. Both programmes have traditionally been under-serviced and have relied heavily on volunteers and NGO/CBO service providers. The EPWP has provided an opportunity to work with these volunteers and develop their skills base and capacity to deliver quality service in an area of great need.

2.2.7. Registering a Non-Profit Organization in South Africa

The Non-profit organization (NPO) Act provides a voluntary registration facility for NPOs. The NPO Directorate within the Department of Social Development registers organizations under the NPO Act No. 71 of 1997 (South Africa Department of Social Development, 2008:4). The primary purpose of the Act is to encourage and support organizations in their contribution to meeting to diverse needs of the population of the republic by Creating an environment in which non-profit organizations can flourish; Establishing an administrative and regularity framework within which non-profit organizations can conduct their affairs; Encouraging non-profit organizations to maintain adequate standards of governance, transparency and accountability and to improve the standards; Creating an environment within which the public may have access to information concerning registered non-profit organization and promoting a spirit of co-operation and shared responsibility within and amongst all stakeholders (South Africa Department of Social Development, 2008:4).

2.3. Process of Primary Health Care Re-engineering in South Africa

Inclusive in the efforts to overhaul the health system, the post-apartheid government ensured that primary health care, delivered through the district health system, was the central aspect of its health policy (Nxumalo, Hlabane and Goudge, 2010: 24). This was established along the principles of PHC as promoted at Alma Ata, in which it envisioned and established a system that was based on community health centres. This vision is reflected in its policy in which children less than 6 years of age and pregnant mothers receive free treatment. As with

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other governments that have attempted to transform its heath system and implement PHC, the South African government has been met with challenges. Diverse factors such as a shortage of health professionals, the historical inequity in the distribution of resources and weak managerial capacity and health system leadership have contributed to the challenges (Nxumalo, 2008:24).

In response to the inefficiencies thereof, however mostly to the neglect of the remnants of apartheid, civil society through mostly non-governmental organisations have overtime come to being. Despite the challenges, there is visible continuation of the efforts to strengthen PHC. Central to the efforts of the revitalisation of PHC was the service agreement that was signed between the Minister of health and the President of South Africa in October 2010 (Downing, 2010). A further output of the efforts was reflected when the Minister of Health established a task team to provide advice on the re-engineering of PHC in South Africa (Nxumalo 2010:24).

A study conducted by Zerfu, Yaya, Dagne, Deribe, Ruiseñor-Escudero, Biadgilign (2012: 2) revealed that Socio-economic support (material and income generating activities) was being received by 108 (47.8%) of the respondents, counseling services (e.g. psychological support) were being received 128(56.6%), 144 (63.7%) alleviation of stigma and discrimination as human right and legal support for study participants. Inadequate external financial support, lack of proper referral systems between different care providers were among the reasons identified for the low quality and redundancy of care and support activities. Nonetheless, many opportunities and prospects, including easily accessible care receivers (PLWHA), good political and societal will were also implicated.

The primary health care (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 outcome indicators (Nxumalo et al, 2011). The factors contributing to these poor health outcomes include the quadruple Burden of Disease (BoD) consisting of HIV and TB, non-communicable diseases, high maternal and child mortality, and violence and injuries; the human resources for health crisis; and emphasis on curative health care (instead of promotive and preventative health care).

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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 Community Health Workers (CHWs) this initiative would not only be a step towards improving health outcomes but also achieving the Millennium Development Goals (MDGs) by 2015 (Ogunmefun, Madale, Matse, Jassat, Mampe, Tlamama and Masuku, 2011: 8).

The establishment of PHC outreach teams is one of the strategies proposed for the re-engineering of PHC in South Africa. Each PHC outreach team will comprise of on average one professional nurse and six CHWs (depending on the population size). The establishment of the PHC outreach teams will facilitate community involvement and participation in identifying health threats, vulnerable groups and individuals and appropriate interventions for addressing these (Department of Health, 2010b). In addition, it may facilitate the collection of population-based health data, which could lead to better health outcomes (Ogunmefun et al., 2011: 8).

The North West province of South Africa has demonstrated poor performance on some health outcomes. For instance, maternal mortality is still relatively high. Data from the District Health Information System (DHIS) shows that the stillbirth and perinatal mortality rates have remained fairly static in recent years (see District Health Barometer (DHB) 2008/09), most deaths occur outside health facilities hence they are under-reported and are not accounted for in the facility-based DHIS data (PMNCH, 2008; NCCEMD, 2008). The North West province (NWP) has therefore been chosen by the Health Systems Trust (HST), Atlantic Philanthropies (AP) and the Department of Health (DOH) as an eligible site for supporting districts and sub-districts to improve management capacity in view of the PHC re-engineering initiative. This is to ensure that all allocated resources would be effectively and efficiently utilised for the delivery of community-based primary health care (PHC) services, especially those that would result in improved maternal, neonatal and child health (MNCH) outcomes (and other health outcomes), through the implementation of the PHC outreach programme in the province (Ogunmefun et al., 2011:8).

It seems that the implementation of the new PHC model will also help to minimize some of the challenges that the CHW programme is facing. Challenges such as duplication of services, training of CHWs, shortages of home based care kits, stipends for CHWs who will

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form part of the programme will be addressed once the PHC model is implemented. (Ogunmefun et al., 2011: 65).

However, some of the challenges that are experienced in the current CHW programme might have serious implications for the success or failure of the implementation of the new PHC model. The PHC outreach teams in the new PHC model are expected to reach a designated number of household per month. The finding in the interviews that were held with the NPO managers revealed the challenges of access to certain communities. Some of the programmes are not effective because CHWs are unable to reach geographically isolated households and transport is cited as one of the current major challenges. Linked with referral systems, the CHWs in the current PHC model are expected to do household visits upon referral from the CHWs. This will require PHC nurses to have transport to do the outreach services. The current mobile services are not very effective. This was reiterated by the number of the NPO managers that unreliable mobile service contributes to high treatment defaulter rates. In addition to this, the NPO managers highlighted that high mortality rates are also linked to poor or limited access to services. The success of the new PHC model is therefore dependent on addressing the challenges that have been highlighted by this audit before the roll out of the programme (Ogunmefun et al, 201: 66).

There are many challenges to South African prevention of mother to child transmission (PMTCT) programmes remain this include the fact that pregnant women need to book earlier, and facilities should accommodate them without turning them away for later appointments. Women may seroconvert during late pregnancy or breastfeeding, potentially resulting in vertical transmission. Re-testing of HIV-negative women through their antenatal phase to the end of breastfeeding is required. This may be done through community outreach by community care workers and can include testing of household members. Longer-term outcomes of children are poorly reported in this and other South African studies owing to difficulties in follow-up of mothers and children. This is best addressed through community care workers who understand PMTCT and support mothers through their pregnancy to after weaning, ensuring regular testing of children at local clinics (Grimwood, Fatti, Mothibi, Eley, and Jackson, 2012:1).

Breen, Brodrick, Cameron, Campbell, Cohen, Colgan, Coetzee, Drenth, Ezer, GunnClark, Gwyther, Kleinsmidt, Marston, May, Ngidi, Nieuwmeyer, Nortje, Scrimgeour, Sephton,

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Sithole, Vawda, (2012: 165) highlighted the two key recommendations in the strengthening of the district health system and the focus on community based services, which include health teams where CHWs play a significant role. It is acknowledged that all organisations working in the health sector will need to collaborate in the provision of primary health care. The importance of a well-functioning referral system from community to clinic to district hospital has been stressed and it is recommended that emergency services and transport form part of a smooth referral process. It is proposed that each CHW will take responsibility for 250 households and that a PHC team will consist of 6 CHWs, 3 staff nurses and 1 professional nurse.

The two fundamental differences to the current primary health care (PHC) approach are: responsibility and accountability for the health of the district lies with the District Health service (DHS); the emphasis is on a proactive, team based outreach into communities, with a focus on health promotion and the identification of those at high risk. Primary Health Care teams operating from the local clinic and made up of a professional nurse, a staff nurse and CHWs, will take responsibility for a number of households within a geographical area (Breen and Brodrick et al., 2012: 165).

The community health workers (CHWs) will have a wide range of roles which focus on health promotion, these include: drawing up a map and profile of the community; doing household assessments, identifying health problems and making appropriate referrals; providing information and education to families; providing psychosocial support; Participating in community campaigns and screening programmes in the community (Breen, and Brodrick et al., 2012: 165).

The proposed re-engineering of primary health care will have a significant impact on the provision of health care at community level. It is essential that organisations providing palliative care position themselves within the district health model, so that palliative care is included in the services available to households. Home Based Carers and Community Health Workers play a vital role in the provision of care to many who would otherwise have little access to any form of assistance. However, this care comes at a cost to the patient, the family, and to all the carers, which makes it is essential that government and donors; firstly acknowledge the critical role that caregivers, particularly women, are playing; Secondly

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provide the financial support needed so that palliative care for all who need it becomes a reality (Breen and Brodrick et al., 2012: 165).

There is a crucial need to recognise that HBCs and CHWs need support to deal with their own emotional needs. The fact that many of those providing care are, themselves, HIV positive, with similar needs to their patients, means that the need for support is even more crucial (Breen and Brodrick et al., 2012: 165).

The stress and fatigue that these carers experience is heightened by: stigma and discrimination; the emotional stress of repeated losses; the physical strain of having to walk long distances to reach patients; the lack of adequate training, protective clothing and gloves Caring for caregivers can consist of many interventions to reduce stress such as; providing training so that HBCs and CHWs feel more confident; providing leisure time; providing reasonable payment so that financial burdens are lessened; organising debriefing and teambuilding sessions and empowering them by allowing them to participate in the decision making process (Breen and Brodrick, et al.,2012: 165).

2.3.1. The right of access to healthcare in South Africa through PHC re-engineering

The Constitution of the Republic of South Africa gives every person the right of access to health care services. This implies that all South Africans have the right to the provision of good health care throughout the course of an illness, including the end of life (Breen and Brodrick, et al.,2012: 165). . In the National Health Insurance (NHI) Green Paper the government outlines the socioeconomic benefits of NHI, arguing that each extra year of life expectancy raises a country's Gross Domestic Product (GDP) per person by 4% in the long run and thus a healthier population contributes to better wealth creation. The new NHI policy is seen as part of the socio-economic benefits of health spending. To successfully implement the NHI, the current health system is to be completely transformed, and this involves re-engineering primary health care (Breen and Brodrick, et al., 2012: 165).

Access to health care depends on access to doctors, nurses, dentists and pharmacists. In South Africa, as well as internationally, there are several different crises confronting human resources within health care services, including:

- Personnel shortages in rural areas and poor urban areas.

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- Many healthcare workers leaving the public health system and going to countries where payment and conditions are better.
- The impact that HIV and TB have on the capacity of the health system by greatly increasing the numbers of people in need of care (Breen and Brodrick, et al., 2012: 165).

Breen and Brodrick et al., (2012: 165) indicated that the re-engineering strategy focuses on promotive and preventive health which supports the right to health. However there is a gap in the strategy in that it does not address the issue of people who may be sick in the home and dying in the home. There is an opportunity for hospices to engage with DOH at district and provincial level to address this gap. Hospices link with existing services at local level and are an important component of PHC and have the opportunity to be part of NHI. HPCA is one of the founding members of the recently formed joint-PHC forum to ensure palliative care reaches those who are sick and dying in the home.

According to Ogunmefun and Madale et al (2011:11) the DOH and other stakeholders should facilitate the process of providing formal training to more CHWs in the NW province, especially those who have grade 12/Matric exam. All training courses, whether short or formal, should be standardised. All CHWs who have inadequate or no training should be provided with adequate training in order for them to be capacitated with the skills to provide quality community-based health services. Many of the CHWs in the NW province need to be capacitated to provide essential community services such as the community component Intergrated Management of childhood illness (IMCI) and Maternal Child Health (MNCH) services. Adequate provision of funds should be made for the payment of stipends to all CHWs in the province.

According to Ogunmefun and Madale., et al (2011:69) there should be adequate provision of materials such as monitoring and evaluation (M&E) tools (e.g. tally sheets, patient registers, etc) and HBC kits. The CHWs that will be deployed for the PHC outreach team programme should be provided with the necessary training, support and incentives (e.g. uniforms, bicycles, etc) as they will be required to expand their services to more households. Nurses should be capacitated with relevant training on how they can enhance their working relationship with CHWs, especially in view of the implementation of the PHC outreach team

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programme. The DOH and DSD should put in place a proper remunerative system for the CHW programme that will enable CHWs to be contracted by districts so that they have job descriptions, performance agreements, uniform reimbursements, as well as stable and dependable income through stipends.

A study conducted by Ogunmefun and Madale et al.,(2011: 11) show gaps in the training, remuneration challenges, the fragmented roles of the CHWs, transport problems, still form the major challenges facing the CHW programme in the North West (NW) Province. This means the recommendations that have been cited since the development of the CHW programme have not been well implemented. Thus, there is a need for the DOH to consolidate all the recommendations from this audit (and previous studies) and integrate them as part of the process of implementing the current PHC outreach team model in the NW province.

2.4. Experience of care givers in Ratlou Sub-District, North West Province

In Ratlou sub-district there are 12 wards and 13 clinics. The Sub-District has no hospital most of the patient s are being referred to Bophelong Hospital which is in Mafikeng and Gelukspan Hospital. In North West province there are 65 NPOs which are rendering services such as Voluntary Counselling and Testing, TB Dots, Health promotion, IMCI, Mental Health. There are about 4050 Community Care Givers which are part of expanded public works programme. The challenge is that NPOs working with Social Development only about 40 to 45 Community Care givers receive stipends. About 2 NPOs are providing youth friendly services. Community Care givers were receiving stipend of about R850 per month which was due to increase to R1000/m for 2009 and supervisors receive a stipend of R3500 per month. About 5 NPOs have professional Nurses. Communities are involved in Community Health and the NPOs are encouraged to have community members on their boards which meet yearly. Department of Health encourages and assists NPOs to draw up operational plans which then feed into the DoH District plans (North West Province Department of Health, 2009: 18).

NPOs conduct a need assessment with their communities and they are linked to various facilities, of which 55 are recommended to facilities within their area to strengthen dawn referral. In the year 2007 and 2008 about 55 Community care givers were trained in HIV and

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AID NQF level 1, and in 2008 and 2009 about 425 Community Care givers were expected to be trained on Auxiliary Training and in 2009 to 2010 about 425 to be trained on NQF level 1. About 51 Community care givers trained by expanded public works programme to level 3 and they were hoping to train more to Level 4. There are about average 15 Community Care givers per NPO. The attitude between Doctors, professional Nurses and Community care givers is that professional Nurses need to be trained to work with Community Care Givers. Roles need to be defined between the professional Nurses and community Care givers. The province is beginning to create linkages with assistance of retired nurses (North West Province Department of Health, 2009: 18).

An Audit of Community Health Workers conducted in the Districts of the North West Province in 2011 by the Department of Health and Health Systems trust show that in Ratlou Sub-district there were about 290 community health care workers and about 1435 Community care workers were from Ngaka Modiri Molema which is the main District. The study further shows that about 3, 3085 (60%) of the CHWs said they are situated in the rural areas, while 1095 (21%) said they are based in urban areas. Only 408 (8%) of the CHWs said they are situated in peri-urban areas. This means the majority of the CHWs in the NW province, who participated in the audit, are concentrated in rural areas, where there is a greater demand for community-based health services. It should be noted that 579 (11%) CHWs did not indicate their location during the audit (Ogunmefun and Madale et al., 2011: 31).

Further findings shows that majority of the CHWs are based in the rural areas across the districts, except for Dr Keneth Kaunda (KK) where a greater proportion of the CHWs are situated in the urban areas. It should however be noted that 31% of the CHWs in Dr KK did not indicate their location. It is therefore imperative for the District DOH officials in Dr KK to update their data as a way forward, after the CHW audit data has been handed over to them. Of the 5167 respondents who participated in the audit, 4533 (88%) said they are caregivers or CHWs, while 198 (4%) are NPO managers and 219 (4%) are either coordinators or supervisors. Across the districts, the majority also referred to themselves as caregivers or CHWs. There are 5167 community based care workers in North West province of which Ngaka Modiri Molema district have about 1435 community health care workers with Ratlou at 290 (Ogunmefun and Madale et al., 2011: 32).

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North West Province consists of 77 non-fixed clinics, 264 clinics, 50 community health centres (CHCs) and 16 district and 4 regional hospitals. Bojanala district consists of a higher number of clinics compared to the other districts (Health systems trust and Department of Health, 2011: 27). The majority, 4085 (79%), of the CHWs provide home-based care service, followed by 3724 (72%) who also render TB Dots service and 3511 (68%) who also offer health promotion services as well as 3197 (62%) who also cater for orphans and vulnerable children. Only 1131 (22%) of the CHWs in the NW province provide integrated management of childhood illness (IMCI) services; this could be regarded as a gap in community-based services rendered by CHWs in the province (Ogunmefun and Madale et al., 2011: 33).

Community Health workers (CHWs) in NW are more likely to have received training in short courses as more than half of the CHWs in the NW province have received HCBC training, followed by 2365 (46%) who have also received TB Dots training. On the other hand, only a few CHWs have received training in formal (and long) courses as only 774 (15%) and 742 (14%) have received training in CHW and AHC respectively. This means more than 80% of the CHWs in the NW province have not received intensive formal training at any of the NQF Levels 1-4 (Ogunmefun and Madale et al, 2011: 38).

The study conducted by the Department of Social Development (DSD) and Health Systems Trust (HST) in 2011 show that about 288 (46%) completed their AHC training over one year while 187 (30%) completed it over 6-11 months. Only 7 (1%) reported over a period of more than one year and four of them did the training over two years, thereby obtaining the National Certificate for Fundamental Ancillary Health care at NQF Level 2 (Health systems trust and Department of Health, 2011: 39; Ogunmefun and Madale et al, 2011: 43).

According to the study conducted by Ogunmefun and Madale., (2011: 47) only 32% of home based care workers had grade 12 (matric exam), while 43% passed grades 8-11. One of the minimum entry requirements for selection of CHWs into PHC outreach teams is that they must be able to read, count and write. Other study shows that at least 75% of the CHWs in the North West province might meet this requirement. Studies have shown that the Community Health workers sector in South Africa relies heavily on many unpaid caregivers due to inadequate funds for stipends. Data from this audit also shows that about 25% of the CHWs do not receive stipends; the majority of whom are found in the Dr Keneth Kaunda

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(KK) district. The study therefore suggests the need for the DOH to address the issue of payment of stipends to all CHWs, especially in view of the deployment of CHWs for the PHC outreach programme, as non-payment might affect the quality of the care provided.

Ogunmefun and Madale et al (2011: 48) training of CHWs is a continuous, community-based, problem-oriented, experiential education process. The CHW training should involve an initial orientation course and short specific courses such as Home-Based Care Training-59 days and an intensive course completed over a few years e.g. Ancillary Health Care – 2 years with the CHWs functioning during this time, gradually extending their range of work as they become more competent. The long and intensive courses enable CHWs to receive formal and accredited training at National Qualifications Framework (NQF) Levels 1-4.

The results from other studies revealed that 17% of the CHWs have not been provided with any training. For those who have been trained, they are more likely to have received training in short courses such as HCBC and TB DOTs than in formal courses such as CHW and AHC. Further findings show that 80% of the CHWs in the NW province have not received formal and intensive training at any of the NQF Levels 1-4. The study also shows that there is a gap in the training of CHWs in the NW province as only 5% of the CHWs have received MNCH training. Furthermore the training courses, especially the short courses, are not standardised as the length of training reported by the CHWs varies for each course. It is therefore imperative for the DOH and other stakeholders to start facilitating the process of getting more CHWs trained in the provision of MNCH services, and also standardise all the training courses, especially in view of the implementation of the PHC outreach team programme in the province (Ogunmefun et al., 2011: 48).

In North West province there were 6439 care givers against the target of 5330 in 2009. Some of the challenges include Delay in payment of stipend and submission of payment list by some districts. In North West province the number of current NGO's is at 367. It has been reported that linkages with paralegal cluster has been formalized. About 130 People Leaving with HIV open support groups existing against the target of 100. It was reported that there is less involvement of people living with HIV. It has been reported that stipend is managed through service providers. In North West province funding has been decentralized in Districts. Home based care workers were trained on stigma mitigation training conducted

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and 600 Community Health Care workers were trained on PHC re- engineering. Care givers were trained on IMCI house hold component, Dots and adherence counseling. Care givers are also involved in campaigns. Care givers roles involve providing ongoing support to people infected and affected by HIV and AIDS, provision of information on HIV and AIDS to communities, Management and implementation of care and support programme, Support NGO's by building capacity (North West Department of Health annual report, 2012: no page).

2.5. South Africa experiences of Community Based Health services programmes

Home and community-based care (HCBC) has emerged as a way to provide cost-effective and compassionate care to people living with HIV (PLHIV) and those affected by the epidemic. HCBC organisations provide integrated services which address the basic needs of those infected and affected such as food, shelter, healthcare, protection from abuse and malnutrition (Ogunmefun, Friedman, Mothibe and Mbatha, 2011:2).

The role Home Community Based in the delivery of primary health care in South Africa are increasingly identified as the most practical and cost effective approach to bring health services to the total population. The institutional based delivery of health care has contributed tremendously to the improved health status of the nation through this option is becoming more cost ineffective without a CBHS component at de-institutionalized level in the community and rendered with an integrated approach between health and social development (South Africa Department of health, 2009: 6).

Several global health authorities including the WHO as well as evidence from South Africa local research studies points to the fact that CBHS will begin to address the gap in services within which the community who should play a more active participatory and become involved in their own health outcomes, instead of just being recipients for such services from professional health & social workers. The CBHS will further lessen the load on the already existing stretched institutions with its limited resources in terms of finances, human and infrastructure noting the impact of chronic diseases such HIV and AIDS on these structures. The empowerment and ownership by the community together with the revised role for community care givers within a more acceptable remuneration and benefits dispensation is what is urgently required to help meet the targets of National and provincial health programs

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but with a particular focus on prevention and health promotion (South Africa Department of health, 2009: 6).

The CBHS will further take the excessive load off the higher level hospitals due to interventions in which the community may participate at lower level in upholding their health status and becoming agents for the production and maintenance of health at household and community level. The impact of HIV and AIDS on our nation demands a total different approach to health service delivery and while CBHS has been practiced though a ad hoc and patchy manner, this CBHS strategy framework will provide the platform for provinces and communities to plan collectively, clarify role definition on who does what tasks and promote team based approaches to ensure quality of health services and improved access for the most vulnerable mothers, children and persons with disability in our communities (South Africa Department of health, 2009: 6).

A national audit of home and community-based care (HCBC) organisations in South Africa showed that most of the organisations were, however, faced with challenges such as lack of access to water, electricity and computer equipment and a formal office space. In addition, some organisations were in need of funds for stipends for their community caregivers (Ogunmefun and Friedman et al., 2011:2).

The audit further show that there is still a gap in the provision of funds for HCBC organisations, as about 23% of the audited organisations did not receive any funds from either the Government or other organisations. In particular, findings from the audit show that the challenge was more pronounced in the Northern Cape. It might be imperative for the Government to explore how more private organisations, businesses and companies can be brought on board regarding provision of funds for HCBC services in South Africa. This will also help reduce some of the financial burden of provision of funds for HCBC programmes on the Government (Ogunmefun, Friedman, Mothibe and Mbatha, 2011:8).

Payment of stipends to community care givers (CCGs) is another challenge that HCBC organisations have been dealing with over the years. The audit conducted in 2003 revealed that the majority of the CCGs in HCBC sector were working without a stipend. The finding from this current audit also shows that the HCBC sector continues to rely heavily on unpaid CCGs, since some organisations indicated that they had some unpaid CCGs. One implication

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is that this may affect the quality of care they provide, since they do not have an incentive or financial motivation. This suggests the need for the Government to provide stipends or salaries for CCGs who are engaged in HCBC services. Furthermore, findings from the audit show that some organisations did not have assets such as access to computer equipment, office space, water and electricity. It is imperative for DSD and DOH to explore how HCBC organisations could attain access to these assets, in order to enhance their ability and capacity to provide effective services (Ogunmefun and Friedman et al., 2011:8).

2.7. Global experiences of Community Based Health services programmes

As the number of people infected and affected by HIV and AIDS epidemic continues to escalate all around the globe, there has been an increase in demand for HCBC programmes, especially in developing countries where health resources are limited (Department of Social Development, 2010: 20).

Dramatically reducing the number of people newly infected with HIV requires radically reshaping the response. Success depends on intensifying what we know works and focusing efforts where they are most needed. Task-shifting to community health workers also shows great promise for reducing costs while maintaining results. Community conversations can democratize problem-solving and result in more locally appropriate, better owned and more sustainable solutions that maximize value for money. Effective partnerships remain fundamental to successful and sustainable HIV responses. Partnerships give voice to the people who are infected and affected, act as a catalytic force for change and provide accountability for political commitments (UNAIDS, 2010: 11).

2.7.1. Global gaps in treatment care and support

Globally fewer than 40% of people living with HIV are aware of their status. Stigma and discrimination act as major barriers to HIV testing and counselling. People leaving with HIV and AIDS experience life-threatening exposure to violence, stigma, loss of family, employment and property. The overall costs of providing HIV treatment will increase as countries scale up treatment, adopt recommendations on earlier initiation of antiretroviral therapy, provide safer but more expensive regimens and respond to the growing need for second- and third-line treatment. Further, the non-drug costs of delivering antiretroviral

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therapy remain high, accounting for up to 60% of the overall costs of treatment (UNAIDS, 2010: 37).

Increasing numbers of people on antiretroviral therapy mean growing needs for lifelong support to fight opportunistic infections and provide palliative and home-based care. The treatment, care and support needs of young people aged between 15 and 24 years are underestimated and unmet in most countries. Social norms around drug use and sexual behaviour can often lead service providers to overlook or actively discourage HIV help-seeking by young people. Integration of treatment programmes with food and nutritional support remains inadequate (UNAIDS, 2010: 38).

Treatment access and adherence can be improved by involving the community in managing treatment programmes and by promoting the scaling up of voluntary testing and confidentiality and reducing stigma and discrimination in health care settings and communities. Strengthening the demand and uptake for testing and treatment will both improve treatment coverage and help to reduce costs for extensive outreach. Greater involvement of community based organizations in treatment maintenance, adherence support and monitoring will reduce the burden on health systems (UNAIDS, 2010: 39).

The bulk of care and support is provided by families specifically women and communities, including community-based and faith-based organizations. Greater efforts are required to ensure men's involvement in care and support. Grandparents often provide care for vulnerable children affected by AIDS; however, the contributions of older people, and their own needs for care and support, must be adequately recognized and supported through cash transfers and other forms of social protection. The acceleration of HIV-specific and HIV-sensitive social protection programming can help to scale up comprehensive and predictable protection, care and support for vulnerable families and children affected by HIV, most of whom currently receive little or no external support (UNAIDS, 2010: 40).

Home base care workers work with families, communities, faith-based organizations to strengthen community and social welfare systems in order to ensure continuous access to treatment and supplies for vulnerable and socially excluded populations and to recognize and support caregivers. Civil society, with particular emphasis on networks of people living with and affected by HIV, will join governments, donors and other stakeholders as partners in the

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leadership this also include advocacy, resource mobilization, implementation, monitoring and evaluation of national HIV responses (UNAIDS, 2010: 41).

2.8. HIV Prevention using Behavioural Interventions in Sub-Saharan Africa

The general lack of financial resources and the widespread impact of the AIDS pandemic are major challenges to governments and communities providing treatment and care to those affected and infected with HIV and AIDS. Community based organizations (CBOs) and non-governmental organizations (NGOs) are crucial for successful combination of the HIV pandemic, as evidenced in Uganda. Many community organizations are involved in community support programmes of various kinds. It is recognised that such community organizations could play an even greater role in HIV prevention, as they are in contract with those people most vulnerable to becoming infected with HIV. Community organizations should base their programmes on sound evidence to maximise the impact of services that they provide to communities (Van Wyk, Strebel, Peltzer and Skinner, 2006: 3).

Care should be taken to include those community members most affected by AIDS including those who are HIV positive and to give them a voice in contributing to decision making. Where certain theoretical approaches are judged to be best suited to intervention in a particular setting, time should be taken to 'educate' community stakeholders about the rationale and benefits of such an approach so that they can make an informed decision about its implementation. The power of stakeholder participation and their commitment to the project can be increased by involving their respective institutions such as health services, schools and places of employment around the community as platforms to launch aspects of the intervention (Van Wyk., et al, 2006: 33).

Government could play a crucial role by setting appropriate policy and legislation-regulating interactions between international donors and local community organisations and, in doing this, harmonising power imbalances between partners. Another way to deal with the imbalance of power between community organisations that provide the intervention and community recipients is by making learning the centrifugal force in participatory processes (Van Wyk., et al 2006: 33).

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A truly participatory process has the potential to create the platform to introduce specific issues within HIV prevention science that demand attention. Another critical barrier to implementing effective prevention programmes is funding. Increased project budgets made it also possible for these programme implementers to employ community members in aspects of the intervention, which in a limited way could be perceived as them 'seeing' the community's need and ploughing, in a symbolic sense, a portion of programme funds back into the community. The use of community members in programme implementation has also been found to improve acceptability of the intervention by community members (Van Wyk., et al 2006: 34).

It is strongly propagated that community programmes integrate both prevention and care programmes. HIV prevention programmes that target youth should also include a component that encourages those who are HIV positive to go for treatment. Knowledge that treatment for AIDS is available may help to reduce the stigma around being HIV positive, and encourage prevention behaviours. Also, the new information that AIDS drugs (ART) are available should be incorporated into prevention messages to ensure that people are fully informed about the nature and extent of treatment, and its implication for further health. Prevention activities and programmes should include those who are HIV positive to prevent re-infection and further infection of others. It is thus recommended that various community organisations involved in the same community work together complementing each other and communicating with each other to maximise their effectiveness in their respective services (Van Wyk., at al 2006: 35).

2.9. Situation of Home and Community Projects in South African

Home and Community Based care is the provision of comprehensive Health and social services by primary and community caregivers in the home and community in order to promote, restore and maintain a person`s maximal level of comfort, social functioning and Health. HCBC and Support programme ensure the provision of a continuum of care and normalization of services for persons who have become vulnerable to HIV and AIDS and other burdens of diseases. It ensures access to integrated services, which address their basic needs for food, shelter, education, health care, family or alternative care and protection from abuse and malnutrition. The programme enable the individual, family and community to have access to services nearest to their home, which encourages participation by people, responds

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to the needs of people, encourage traditional community life and strengthens mutual aid opportunities and social responsibilities (South Africa Department of Social Development, 2007: 8).

The Home and Community Based Care (HCBC) Support Programmes is a well-established approach adopted by government to mitigate the socio-economic impact of HIV and AIDS and other conditions at community level. The National Strategic plan on HIV and AIDS and STI 2007 to 2011 affirmed the role of the National Department of Social Development and Health as lead departments that should jointly take responsibility for execution and attainment of the goals of the National Plan, primarily in reducing the impact of HIV and AIDS in communities. These two departments subsequently took lead in developing various guidelines for interventions to facilitate the implementation of the HCBC programme (South Africa Department Development, 2007: 6).

Through HCBC interventions, local community resources are mobilised thereby promoting greater access to much needed services. Consequently, over the years there has seen an unprecedented growth of HCBC organizations initiated by civil society and supported by government, private sector, bi-lateral and multi-lateral agencies as well as both local and international donors agencies. The significant role of HCBC which is pivotal in the implementation of the programme cannot be undermined and the support of the private sector through the Corporate Social Responsibility programmes cannot be overemphasized (South Africa Department of Social Development, 2007: 6).

Home and Community Base care as a programme evolved from humble beginnings into one of the important integral part of the government-supported interventions that aims to build capacities of communities and ensure that members of the communities are able to access integrated support and care within their communities. Government recognizes the need for continued overall support required to reach the agreed upon levels of service standard as set in the norms and standards. It further recognizes that better consistent and sustained HCBC programmes will only be ensured through a concerted effort of all parties concerned especially NGOs, within a systematic supportive environment (South Africa Department of Social Development, 2007: 24).

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2.10. Progress made with regard to Home and Community Based Care (HCBC) Projects in South Africa

Provision of HCBC has grown rapidly over the last five years with increase numbers from 13 organizations funded in 2001 organisations compared to 1823 in 2007 and in 2008. Over 600 community care centres/drop-in-centres developed, this constitute 70% of the sub-districts in the country with up to 35 000 community care givers trained. Number of beneficiaries for the social assistance has increased from 3,5 million in 1999 to 12 million in 2008, Of the 9 452 409 children eligible for social security, 8 838 963 are in receipt of grants including 98 000 care dependency grant and 412 000 benefiting from foster care grant Substantial Increase in budget for HCBC (South Africa Department of Health, 2009: 15).

The budget was made available in both National and provinces for capacity building. There is increased donor funding for the program Technical support for the Monitoring and Evaluation. Development of core indicators for the Home and Community Based Care (HCBC) and the Orphans and Vulnerable Children (OVC) programs increased number of care givers receiving government stipend (South Africa Department of Social Development, 2009). There were 65 NPOs in North West province of which two NPOs were providing youth friendly services. In 2009 Care givers were receiving stipend of R850 but due to increase to R1000 P/M. About 555 Care givers were trained on HIV and AIDS NQF Level 1 and 500 care givers were trained on Auxiliary Training (South Africa Department of Health, 2009: 158-178).

2.11. Challenges Facing HCBC in South Africa

In the study commissioned by the Department of Social Development in 2006 Management challenges have been recorded under financial, personnel, training and capacity building as well as infrastructure. HCBCs that are not funded by the Departments of Health or Social Development requested funding from either of the government departments and they were not sure how to access funding from these departments. The HCBCs require funding not only for stipends but also to cover basic expenses such as repairs, telephone and transport costs. Some HCBCs do not have the funds to insure their equipment so if anything gets damaged; they often have to wait for financial assistance before being able to repair the items (South Africa Department of Social Development, 2006: 65).

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Many HCBCs are also concerned that the volunteers themselves are in need of emotional support and that there is no support for carers. They also feel that while they are grateful for the time offered by part-time staff, full-time help is required for continuity and non-interruption of services and this require funding for stipends. They are also concerned that some carers have not received field supervision or in-service training. While many are grateful to be awarded office space within an NGO, church, school or clinic, some still have to pay for electricity and water. HCBC also need space to store food parcels and other supplies (South Africa Department of Social Development, 2006: 53).

Caregiver challenges are recorded under salaries and incentives, supplies required emotional stress and logistical issues. Regarding salaries and incentives, many have complained that the R500 per month is insufficient since they usually pay for telephone and transport costs themselves in order to carry out their functions. They have to walk long distances which wear out their shoes and clothing. Those who don't receive any stipend say that they are hungry and need to be clean before presenting themselves at the homes of the needy. Many rely on child care grants and come from homes where no-one is employed. The umbrellas from the home-care kits were not strong enough to withstand all weather conditions. There is not a consistent supply of materials from the Department of Health (DOH), despite caregivers requesting these items (South Africa Department of Social Development, 2006: 54).

Emotional stress usually arises when carers feel that are not satisfying the needs of the families, especially when the need for food or shelter far outweighs the need for care and support. HCBCs that only provide care and support miss the opportunity to provide food and nutrition which is the basic requirement of most households in need. Carers feel that it is within their realm of responsibility to take a sick person to hospital if necessary but they feel helpless without transport money. Furthermore, some clients are very sick and need at least two people to assist in taking them to hospital. In areas where there are no tarred roads and there are mobile clinics, to carry the sick person to the mobile clinic still poses a logistical challenge (South Africa Department of Social Development, 2006: 55).

While most HCBCs do not send their volunteers into the field without some form of training, access to the 59-day training is not always timeous. There are no certificates issued for those who complete the 59-day training, yet many feel that the stipend depends on this training

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qualification. Funding delays cause interruptions in feeding schemes and food parcel delivery. HCBC carers feel unsupported if there is no social worker, clinic or Voluntary Counselling and Testing (VCT) service in the area because this hampers their service delivery, creating even more transport challenges. Another challenge lies in the fact that it is costly and time-consuming to obtain the signatures of board members who live in another areas (South Africa Department of Social Development, 2006: 55).

Key barriers to implementing effective prevention programmes are the following: conflicting messages about HIV/AIDS being given to communities from government as well as local groups; lack of unification on community level; and resistance to health technologies. The key to their success in lowering the rate of HIV infection lies in this message being consistently propagated at all levels government, health services and communities or grassroots level. Conflicts and conflicting ideas within a community present another major barrier to effective prevention programmes as these conflicts divide the community, create an atmosphere of distrust and suspicion, and bedevil efforts to utilise resources in the community (Van Wyk., 2006: 32).

These conflicts are often rooted in the race, culture and economic make-up and resultant inequalities that exist within communities. In African context of severe poverty it is often believed that community programmes should necessarily have a social development component. Thus, when protective measures such as condoms are introduced to communities without addressing other urgent community needs, these are almost always viewed with scepticism and distrust (Van Wyk.,, et al 2006: 33).

The HCBCs have established networks with other government departments. However networks with other CBOs and NGOs are lacking. The study conducted by Social Development shows that almost all of the care-giving staff has some form of training in home community-based care. In all, except for one HCBC, their income equals their expenditure. The results further indicate that the cost category breakdown shows that income is spent on core essential expenditure items only. In fact, in most cases they stretch their income to cover more beneficiaries by trying to feed more people, make more visits, etc. which at a certain point compromises the quality of service delivered (South Africa Department of Social Development, 2006: 59).

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2.12. The experiences of Home and Community Based Care (HCBC) programmes In South Africa

The finding on the appraisal of Home Community-Based Care conducted in 2003 shows that the main models of HCBCs are still Community Based Organizations (CBOs) and NGOs. The study results further highlighted that there is a relatively high percentage about 57% of HCBCs that are self-funded and informally organised of which 34% are government funded and 9% were funded by others. The study further reveal that majority of HCBCs that are unfunded operate in a vacuum without any direction which is also not sustainable. The literature reveals that funded programmes are fortunate in that they can provide continuity of service with full-time staff members and can reach more beneficiaries on a monthly basis. However, having full-time unpaid staff is not sustainable for funded or unfunded HCBCs. The study further reveals that a low percentage of HCBCs had computers and maintain financial or even client records. HCBCs require basic equipment, finances, trained and paid staff, and protocols for standards of care in order to become an even more effective force in the provision of home community-based care (South Africa Department of Social Development, 2006: 56).

Further literature highlighted that HCBC caregivers bring services to the homes of people who cannot reach them. They do this by not only by providing basic nursing care but also by assisting families with grant access and identity documents. They also encourage community members to participate in income generation and skills development activities. Since caregivers are from the community they are very sensitive to the cultural and traditional views and understand the needs of the community. HCBCs are providing an important service in the continuum of care. To do their jobs effectively they require support from Departments of Social Development and Health (South Africa Department of Social Development, 2006: 56).

Despite the fact that there is a lack of equipment and appropriate record-keeping at HCBCs, they do have the ability to supply data that can be used for the on-going monitoring and evaluation of services. Some of the key challenges faced by HCBCs are in terms of funding, staffing and the provision of supplies from the government departments. The interruption in the flow of funds causes interruption in service delivery. There are inconsistent levels of HCBC training received without certification. The provision of supplies from the government

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departments is inconsistent or lacking (South Africa Department of Social Development, 2006: 58).

A study commissioned by the Department of Social Development in 2006 indicated that stipend is requested for all trained staff. The study highlighted that there was no knowledge of how to access stipends and training via the Expanded Public Works Programmes (EPWP). Specific training is requested on bereavement and family counselling. Training is also required on how to handle stigma and discrimination relating to HIV and AIDS. HCBC caregivers need to be supported by professionals such as nurses and social workers in order to earn their deserved respect for the role they are playing in the community, as and when the need arises. There is a need to train more male caregivers for counselling of sick male beneficiaries and male-heads of households (South Africa Department of Social Development, 2006: 58). Further literature highlighted that there is no large-scale studies on home and community-based care have been conducted in South Africa and no research has looked specifically at issues of organisational capacity among HCBC organisations (South Africa Department of Social Development, 2006: 21).

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An investigation of HCBC in South Africa which was conducted by Russell and Schneider (2000), found much evidence of attempts to provide care at community level, even though the coverage of services offered by HCBC organisations was still 'patchy.' There are five identified emerging models of care which are as follows (South Africa Department of Social Development, 2006: 21);

- funding, technical assistance and support programmes;
- advocacy and community mobilisation;
- drop-in centres and support groups;
- home visiting programmes;
- Comprehensive home-based care.

Among the challenges they noted that face HCBC organisations were: managing a volunteer base, organisational structure, staff capacity, access to resources, forming partnerships and linkages, and a lack of standardisation in the quality of training and services. The study concluded that there is a need for a large-scale technical assistance or capacity building programme, the development and dissemination of standards and guidelines for care, and the

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creation of a monitoring and evaluation (M&E) system if community-based care is to become effective and sustainable (South Africa Department of Social Development, 2006: 21).

An evaluation for The POLICY Project which examined the operations of seven hospices in South Africa that are implementing the Integrated Community-based Home Care (ICHC) model promoted by the Department of Health and the Hospice Association of South Africa. In relation to capacity issues, the report highlighted certain challenges in the implementation of ICHC, including the high demand for care services in many communities, the need for strong organisational management and infrastructure within hospices in order to cope with changing needs, and the growing demands on management resources within hospices and similar institutions (Department of Social Development, 2006: 21).

The rapid appraisal of home/community-based care projects conducted by the Departments of Health and Social Development in 2003 in South Africa reveal that close to 900 organisations were identified, with approximately half being NGOs and another third being CBOs. The greatest number of HCBC organisations was identified in the Eastern Cape and KwaZulu-Natal. More than 30,000 personnel were affiliated to HCBC organisations, including more than 15,000 volunteers that were not receiving stipends and more than 4000 volunteers that were receiving stipends. Only a few organisations had the capacity to train other groups, and training was primarily focused on service delivery issues. For example, the study found that more than 29,000 personnel had been trained in HIV and AIDS and more than 17,000 in HCBC; however, only 2,983 were trained in project development and management. Organisations were in need of professional staff, management information systems, and basic office equipment. The study revealed that HCBC funding comes primarily from government, with comparatively little coming from NGOs, international organisations, and businesses (South Africa Department of Social Development, 2006: 22).

The national evaluation of HCBC programmes conducted by Community Agency for Social Enquiry (CASE) in 2004 for the Departments of Health and Social Development found that beneficiaries of HCBC services valued the care being provided to them by HCBC organisations, but that the impact of this care was limited by the lack of basic care giving supplies and food parcels. Caregivers were found to be highly committed to their work, but only half of them reported receiving stipends and the amounts received varied widely. The relationship between the Departments of Health and Social Development was found to be

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constructive on the whole, but links between national and provincial government, on the one hand, and local government, on the other, needed to be further strengthened (South Africa Department of Social Development, 2006: 22).

Further research findings shows that about 92% of the 120 organisations surveyed were registered as NPOs. Forty-eight per cent of the organisations had at least one full-time or part-time paid staff person. Sixty per cent of the organisations named lack of finances as their biggest problem, with 23% citing lack of transport and infrastructure. The study reveal that most commonly noted internal organisational challenge was shortages of staff linked to absence of salaries and more than 85% of organisations surveyed provide basic training and support on home-based care, child and orphan care, training on first aid and counselling to their caregivers (South Africa Department of Social Development, 2006: 22).

Similar study conducted in South Africa on the evaluation of the costs of HCBC programmes and the factors that promote and hamper HCBC activity found that although HCBC organisations' resources overall were limited, the research found that they manage their available funds well and spend their income on essential expenditures only. It was further discussed that in many cases, organisations stretch their resources to cover a greater number of beneficiaries, which at some point has negative consequences for the quality of services. The study found that the higher the cost of services, the better the content of the service (South Africa Department of Social Development, 2006: 22).

The study further concludes that the HCBC programmes examined were well-established with adequate infrastructure to deliver services in the community. HCBC staffs are generally trained and are sensitive to the needs and values of the community they serve. However, they need financial and material support from the government departments to deliver better quality services consistently CADRE conducted an audit of local-level responses to HIV and AIDS in an urban, rural and small town setting in South Africa in 2003-2004, mapping the HIV and AIDS-related activities being carried out by NGOs, CBOs and FBOs (South Africa Department of Social Development, 2006: 23).

In the study conducted by CADRE it was found that about 70% of the 88 organisations surveyed provided some form of care and support services, such as counselling, support groups, home-based care, and assistance to orphans and children. Civil society organisations

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were the primary providers of care and support services in all three sites. Most of the organisations relied heavily upon the contributions of volunteers, although only 10% of them paid stipends. The survey shows that about 40% of the organisations surveyed were receiving funding from government. Challenges around resources were commonly cited and there was a general lack of capacity for basic monitoring and evaluation (South Africa Department of Social Development, 2006: 23).

Operational research conducted by the Horizons Programme on six home-based care programmes in four provinces of South Africa indicated that training and remuneration also vary, with the most common model being trained field staff this include receiving a stipend or incentive supplemented by a professional, salaried worker such as nurse or social worker. The study reveal that some of the main issues affecting caregivers include: lack of sufficient resources to meet the needs of sick patients; insufficient acknowledgement of their efforts and remuneration for their work; and concern that families of sick patients rely on them more than is practical or desirable. The study found that record keeping and data collection systems are not as developed in HCBC organisations as they could be, in part because of the lack of funding for institutional development and administrative systems. The researchers conclude that there is a need for longer-term funding arrangements for HCBC organisations which would allow them to plan better for the future. The economic and emotional support needs of caregivers also need to be addressed (South Africa Department of Social Development, 2006: 23).

The study commissioned by the South Africa Department of Social Development (2006) revealed that among the 12 HCBC organisations researched, nine were registered, one had applied for registration and was awaiting notification, one was unregistered and one had been deregistered. The more mature organisations did not express any difficulty in regard to applying for or complying with the NPO Act. At least two registered organisations had had their initial applications returned as incomplete, while the unregistered organisation had little knowledge about the application process or how to approach it. HCBC organisations cited access to funding as the main motivation for registering as NPOs, but do not fully understand the compliance implications of registration (South Africa Department of Social Development, 2006: 26).

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The study conducted in South Africa further revealed that of the 12 HCBC organisations interviewed, 11 had either an executive committee or management committee that oversees day to day operations; of these, two also had an external board of directors. The twelfth organisation had only a board of directors. A small number had programme managers that oversee specialised teams of personnel. The most common management model in relatively young HCBC organisations is an Executive Committee comprised of five to seven office holders such as chairperson, deputy chairperson, treasurer and secretary who are chosen from among the HCBC members and oversee the day to day functioning of the organisation. The committee members are selected from among the member-caregivers, and members generally have no particular skills or training for their posts. The role of the chairperson is commonly understood as representing the group and as chairing the monthly meetings. The secretary takes minutes and the treasurer cashes cheques, collects receipts and in some cases tracks spending (South Africa Department of Social Development, 2006: 27).

The results from the study reveal that stipend was paid to volunteers in 10 of the organisations; the other two organisations were unfunded and therefore not in a position to pay stipends. Stipends were generally R500 per month. Apart from one organisation where a lunch allowance was paid, there were few or no tangible or material incentives for volunteers apart from the stipend. One of the notable differences between the HCBC organisations was the extent to which they need assistance to handle their financial affairs. While some organisations have evolved systems and basic expertise that allow them to manage their finances relatively independently, others receive significant support from the Department of Social Development (South Africa Department of Social Development, 2006: 29).

The study shows that most organisations did not have such formal and regular processes in place, and planning is more loosely informed by 'meetings with stakeholders' or 'door-to-door visits' in the community. In the study only three organisations mentioned conducting some type of situational analysis, and all of these were once-off efforts. Some HCBC organisations noted that they face operational challenges due to the lack of transportation and due to insufficient or sporadic availability of key supplies, such as home-based care materials. Particularly in rural areas, lack of transportation or funds to cover transport costs limits the quality and scope of the services provided (South Africa Department of Social Development, 2006: 32).

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Research findings show that about 8 of the 12 HCBC organisations in this study had links with other organisations. Emerging organisations were the least networked, but the more established organisations reported links with a range of groups such as local AIDS councils, home-based care networks, the Khomanani campaign, local health forums, hospices and other 'stakeholder' meetings. The study also highlighted that HCBC had links with government departments not only Social Development and Health, but also Education and Agriculture. One of HCBC organisations evaluated had a close links with the National Hospice Association (South Africa Department of Social Development, 2006: 34).

2.13 Further Recommendations to the South Africa Departments of Health

The study conducted by the Department of social Development in 2006 further explains that training is required in accessing government and other funding. The funding policy should be uniform across provinces with regard to funding amounts, the stipend amount, procedure for application and award and guidelines as to exactly what is funded in monetary and material terms such as example, supply of food parcels. To share costs of overheads, new HCBCs should form part of or partner with an umbrella organisation already providing services to the community. Funding should also consider the cost of de-briefing of carers (South Africa Department of Social Development, 2006: 58).

Income generation activities need a financial boost. The key caregiver challenges are the receipt of stipends, funding and supplies from either the Departments of Social Development or Health. There should be a funding agreement from the departments to supply home-based care kits, food parcels, protein porridge, gloves, HIV and AIDS literature and condoms to each HCBC on a regular basis. With the supply of these provisions, a clear procedure should be in place for HCBCs to reapply for further supplies. Presently there is not a consistent flow of supplies which undermines the delivery of services. The approval of the distribution of food parcels is a lengthy (South Africa Department of Social Development, 2006: 58).

Guidelines for a minimal package of care along with basic monitoring and evaluation tools should be developed and implemented. The setting up of a register of HCBCs whether funded or not should be on-going as per the Appraisal on HCBCs conducted by DOSD with a longer-term view of introducing standards of care to unfunded organisations. The Departments should consider the provision of supplies to all HCBCs irrespective of whether they are

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funded or not. In this way a register of all organisations can be maintained and minimal standards implemented (South Africa Department of Social Development, 2006: 59).

Since government financial resources are limited, the sustainability of HCBCs through capacity building, training of their management staff and training of all caregivers should be ensured. Training of management staff should include training in establishing and managing successful income-generation projects that can contribute to the longer-term survival of the HCBC programme. As part of the process towards an exit strategy, a mentorship programme could be developed to encourage local business communities to mentor HCBCs. The fact that HCBCs are community based provides incredible benefits since the community is responding to its own needs. Individuals from the community who are employed should be encouraged to volunteer to take on mentoring roles and assist those who are holding management positions (South Africa Department of Social Development, 2006: 59).

Funding for stipends should be considered via the Expanded Public Works Programme (EPWP). Funding for service delivery should be targeted towards the number of beneficiaries and the content of the service being provided. The funding request should include information about other sources of funding to avoid duplication and to ensure that the service can be adequately provided. There is a need to encourage retired medical staff to volunteer to supplement the services of carers. The requirement that HCBCs provide financial audited reports has financial implications for the HCBC programme as well as the funder since funding for the audit needs to be incorporated in the request for financial support (South Africa Department of Social Development, 2006: 60).

The study conducted by the Department of Social Development concluded that there are two types of HCBCs those that are funded by a government department, a local or foreign donor, local church and those that are not. Funded organisations, no matter how small the funds, are more formalised in their reporting and documentation. Unfunded organisations do not keep records or documentation and do not have the same delivery commitments. Collaboration is required amongst all stakeholders to take the home community-based care programme to the next level (South Africa Department of Social Development, 2006: 63).

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2.14 Home and Community Based Care norms and standards in South Africa

Rationale for Home and Community based care (HCBC) in South Africa that all communities are capable of offering care and support services to vulnerable families provided they are strengthened and empowered. Family-home environment is the most appropriate place for care and support of people infected by HIV and AIDS as opposed to institutional care. Removing people living with AIDS from their homes and communities at whatever stage of the illness can only promote denial, stigma and discrimination. All chronic conditions, including HIV and AIDS can be managed, if both family and community resources are mobilized. Caring for people in their homes and communities makes HIV and AIDS a social and community issue. The HCBC approach does not imply shifting the burden by government to families and communities, but to ensure that people infected and affected by HIV and AIDS have access to integrated services within their communities (South Africa Department of Social Development, 2007: 8).

2.14.1. Institutional Development

Institutional development focuses on aspects such as governance and leadership as well as sustainability of the HCBC organization. Governance and leadership is provided by an oversight committee known as the management board or committee. The board should consist of committed members with skills and capacity to provide services that include, but not limited to determining strategic direction, development of policies, financial accountability and management of the HCBC organization. Each organization is led by a management board or committee comprising of at least five members such as a Chairperson, Deputy Chairperson, Deputy Secretary and Treasurer. People to be invited to the management board are community leaders, retired professionals, people living with AIDS, people with Disabilities, older persons, Nurse, Psychologist, Social Worker (South Africa Department of Social Development, 2007: 12).

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2.14.2 Governance and Leadership

HCBC should compile and submit reports timorously to relevant stakeholders including sponsors. They should host weekly staff meetings and monthly management meetings with caregivers and ensure that weekly, monthly, quarterly and annual reports are available. Written documentation that outlines recruitment, job descriptions, code of conduct and exit strategies for community care givers should be maintained. All community caregivers should be encouraged to go through Adult Basic Education and training or have grade 12. All staff including community care givers should receive a three day induction within a month of joining the organization. All caregivers should undergo basic HIV and AIDS training, psychosocial support and on the job training for at least ten days within 12 months of joining (South Africa Department of Social Development, 2006: 14-16).

2.14.3 Sustainability of the Organization

Every organization should have a strategic plan; the strategic plan should be implemented and reviewed twice per month. The sustainability plan should cover aspects such as communication, networking, fund raising and external stakeholder engagement strategy. A document profiling the organization in order to market the services of the HCBC programme. Individual records of the community care givers are kept safe providing detail information such as signed engagement contracts, care givers role description, training and development plan, curriculum vitae, copy of identity document, performance management and up to date work plans. Meetings held are guided by an agenda; led by a chairperson; minutes are recorded, circulated and filed accordingly (South Africa Department of Social Development, 2007: 16-17).

Programmes that utilise members of the target community to deliver the intervention demonstrate a greater likelihood of sustainability. Interventions such as a peer education and community mobilization not only bring about a natural transference of knowledge and skills to members of the intervention teams through training components, but also have better prognosis of the intervention being sustainable beyond the duration of the study (Van Wyk., et al 2006: 31).

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2.15.4 Health promotion, prevention and Education

This involves creation of awareness about HIV and AIDS, prevention of new infections and education about care and management of those who are infected and affected by HIV and AIDS. Such services include but not limited to awareness campaigns, information dissemination and building of knowledge based about AIDS and its management (South Africa Department of Social Development, 2007: 18-20).

2.15.5 HIV/AIDS Care and Support

These services are about sustenance of life to the extent that available resources and the condition reinforce each other positively or finally lose benefit for the client. This involves strengthening the capacity of the family and community, as well as creating a conductive family and community environment for the provision of care and support. Services are further aimed at enhancing the functioning of affected households and creating a conductive and safe environment for the care and support of orphans and vulnerable children, such services include psychosocial support, identification of OVC, palliative care and provision for material assistance (South Africa Department of Social Development, 2007: 20-22).

2.15.6 Sustainable Livelihood Programmes

The sustainable livelihood approach is a way of putting people at the centre of the development thereby increasing effectiveness of development. Containing in this cluster are services that ensure food security to families in need on a short term basis and to give them a chance on a long term basis to gain control over their lives in a sustainable manner. Included here are services such as provision of food parcels, creation of community vegetables gardens, establishment of community multi-purpose centres (Drop in Centres) that provide cooked meal especially for child-headed households and income generation projects (South Africa Department of Social Development, 2007: 22-23).

2.15.7 Procedure for Non-Profit Organization

The organization must first introduce themselves to the traditional leaders, councillors or etc. The traditional leaders should have an understanding of the community multipurpose centres.

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Community meetings should be organised for by-in to the process. The community should select the CBO, which is going to render the service. People should have information and understanding of HIV and AIDS issues. Tribal authority and Local government can be approached with donations for a structure or a plot. People's expectations and uncertainties should be addressed (South Africa Department of Social Development, 2008: 23).

2.16 Conceptual Framework for Home and Community Based Care

Home community based care is an effective way of involving families and communities, especially in HIV and AIDS care and support. Patients prefer to die at home and their family members also prefer them to die at home. Survivors whose family members died at home or in a hospice felt less guilty than relatives of patients who died in hospital. While the hospital provides good medical care in hygienic conditions it isolates the patient from the family. Hence, the training of family caregivers is an important service that HCBC organizations can provide (South Africa Department of Social Development, 2008: 1).

Once the policy objectives of home community home based support can be sustained for as long as possible. No institution or organization can carry the burden alone and therefore integration of services through referrals and networking is essential. HCBC programmes operate with full-time paid personnel or volunteers and with donations received and supplied. They also operate with skilled, semi-skilled or unskilled community caregivers, contributing to differing cost structures and quality of service. HCBCs are funded by either the Departments of Social Development, Health, an international donor, Local community or by project members themselves (South Africa Department of Social Development, 2008: 1).

Home Community-Based Care (HCBC) is defined in this study as the provision of comprehensive services which include health and social services by formal and informal care givers in the home or close to home, including institutional care with an out-reach programme. Although these services are not restricted for people living with HIV and AIDS, most of the services are target at families and people affected by the disease. HCBC programmes play an important role in empowering the community through promoting self-reliance. Communities with the highest infection rates are often marginalised and most vulnerable to HIV transmission and therefore need sustainable intervention programmes (South Africa Department of Social Development, 2008: 1).

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A study conducted by department of Social Development on the evaluation of cost and process indicators for Home and Community Based Care (HCBC) programme, in four districts of four provinces Nelson Mandela Metropolitan in the Eastern Cape, Ugu in Kwazulu Natal, Sekhukhune in Limpopo and Ehlanzeni in Mpumalanga, reveals that in terms of the coverage, the fewer the number of clients per care giver, the grater the intensity of visits. It is therefore important to decide upfront who the key beneficiaries are, how many there are, how often they should be visited and then to calculate how many visits each care giver should make. This will determine if there is any capacity left in the organization to service more clients or whether to recruit more volunteers (South Africa Department of Social Development, 2008: 27).

The study found that all HCBCs except one have a management board made up of non-executive members advising the project team. Most carers are unpaid volunteers from poor communities helping other poor and destitute people carers themselves from burnout and require emotional support. Funding from the government departments has primarily been for the payment of stipends. Those carers who offer their labour only as a package of care feel unwelcome. Integration of services with other NGOs and CBOs is limited. HCBCs have done well in achieving their annual objectives. However there is no recording of expenses if the programme or activity is not funded or if the staff members use their own funds. Institutional memory is held in the memories of a few management and care giver staff (South Africa Department of Social Development, 2008: ix).

Almost all care givers have a minimum of grade 10 qualifications; many have grade 12 and some have tertiary qualifications. Care givers are requiring training in counselling particularly bereavement counselling and the 59 day training course because they believe it is linked to the receipt of stipends. Some of management staff members also have other form of HCBC training but request more management training. The key management challenge was to obtain funding and other form of support from government departments. The key caregiver challenges are the receipt of stipends, funding and supplies from either the department of social development. All the 13 HCBC targeted their efforts towards orphans and vulnerable children (OVCs) and sick family members and to lesser degree, the youth, elderly and the disabled (South Africa Department of Social Development, 2008: x).

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Services provided by HCBC and the content of home visit service depends on the length of the visits as well as supplies provided. Caregivers managed to package their care according to 20-minute, 30-minute, and one hour or three-hour treatment. Both health and social care services are being offered. Services such as preventative services, intervention, capacity building, training of family care givers, poverty alleviation, treatment of minor wound, nutritional support and a referral system to government departments are being offered. There is almost no referral to other organization offering service to community (South Africa Department Development, 2008: x).

2.17. Approaches to community development projects

There are two mainstream approaches to developing HIV prevention programmes within communities; thus include participatory approaches that develop the programme from the bottom up, starting at the level where the community is currently, and theoretical approaches that follow a predetermined course, mode of action or way of interpreting behaviour. Traditionally, developing countries have favoured participatory approaches, whereas theoretical approaches tend to have their roots in western-based theories of psychology and health promotion. Community based programmes that are participatory approaches are increasingly being favoured above individualistic approaches for HIV prevention, as many social scientists and community activists that social dynamics have as much influence, if not more, over individual decisions about sexual behaviour than individual cognition. Participatory programmes draw on the active participation of members of the community in the implementation of the intervention or in some or all the stages of development and implementation. Although peer education and community mobilization programmes are described separately, those are not mutually exclusive and may be combined in some programmes (Van Wyk., et al 2006: 11).

Effective community based prevention strategies require an environment that enables individuals to make decisions and changes behaviours towards safe sex practices, whether abstaining completely, staying faithful to one partner or using condoms regularly. The need for demonstrative political will in the fight against HIV/ AIDS and effective community-wide or national awareness programmes have been advocated as steps towards establishing a platform from which community-based prevention programmes could be built. Community organisations would need knowledge about the community and dominant modes of HIV

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transmission in the community. Without such information, intervention programmes would not reach those who are most at risk for infection. Lastly, community organisations would benefit from a grounded knowledge and understanding of health promotion models in developing interventions that are tailored to community contexts (Van Wyk., et al 2006: 32).

The most important strategy to overcoming barriers in the community towards prevention programmes is involving the community in aspects of development, implementation and even monitoring and evaluation. This has been done through peer education training, community mobilisation and stakeholder participation. However, before these techniques are implemented, community characteristics have to be explored and resultant reports verified by a selected number of community members. Members of the community could be approached to form part of stakeholder panels, planning councils or community forums that would be consulted throughout the process of development and implementation of the programme (Van Wyk., et al 2006: 33).

Effective prevention at community level requires that intervention activities be aligned with overarching national strategies. At government level national frameworks should be developed to regulate community activities. All community organisations should be mandated to subscribe to these guidelines. At provincial or regional level a secretariat should be established to monitor and support community organisations in accordance with national frameworks. Part of this mandate should be to set up forums for dialogue and collaboration between various community organisations. The secretariat may also act in a guiding capacity, drawing attention to specific issues at community level that demand attention for intervention (Van Wyk., et al, 2006: 34).

The national framework should develop frameworks for partnerships between local service providers and community organisations and international donors. Such a framework may serve as a means to hold community prevention programmes accountable to good practice and sustainability. Also, such a framework may ease concerns by NGOs and CBOs regarding funding, by setting up guidelines for exchange between these partners and creating capacity within smaller organisations to apply for funding grants. Incentives should be given to academic institutions to strengthen and complement research capacity in community organisations for the implementation of evidence- based programmes and rigorous evaluation of interventions (Van Wyk., et al 2006: 35).

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2.17.1 Development Management

According to Van Der Waldt and Knipe (1998: 130) development Management is a process whereby a person, community or a state manages development activities in order to achieve an objective, and continuously takes account of the environmental influences on the process. Community Development refers to the process and a method aimed at enhancing the capacity of communities to respond to their own needs, and at improving their capacity for development, through community mobilization, strength-based approaches and empowerment programmes (South Africa Department of Social Development, 2008: 18).

2.17.2 Community Capacity Building

It is the process and means through which national Governments and Local Communities develop the necessary skills and expertise to manage their environment and natural resources in a sustainable manner within their daily activities (South Africa Department of Social Development, 2008: 24)

2.17.3 Sustainable Development

It is a parallel paradigm emerging out of the environmental sector, within enormous significance for community development, it focuses on integrating strategies for economic growth, social development and environmental protection into a new paradigm for development, and it is intended to provide a framework for global, national and local development strategies (South Africa Department of Social Development, 2008: 25). South Africa have adapted this definition and incorporated it into the National Environmental Management Act (Act 107 of 1998), which states; Sustainable development means the integration of social, economic and environmental factors into planning, implementation and decision making so as to ensure that development serves present and future generations.

The sustainable development paradigm includes the notion of equity within development and introduces the concepts of inter-governmental equity, namely avoiding actions that will pass a disproportionate burden of degradation or environmental rehabilitation onto future generations. South Africa aspires to be a sustainable, economically prosperous and self-

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reliant nation state that safeguards its democracy by meeting the fundamental human needs of its people, by managing its limited economical resources responsibly for current and future generations and by advancing effective integrated planning and governance through national, regional and global collaboration (South Africa Department of Social Development, 2008: 26).

The national vision is underpinned by a set of principles that guide all decisions and actions taken to achieve the vision. The principles underscore a cyclical and systems approach to achieving sustainable development they are;

- Efficient and sustainable use of natural resources;
- Socio-economic systems are embedded within and dependent upon eco-systems; and
- Basic human needs must be met to ensure resources necessary for long-term survival are not destroyed for short term gain (South Africa Department of Social Development, 2008: 26).

2.17.4 Local Economic Development (LED)

The South Africa Department of Social Development guide (2008: 26) points out that Local Economic Development (LDE) defies easy definition and is sometimes regarded as both a process and an end product. It was stated that LED is an essential process in which local; governments and/ or community based groups manage their existing resources and enter into partnership arrangements with private sectors, or with each other, to create new jobs and stimulate economic activity in an area. LED is about local people working together to achieve sustainable economic growth that brings economic benefits and equality of life to all in the community.

2.17.5 Community Participation

According to Van Der Waldt and Knipe (1998: 142) Community participation is an active process in which the clients, or those who will benefit, influence the direction and improvement of a development project aimed at improving the welfare of the people in terms of income, personal growth, independence and other Values regarded as valuable.

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Community participation is an active process in which the clients, or those who will benefit, influence the direction and implementation of a development project aimed at improving the welfare of people in terms of income, personnel growth, independence and other values regarded as valuable. There are various structures available for the community to become involved in the project management process. The benefits of community participation are that accurate facts are obtained about local conditions, which facilitates solving problems, identifying needs, and resources and determining the capacity of community members. This means that development projects can be implemented and managed effectively and efficiently. In addition, this promotes the independence of community and the sustainability of the relevant development activity/ activities (Van Der Waldt., et al 1998: 145).

However the greatest advantage in probability that people are directly involved in the development activity or project, and that it directly involved in the development activity or project and that it will therefore benefit more members of the community. Nevertheless despite these advantages, there are a number of disadvantages connected to community participation, which are as follow:

- Projects may be slowed by a lengthy negotiation process with the community or certain groups in the community;
- More personnel members are required to deal with the increase in participation;
- Community members may oppose projects when they are consulted on them; The community can participate in the development process in unpredictable ways; and
- Excess input can be received from people with little or no experience and knowledge of a certain problem or situation (Van Der Waldt., et al 1998: 145).

Community participation should therefore be encouraged, in the first place to empower members of the community, but also to benefit more people through the relevant development activity. In addition, participation can greatly increase the effectiveness and efficiency of development projects. However, it is important that the disadvantages of community participation are kept in mind during the implementation of any development project (Van Der Waldt., et al 1998: 144).

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2.17.6 Empowering the Community

Development does not entail the delivery of goods and services to a passive community, but rather requires involvement by and empowerment of the community (RDP White paper, 1994: 8). There are two views of community empowerment. The first view of community empowerment is that empowerment is the development of skills and abilities which enable people to interact more effectively with the development system and process. The second view is that empowerment is a process which is aimed at equipping people to make decisions and implement these decisions regarding development. Empowerment can therefore be described as a process which provides power to be used to gain access to resources and to ensure the utilization of these resources in the achieving of developmental objectives (Van Der Waldt., et al 1998: 145-156). Empowerment should, however, also equip people to decide what they perceive as community development. All of these views have one common element, namely capacity building (Van Der Waldt., et al1998: 145-156).

Van Der Waldt., et al (1998: 145-156) argues that capacity building is an attempt to improve skills and knowledge of the beneficiaries, in order for them to take responsibility for the management of development and development projects. Capacity building also has to do with the ability to provide change and influence it, to make informed decisions, to access resources and to use them and to manage the use of the available resources. According to Van Der Waldt., et al (1998: 145-156) Communities can be empowered by involving them in the total project cycle. This means that the people must participate in all phases of the project through the available structures. Local government and public managers should accept these structures and encourage participation by the community.

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2.18 Project management and upliftment

In recent years there has been an increasing awareness of the need to develop communities. Requests are continually addressed to the public and private sectors to help developing communities to help themselves. As a result of these requests, various development projects have been initiated in various communities. However, often these projects have not progressed much beyond the needs determination stage, and just as often, the completed project has also failed (Van Der Waldt., et al, 1998: 118) By applying a public management

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technique such as project management, these mistakes of the past can be avoided. Local authorities and their communities face awesome challenges in new South Africa.

The identified socio-economic needs place great pressure on all institutions and individuals involved in community outreach. Project management allows through planning taking place in the development of a particular community, which leads to the successful implementation of projects. By making the community aware of the project management process, possible problems can be avoided in the community itself and the development that must occur within the community. Poverty perhaps has the greatest impact, and as a result, also closely related to communication and its importance in the management of community development projects (Van Der Waldt., et al 1998: 118).

It can be concluded that development projects must be managed properly and successfully. The initiator and developer must take all aspects of the management process, including the phrases of project management, into account when undertaking development projects in the community. However, it is also important that the project manager, and therefore public manager, always be aware of environmental variables and sensitive to the particular conditions of every community. The community is always the motivational force behind projects and programmes that focus on social and economic upliftment and therefore also the most important role player in the project management process (Van Der Waldt., et al 1998: 120).

2.19 The Role of Government in Managing Development Projects

Government, and specifically Local Government, has a major role to play in the management of development projects and programmes in communities. The role of government may be played out by councillors or officers, depending on the nature of the project and a particular style of local authority. There are no hard rules and fast rules about where to draw the lines of responsibility, except of course that ultimately it is the councillors who are accountable to the community. Where counsellors are actively involved, the description of the project brief, should confirm which committee is accountable for the project, the extent of the involvement councillors expect, and the limits to the authority of offers to act on their behalf in the management roles (Van Der Waldt., et al 1998: 133).

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In practice, much of top management's role in government is delegated to officers for the majority of local government development projects. The responsibilities of officers should be delineated clearly. There are likely to be a number of chief officers who will expect in some way to be represented in the project and who will expect in some way to be represented in the project's top management. For example, the chief executive officer, the treasure and other support functions, as well as service departments, are all likely to be involved in any substantial projects. At councillor level, the local government's way of doing things is through committees, and the project will have to report to committees as members prescribed. This is a familiar process in any local authority in South Africa (Van Der Waldt., et al 1998: 133).

2.20 Community Involvement in the Project Cycle

According to Van Der Waldt., et al (1998: 146) public manager should apply the principle of project management, but also those of the management of diversity and the management of change in the decision making process, which goes hand in hand with the identification of needs. The following are some things that the public manager can do to help the community to become involved in the project cycle;

- Draw up a socio-economic and political profile of the community; Identify development needs;
- Determine constrains and basic services and products that are available;
- Draw up an inventory of available resources, services and amenities and their quality;

According to Van Der Waldt., et al (1998:146) It is very important that public managers, also called development agents, act as facilitator to communities that are trying to determine their development needs. Community participation in the needs determination process is extremely important. When a development agent helps members of a community to identify their needs, it is important to realise that the agent's perception of what the needs are is not necessarily correct or accurate. The community itself will know what it requires and it is important that certain ideas are not forced upon it.

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2.21 Conclusion

There are various approaches which are being used to improve Home and Community Care programmes. The implementation of Home and Community based care (HCBC) differ from county to country depending on their experiences. The literature highlight most challenges HCBC such as lack of funds, transportation, delay in payment or non-payment of stipends. Home and Community based care workers are also facing socio-economic and political challenges. The community must be motivated to become involved itself and to participate in planning, and implementing the Home and Community Based Care programmes.

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CHAPTER THREE: RESEARCH DESIGN AND METHODOLOGY

3.1. Introduction

This chapter outlines the research methods which were used to conduct the study. In this chapter the researcher also discussed the research design and population. In addition, the chapter also focuses on the instrument that the researcher used to collect data, the sampling procedure deployed and its technique. This chapter outlines the plan in which the researcher used to conduct his study.

3.2. Research design

A descriptive, cross-sectional design was used to examine the experiences and challenges facing home and community based care givers on HIV/AIDS care and support services in Ratlou sub-district. Mouton (2001: 55) defines research design as a blueprint or detailed plan for how a research studies should be conducted. This involves the whole process of planning and carrying out a research study. It provides a guideline according to which a selection can be made of which data collection methods will be most appropriate to the researcher's goal and other selected design (De Vos, 2002: 137). A research design is a blueprint for conducting a study that increases the probability that the study findings are a true reflection of reality (Burns and Grove, 2003:195). Clues to the appropriate design are found in the research purpose, framework, research objectives, questions and hypothesis (Burns and Grove, 2003:195).

The term research design and research methodology are often used interchangeably even by researchers to mean the same thing. The two terminologies are however different. According to Mouton (2005: 74) a research design is a plan or blue print of how a researcher tends to conduct a study. This involve plans for data collection, the instrument for gathering information, how information gathered would be processed and analysed to give meaning to a research finding. Terre-Blanche, Durrheim and Painter (2006: 36) define research design as a strategic framework, a plan that guides research activity to ensure that sound conclusions are reached.

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In this study descriptive study design with both qualitative and quantitative approaches were used to describe the experiences of Home Community Based care givers when rendering HIV care and support services. Descriptive studies are designed to gain more information about a phenomenon as it naturally occurs (Burns and Grove, 2003: 200). It is designed to develop theories, identify problems with current practices or determine what others in similar situations are doing (Burns and Grove, 2003:200).

Descriptive studies are designed to gain more information about a phenomenon as it naturally occurs (Burns and Grove, 2003: 200). It is designed to develop theories, identify problems with current practices or determine what others in similar situations are doing (Burns and Grove, 2003:200). The term descriptive research refers to the type of research question, design, and data analysis that will be applied to a given topic. It can involve collections of quantitative information that can be tabulated along a continuum in numerical form or it can describe categories of information. Descriptive research involves gathering data that describe events and then organizes, tabulates, depicts, and describes the data collection (Jonassen, 1996: 1196-1205).

3.3. Research methodologies

In this study the researcher utilized triangulation methods of both qualitative and Quantitative research paradigms as a nature of the study, and only limited numbers of respondents are going to be considered. A qualitative and Quantitative research approaches were deployed by using descriptive design. The use of more than one paradigm (triangulation) is further meant to combine appropriate research perspectives and methods that are suitable for taking into account as many different aspects of a problem as possible (Flick, 2002: 49).

Research methodology present taken to solve the research problem or to answer the research questions, including processes to collect and analyse data (Brink, 2006:191). Research methods are techniques used by a researcher to structure a study to gather and analyse information relevant to the research question (Burns and Grove, 1997:8). Ghauri and Gronhaug (2005: 108) describe research methodology as a systematic, focused and orderly collection of data for the purpose of obtaining information, to solve or answer a particular research problem or question.

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In this study the researcher have utilize Quantitative research paradigms as a nature of the study, and only limited numbers of respondents are going to be considered. A Quantitative research approach was deployed by using descriptive design. Quantitative research is research methods that emphasize precise, objective, and generalizable findings (Rubin and Babbie, 2005: 754).

The researcher used quantitative research in order to conduct research that will produce results that are objective. The researcher used quantitative research in order to conduct research that will produce results that are objective.

The study adopted a qualitative research approach because it studies events in their own natural setting. McMillan and Schumacher (1993: 43); Creswell (1994: 147); Strauss and Corbin (1990: 17) further indicate that qualitative research refers to the research about the people's lives beliefs, and behaviour. Fraekel and Wallen (1990:37) add that qualitative research is concerned about the quality of particular activity than how often it occurs. Qualitative research describes the depth, richness, and complexity inherent in the phenomena and involves putting pieces together to understanding the whole (Burns and Grove, 2003:357).

The qualitative approach are based on the world view that there is no single reality, perceptions differ from persons and over time and what is known has meaning only within a given context (Burns and Grove, 2003:357).Thus, qualitative research method is appropriate for this study since the aim is to assess experience facing home and community based care workers when working on HIV and AIDS care and support programme.

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3.4. Study area

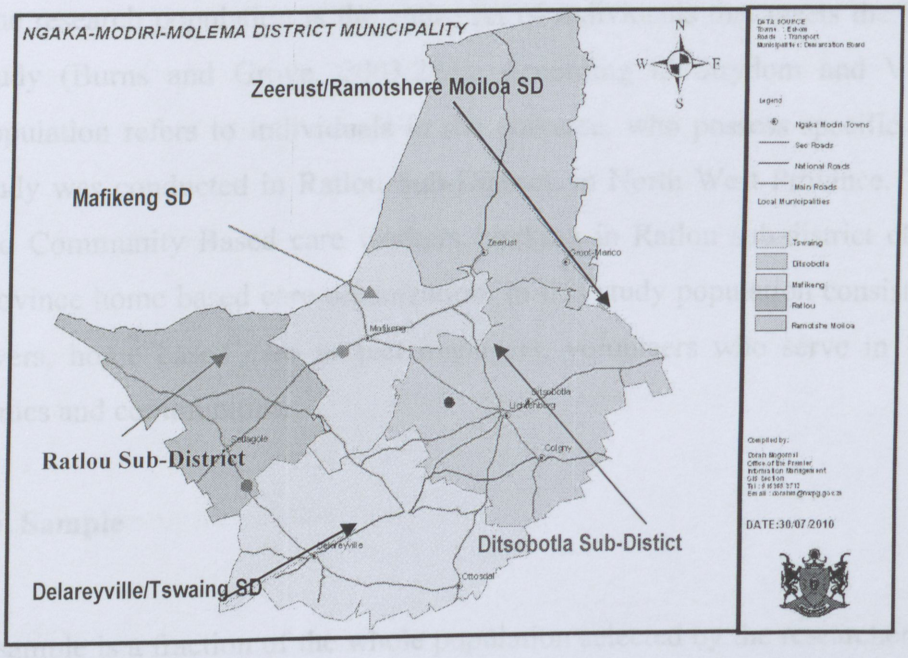


Figure 1: Map of Ngaka Modiri Molema District showing Ratlou Sub-District

According to Census 2005 released in July 2008, the province is estimated to have a total population 3 669 349 million of which the North West provincial Department of Health is serving and about 354 552 population is from Ngaka Modiri Molema. According to the Community Survey by Statistics South Africa (2007), the population of the municipality is estimated at 290 228 people and about 102 987 people of the total population fall within the age category of 15 to 34 years. Approximately 75% of Ngaka Modiri Molema district is rural. The rural areas are in the southern and western part of the municipality and are under tribal control. The challenges facing the community within the boundaries of the municipal are that; people have to travel long distance to access health care facilities; mobile clinics that service the rural areas are not consistent in their visits to these areas, some clinics do not operate 24 hours. Ngaka Modiri Molema District Municipality have four (04) local municipalities surrounding Mafikeng Local Municipality, these are: Ramotsere Moiloa, Tswaing, Ditsobotla and Ratlou (Mafikeng Municipal Integrated Development Plan (IDP) document

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3.5. Population of the study

The research population is the entire set of individuals that meets the sample criteria of the study (Burns and Grove, 2003:233). According to Strydom and Venter (2002: 199) a population refers to individuals in the universe, who possess specific characteristics. The study was conducted in Ratlou Sub-District, in North West Province. There are 290 Home and Community Based care workers working in Ratlou sub-district clinics of North West Province home based care organization. In this study population consist of home based care givers, home based care project managers, volunteers who serve in 12 clinics of Ratlou clinics and communities.

3.6. Sample

A sample is a fraction of the whole population selected by the researcher to participate in the study (Brink, 2006:124). A sample thus comprises the elements of the population considered for actual inclusion in the study or it can be viewed as a subject of measurements drawn from a population in which we are interested. Sample is a small proportion of the total set of objects, events or persons that together comprise the subject of our study (De Vos, Strydom, Fouche and Delport, 2000: 199).

In this study the researcher selected the following as participants; home based project managers with more than three years experience managing projects, community care givers and volunteers with more than 3 years experience of working in home based care. In this study participants selected are key informants to patients who are in need of care and support, infected and affected by HIV and AIDS. The respondents have experience and knowledge of working with patients at clinic and community level.

13.6.1. Sampling Method

In this study a non probability, purposive sampling was used to ensure that participants are selected based on their knowledge on the phenomenon. In Purposive sampling a particular case is chosen based on researcher `s judgement because it illustrate some feature, knowledge or process which the researcher is interested to study (Silverman, 2000:104) as cited by De

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Vos (2000:334). Research sampling involves the selection of the sample that can be a group of people, events, behaviours or elements (Burns and Grove, 2003:233). The researcher used purposive sampling in order to select care givers and Home Community Based Care project managers. The researcher purposefully select projects that have to do with the study as only home community based care givers and project managers were considered.

3.6.2. Sample Size

The sample size consist of 70 respondents were purposively selected from 290 study population in Ratlou sub-district home Based care projects.

Table 3.1: Sampling of the Study

Position	Population	Sample size
Care givers (volunteers)	70	11
Care giver (full-time)	206	54
Home Community Based care project managers (full-time)	14	5
TOTAL	290	70

Inclusion criteria

- Home community based care workers working in Ratlou clinics setting only
- Participants had at least 3 years experience of working in home based care to can provide in depth information.

Exclusion criteria

- Home community based care workers working in areas other than Ratlou Sub-district clinic setting were excluded.

3.7. Data collection methods

A questionnaire and interview guide was comprised of the following sections; Demography information of the respondent, challenges facing home based care workers when rendering HIV care and support services within the sub-district, availability of training, capacity building and knowledge, Home based care integration with Health systems and community,

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sustainability of Home community based care project, availability of equipment, supplies and resources to deliver the services and availability of services rendered by HCBC.

Data collection is the precise and systematic collection of information that is relevant to the purpose, objectives, questions or hypotheses of the study (Burns and Grove, 2003: 49).
Polit, Beck and Hungler (2004:53) define the instrument as the means of collecting precise information relevant to the objectives of the study. The collection of data is related to the problem, hypothesis or suppositions of the research and aims to obtain elements so that the objectives proposed in the research may be achieved (Silva Menezes, Pezzi and Lappoli, 2001: 34). The following two methods were used to collect data: questionnaire and interview schedule.

3.7.1. Questionnaire

In this study questionnaire was self administered together with 70 selected Care givers, Volunteers and Project managers, the questionnaire contained closed ended questions on the challenges facing home based care givers. Questionnaire was given to the volunteers, and Community Health Care givers to answer closed ended questions on their own in the presence of the researcher in order to provide guidance and more clarification. According to White (2003: 66) a questionnaire is an instrument with open or closed questions or statements to which respondents must react. The Questionnaire took at least thirty (30) to forty-five minutes (45 min) fill in the answers.

3.7.2. Interviews

For the qualitative component, five (05) in-depth interviews were conducted separately with key informants of selected home based care project managers. These interviews were intended to capture respondents' experiences and challenges facing home based care givers in the process of primary health care (PHC) re-engineering. A semi-structured interview guide was developed to conduct in-depth interviews with the home based care project managers. De Vos (1998: 299) describes the interview schedule as a guideline for the interview and it contains questions that are important to the research. The main purpose of incorporating this component was to obtain in-depth information from the managers in order to complement

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data that was collected from the care givers using a questionnaire. The interview guide consisted of probing questions that are similar to the issues raised in the quantitative tool.

3.8. The pilot testing

Pilot testing is the practical possibility to carry it out, the correctness, and the adequacy of the method and instrument measurement (De Vos, 2002: 211). A pilot study is a smaller version of the proposed study and conducted to refine methodology (Burns and Grove 2003:43). Pre-testing of the instrument was conducted to measure face to face validity of an instrument and to improve questions so that the instrument becomes relevant to the study and to determine whether the instrument and analysis will be adequate and appropriate.

Pre- test was conducted to measure the suitability of the questionnaire to check certainty of possible errors and the surest protection against such error. The researcher also ask for comments on the wording of the questions, the sequence of the questions, possible redundant questions, the sequence of the questions, and missing and confusing questions. The researcher pre-tested the interview guide to find out if participants will understand the questions, if the questions mean the same thing to all participants, if it provides you with the data you need, and how long it takes to complete.

3.9. Methods of data analysis

According to De Vos et al (2005:333), data analysis is a process of bringing order, structure and meaning to the collected data. According to White (2003:82) data analysis is primarily an inductive process of organizing the data into categories and identifying portents (relationships) among the categories. It is a systematic process of selecting, categorizing, comparing, synthesising and interpreting to provide explanations of the single phenomenon of interest.

In this study Quantitative data was analysed in descriptive statistics. Data was captured in a coded Microsoft excel worksheet and imported in SPSS V19.0 Data was described and summarised by tabulating them. Descriptive Frequency in this study was reported in terms of numbers and percentages and will appear in the form of tables. In this study the service of a statistician was not utilized.

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Qualitative data analysis: In order to analyse data collected through interview guide the researcher used steps of qualitative data analysis as described in Creswell (1994:154-156). The steps by Creswell are as follow;

- Step 1: The first step is to transcribe the interview.
- Step 2: Preliminary exploratory analysis.
- Step 3: Making connections to the research questions.
- Step 4: Inter-rater reliability.
- Step 5: Interpret findings.

In Qualitative data analysis data was analysed into manageable themes, patterns and trends. Transcription and analysis of the interviews began by following the first interview and by analysing the transcribed interviews, line by line, highlighting important ideas and themes. Verbatim transcripts was then analysed by means of thematic content analysis.

3.10. Ethical consideration

According to De Vos and Straydom (2000:63) ethics is a set of moral principles that are suggested by an individual or group are subsequently widely accepted, and offer rules and behavioural expectations about the most correct conduct towards experimental subjects and respondents, employers, sponsors, other researchers, assistants and students. According to Collins (2000:107) ethics represent certain standards according to which a particular community or group agree to regulate its behaviour. It was further explained that ethics are a set of moral principles.

The study adhered to all ethical specifications. Permission to conduct research will be obtained from the participants. The researcher had the chance to meet each participant personally and talk to him or her about the research, informing him or her of the purpose of the study. A letter was presented explaining the aims of the study and what was expected from participants. The letter was distributed to all participants and the researcher read through with participants. Participants were given time to ask questions. The letter informed

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participants of the amount of participation and time required. Participants were requested to sign a consent form agreeing to participate in the study.

The proposal of this study was presented to the Higher Degree Committee (HDC) of the School of Management science at the University of Venda and permission to conduct the study was obtained from the North West Provincial Department of Health and Home Community based care projects.

The following are ethics to be considered in the study;

- **Informed Consent:** The researcher made it clear to the respondents, that the research is being conducted for academic purpose. In this study the researcher informed the respondents about the way in which the research process will be conducted.

- **No Harmful Deception of Subjects or Respondents:** In this study the researcher informed the respondents that there will be no information that will harm the psychological and emotional wellbeing of the respondents due to giving false information or using swearing words.

- **Respect the Privacy of Subjects and Others:** The researcher promised the respondents that their privacy is going to be kept safe. The researcher ensures this by not disclosing participant names and by hiding respondent answers after data analysis.

- **Right to Withdraw:** The researcher respected the rights of the respondents to withdraw from the study if they feel unwilling to respond, as there is no one to be forced to participate in the study.

- **Honesty:** The researcher was honest in the disclosure of this result and in analysing the data. The researcher presented the purpose of the study, and his role in the study.

- **Anonymity and Confidentiality:** The researcher also guarantees confidentiality and anonymity. The researcher promised that he is not going to discuss his study findings

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with other people except academic staff. The respondents were also told that they have the rights not to reveal their names, residential addresses.

3.11. Conclusion

This chapter has covered all issues concerning overall research methodology adopted, population identification, sampling procedures and units of analysis, the means of study sites and methods for data collection and analysis. The issue of how data will be collected and analysed were dealt with in this chapter. The next chapter deals with the interpretation and analysis of data to be collected.

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CHAPTER 4: DATA PRESETATION, INTERPRETATION AND ANALYSIS

4.1 Introduction

This chapter discusses the analysis and interpretation of data. In this chapter, data was collected from the response to the interview guide and a questionnaires that were administered among home based care givers in Ratlou Sub-District was presented, analysed and interpreted. The focus of this chapter therefore summarised presentation of research results.

The objectives of the study were:

- To identify and describe major challenges facing home based care workers when rendering HIV care and support services within the sub-district
- To assess sustainability of home community based care project
- To assess home based care integration with health systems and community
- describe care and support services rendered by home and community based workers

This chapter provides the data analysis for the study under the following sections: Socio-demographic information, challenges facing home based care workers; availability of training, capacity building and knowledge for home based care workers; integration with Health systems and community; sustainability of Home community based care project; availability of equipment, supplies and resources to deliver the services; care and support services rendered by home and community based workers.

4.2 Response rate

In this study 5 interviews were conducted with all home based care project managers based in Ratlou sub-district, of which all 5 respondents agreed to take part in the interviews. With regard to questionnaire about 70 respondents answered questionnaires. The response rate was 100%. Despite the request to respond to all questions, all of the respondents responded to all of the questions. Polit and Beck (2006) indicated that at least fifty percent of the sample is required from respondents; this also assists in overcoming response bias.

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4.3 ANALYSIS OF DATA COLLECTED THROUGH QUESTIONNAIRE

This section presents the results of the quantitative component of the research collected using questionnaire. The section is divided into seven parts;

- Section A: socio-demographic characteristics of participants
- Section B: challenges facing home based care givers
- Section C: project sustainability and accessibility
- Section D: integration with health systems and community participation
- Section E: care and support services rendered by home and community based carers

Descriptive statistics was used to describe the population considered throughout this study. According to Adler and Clark (2008: 23) "descriptive statistics are used to describe and interpret collected data from the study sample". "Frequencies are the number of cases in each category of a variable and are displayed in terms of tables, pie graphs and bar charts.

According to the responses in this report response alternatives mainly include Yes or No "strongly agree", "agree", "disagree", "strongly agree" and "not sure". For the purpose of data analysis and interpretation, response alternatives were grouped as positive and negative responses.

SECTION A: SOCIO-DEMOGRAPHIC CHARACTERISTICS OF PARTICIPANTS

One of the questions articulated in the questionnaire and interview guide was to determine the demographic profiles of the respondents. In doing so, the gender is the majority could be easily identified, as well as a generally determining the sum total of the whole population. This section describes respondents in terms of their age, marital status, qualifications and years of experience.

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Table 4.1: Age of the respondents (n=70).

Age	Frequency	Percent (%)
18 years and below	0	0%
19- 35	16	23%
36- 45	30	43%
46-55	21	30%
56-65	3	4%
66 and above	0	0%
TOTAL	70	100%

Of the respondents responses received were no less than 18 years of age. The mean age of the participants was 30 years, with range from 19 to 65 years Majority of the respondents 30 (43%) were aged 36-45; followed by 21 (30%) aged 46-55 years of age; about 16 (43%) were aged 19-35 and only 3 (4%) were aged 56-65.

Table 4.2: Distribution of respondents by gender

SEX	Frequency	Percentage
Male	9	13%
Female	61	87%
Total	70	100%

Of the questions articulated in the questionnaire was determined by the demographic profile of the respondents this was presented in a manner in which the percentages of males could be compared to the percentage of females. In doing so, a total of 70 (87%) care givers were interviewed, of which 61 (87%) were females (table 4.2). This show that majority of home based care givers are females, therefore further measures must be taken to ensure that man/males also take part in care giving for males this will ensure openness among males during care giving.

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Table 4.3: Respondents marital status

Marital status	Frequency	Percentage
Single	36	51%
Married	27	39%
Widow/Widower	4	6%
Separated/ Divorced	3	4%
TOTAL	70	100%

A total of 36 (51%) respondents were single, of which 27 (39%) of the respondents were married. In this study 4 (6%) of the respondents were widow, 3 (4%) were Divorced/separated. This show that majority of the respondents 36 (51%) were not married.

Table 4.4: Respondents Highest Educational Qualification

Educational Qualification	Frequency	Percentage
No formal Education	30	43%
ABET Certificate	13	19%
Grade 12	26	37%
Other	1	1%
TOTAL	70	100%

About 30 (43%) respondents had no formal education. About 26 (37%) of the respondents had only grade 12 and 13 (19%) obtained ABET training certificate. In this study 1 (1%) of the respondents had other qualifications not disclosed. This show that further interventions need to be done to ensure that care givers are provided with further training and skills which can also create employment opportunities for them in the future in case if the project lapse due to lack of funding.

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Table 4.5 Position of home based care giver in the project

Position	Frequency	Percentage
Care givers (volunteer)	11	16%
Care giver (fulltime)	54	77%
Home Community Based care project managers (full-time)	5	7%
TOTAL	70	100%

Respondents by position titles which the holds represent as follows: about 11 (16%) of care givers were volunteers, with majority at 54 (77%) were care giver employed fulltime. This results shows that 5(7%) of the respondents were project managers. This also shows that there are still care givers who are volunteers in order to render services for people infected and affected by HIV and AIDS.

Table 4.5: Years of service as care giver in a project

Experience	Frequency	Percentage
Less than 1 year	3	4%
2-4 years	31	44%
5-10 years	21	30%
11-15 years	11	16%
16 years and above	4	6%
TOTAL	70	100%

Table 4.5 above shows that majority of the respondents 31 (44%) had 2-4 years working experience in the project, of which 21 (30%) have 5-10 years experience, about 11 (16%) have 11-15 years of working experience, 4 (6%)had 16 years and above, 3 (4%) has less than 1 year.

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SECTION B: CHALLENGES FACING HOME BASED CARE GIVERS

Table 4.6: There is no good relationship between home based care giver and patients

	Frequency	Percentage
Strongly agree	2	3%
Agree	9	13%
Disagree	44	63%
Strongly disagree	15	21%
Not sure	0	0%
TOTAL	70	100%

The majority of respondents 44 (63%) are disagreeing with the statement that there is no good relationship between home based care giver and patients. It is assumed that there is a good relationship between care givers and patient. In this study about 9(13%) agreed, were 2(3%) strongly agreed. The results also show that about 15 (21%) have strongly disagreed with the statement that there is no relationship between patients and care givers. Base on above it can be evident that there is a good relationship between care givers and patients.

Table 4.7: There is no good relationship between home based care giver and health care workers at clinic level

	Frequency	Percentage
Strongly agree	7	10%
Agree	10	14%
Disagree	36	51%
Strongly disagree	13	19%
Not sure	4	6%
TOTAL	70	100%

The results shows that majority of respondents 36 (51%) disagreed that there is no good relationship between care givers and health care workers, of which 13 (19%) strongly disagree. Only about 10 (14%) of the respondents agreed that there is no relationship between

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health care workers and care givers. About 7 (10%) strongly agree, 4(6%) were not sure if there is a good relationship. This show that good relationship does exist between health care workers and care givers.

Table 4.8: HCBC givers are not receiving support from department of health

	Frequency	Percentage
Strongly agree	3	4%
Agree	16	23%
Disagree	40	57%
Strongly disagree	6	9%
Not sure	5	7%
TOTAL	70	100%

Majority of the respondents disagreed 40 (57%) with the statement that home based care givers are not receiving support from the department of health. Of which about 16 (23%) agreed with the statement that there is no good relationship. About 3 (4%) strongly agree with 6 (9%) strongly disagree and 5 (7%) not sure that core givers are not receiving support. About 5 (7%) were not sure about the relationship that exists between their home based care project and the department of health. However, this shows that the relationship does exist with the department of health personnel..

Table 4.9: Patients are ignoring caregivers

	Frequency	Percentage
Strongly agree	3	4%
Agree	30	43%
Disagree	29	41%
Strongly disagree	3	4%
Not sure	5	7%
TOTAL	70	100%

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Table 4.9 shows that about 30 (43%) for the respondents feel that patients are ignoring them, about 29 (41%) disagreed with the statement that indicate that patients are ignoring them. About 3 (4%) strongly agree, with 3 (4%) strongly disagree and 5 (7%) not sure that patients are ignoring care givers. This shows that patients are ignoring care givers when they are providing HIV and AIDS care and support.

Table 4.10: Care givers are not always welcome by family members

	Frequency	Percentage
Strongly agree	2	3%
Agree	33	47%
Disagree	31	44%
Strongly disagree	3	4%
Not sure	1	1%
TOTAL	70	100%

Table 4.10 shows that about 33 (47%) of the respondents agreed that care givers are not always welcomed by family members. The results further show that 2 (3%) strongly agree, 3 (4%) strongly disagree, 1 (1%) not sure that core givers are not always welcome.
About 31 (44%) disagree that patient are not welcome by patients family members. This confirms that home based care givers are experiencing challenges when they are visiting patients as they are still not allowed or given full permission to give full care and support services.

Table 4.11: Patient are ignoring care givers when giving them support services

	Frequency	Percentage
Strongly agree	5	7%
Agree	22	31%
Disagree	32	46%
Strongly disagree	6	9%
Not sure	5	7%
TOTAL	70	100%

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Majority of the respondents 32 (46%) disagree with the statement that patients are ignoring care givers when they are providing HIV /AIDS care and support. In this study the results show that 5 (7%) strongly agree, 6 (9%) strongly disagree, with 5 (7%) not sure that patient are ignoring care givers. However, 22 (31%) agreed with the statement that patients are ignoring care givers when they are rendering HIV care and support. This means that there are still patients who are not accepting service rendered by care givers.

Table 4.12: Patients are not appreciating services

	Frequency	Percentage
Strongly agree	5	7%
Agree	15	21%
Disagree	36	51%
Strongly disagree	7	10%
Not sure	7	10%
TOTAL	70	100%

Majority of the respondents disagree that patients are not appreciating HIV and AIDS care and support services rendered by home and community care givers. About15 (21%) show that they agreed to appreciate care and support services. In this study 36 (51%) show disagree, 7 (10%) strongly disagree, 7 (10%) not sure and 5 (7%) strongly agree that patients are not appreciating the service. This could be due to the fact that care givers are staying in the same area. There above results shows that patients have interest in HIV care and support services.

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Table 4.13: Patients are not taking prescribed medication regularly

	Frequency	Percentage
Strongly agree	5	7%
Agree	22	31%
Disagree	33	47%
Strongly disagree	3	4%
Not sure	7	10%
TOTAL	70	100%

Table 4.13 illustrate that patients are taking prescribed medication as 33 (47%) disagree with the statement that patients are not taking prescribed medication regularly. In this study about 5 (7%) strongly agree, 3 (4%) strongly disagree, with 7 (10%) not sure that patients are not taking prescribed medication regularly. About 22 (31%) of the respondents agree that patients are not taking prescribed medication regularly. This confirms that patients are able to take their prescribed medication regularly.

Table 4.14: Patients refusing HIV care and support services

	Frequency	Percentage
Strongly agree	3	4%
Agree	17	24%
Disagree	36	51%
Strongly disagree	9	13%
Not sure	5	7%
TOTAL	70	100%

The table above illustrate that majority of respondents 36 (51%) disagree with the statement that patients are refusing care and support services. In this study 3 (4%) strongly agree, 9 (13%) strongly disagree 5 (7%) not sure that the patients refusing HIV care and support services. About 22 (24%) agreed that patients are refusing their care and support services. The results reveal that most patients are taking up care and support services seriously, however much still need to be done to ensure that patients fully trust HIV care and support provided by care givers.

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Table 4.15: There is lack of fund within the organization

	Frequency	Percentage
Strongly agree	22	31%
Agree	32	46%
Disagree	9	13%
Strongly disagree	4	6%
Not sure	3	4%
TOTAL	70	100%

The majority of the respondents 32 (46%) agreed with the statement that there is lack of funds within the organisation, of which 22 (31%) also confirm by strongly agreeing that there is lack of funds within their home and community based care project. In this study 9 (13%) disagree, 4 (6%) strongly disagree, 3 (4%) not sure that there is lack of fund within the organization. This shows that there are large numbers of project which are not funded and this might leave project to lapse due to lack of funds to sustain their services.

Table 4.16: There is Late or delay in payment of stipends

	Frequency	**Percentage**
Strongly agree	32	46%
Agree	26	37%
Disagree	9	13%
Strongly disagree	3	4%
Not sure	0	0%
TOTAL	70	100%

Majority of the respondents 32 (46%) strongly agreed that there is delay in payment of stipend, of which 26 (37%) agreed. In this study the results show that 9 (13%), with 3 (4%) strongly disagree that there is a late or delay in payment of stipends. This shows that home based care givers are not receiving their stipend on time. This could be as the results that stipend are paid via service provider.

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Table 4.17: The is lack of resources within the organization

	Frequency	Percentage
Strongly agree	25	36%
Agree	29	41%
Disagree	13	19%
Strongly disagree	3	4%
Not sure	0	0%
TOTAL	70	100%

There above table show that 29 (41%) of the respondents agreed that there is lack of resources within their organization that hinder with their HIV care and support services. This was further confirmed as 25 (36%) further agree, with 3 (4%) strongly disagree. However 13 (19%) disagreed as they felt that they do have resources available within their organization. This further confirms that there is lack of resources within the organization.

Table 4.18: Lack of knowledge about home based care

	Frequency	Percentage
Strongly agree	12	17%
Agree	16	23%
Disagree	37	53%
Strongly disagree	4	6%
Not sure	1	1%
TOTAL	70	100%

The results show that 57 (53%) of the respondents felt that they have knowledge about home based care services. The results further show that 4 (6%) strongly disagree and 1 (1%) was not sure if there is lack of knowledge about home based care. However about 16 (23%) felt that they don't have knowledge about home based care services was further confirmed by 12 (17%) which strongly agreed with the statement that they lack knowledge about home based care.

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Table 4.19: There is political Interference from communities

	Frequency	Percentage
Strongly agree	4	6%
Agree	38	54%
Disagree	14	20%
Strongly disagree	8	11%
Not sure	6	9%
TOTAL	70	100%

Majority of the respondents 30 (54%) felt that there is political interference when they are rendering HIV care and support services within their communities. Only 14 (20%) disagreed with the statement and 8 (11%) strongly disagreed. The results further reveal that 4 (6%) strongly agree with 6 (9%) not sure that there is political interference from communities. This further confirm that there is political interference in home based care services which might results in disturbing home based care services.

Table 4.20: Lack of supervision and support

	Frequency	Percentage
Strongly agree	8	11%
Agree	22	31%
Disagree	31	44%
Strongly disagree	6	9%
Not sure	3	4%
TOTAL	70	100%

The study show that 31 (44%) of the respondents disagree with the statement that there is lack of supervision and support for home and community based care givers. The study results further shows that 8 (11%) strongly agree, 6 (9%) strongly disagree, 3 (4%) show they were not sure about lack supervision and support.

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However 22 (31%) agree that there is lack of support for home based care givers. This confirms that there is still need of support for home based care givers. However majority of care givers are provided with supervision and support.

Table 4.21: There is no links with local clinics

	Frequency	Percentage
Strongly agree	3	4%
Agree	18	26%
Disagree	37	53%
Strongly disagree	11	16%
Not sure	1	1%
TOTAL	70	100%

Majority of the respondents 37 (53%) disagree with the statement that there are links with local clinics. The study results show that 3 (4%) strongly agree, 1 (1%) not sure if there is no links with local clinics. About 18 (26%) of the respondents agree that there are no links with local clinics; this was further confirmed as 11 (16%) disagree with the statement that there are no links between clinics.

Table 4.22: Nurses are not providing support to care givers

	Frequency	Percentage
Strongly agree	6	9%
Agree	16	23%
Disagree	34	49%
Strongly disagree	13	19%
Not sure	1	1%
TOTAL	70	100%

Majority of the respondents 37 (49%) felt that nurses are providing support to care givers; this was further confirmed as 13 (19%) disagree with the statement that there is no support. The study results further confirm that 6 (9%) strongly agree, with 1 (1%) not sure if nurses

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are not providing support to care givers. About 16 (23%) agree that they are not provided with any form of support from their local supporting clinics. This concludes that care givers are receiving support from their local clinics which they are supporting.

Table 4.23: There is lack of transport to visit clinics

	Frequency	Percentage
Strongly agree	29	41%
Agree	27	39%
Disagree	12	17%
Strongly disagree	2	3%
Not sure	0	0%
TOTAL	70	100%

Majority of the respondents felt that there is no means of transportation for patients when they want to visit clinics as 29 (41%) strongly agree with the statement with 27 (39%) agree. The study show that only 2 (3%) strongly disagree that there is lack transport to visit clinic. Only 12 (17%) felt that patients have access to means of transportation. It can be concluded that patients are still struggling to access clinics for referral and follow up visits.

Table 4.24: There is stigma and discrimination attached to HIV patients

	Frequency	Percentage
Strongly agree	9	13%
Agree	21	30%
Disagree	31	44%
Strongly disagree	5	7%
Not sure	4	6%
TOTAL	70	100%

The above table show that majority of respondents 21 (44%) disagreed that patients are still faced with stigma and discrimination which are faced by HIV patients. The study show that 5 (7%) strongly agree, with 4 (6%) not sure that there is still stigma and discrimination attached

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to HIV patients. However 21 (30%) agreed that patients are still faced with discrimination, which is also confirmed by 9 (13%) strongly agreed. This shows that patients are still faced with discrimination and stigma against HIV and AIDS.

Table 4.25: There is lack of nutritional supplements for HIV positive patients

	Frequency	Percentage
Strongly agree	17	24%
Agree	28	40%
Disagree	16	23%
Strongly disagree	7	10%
Not sure	2	3%
TOTAL	70	100%

The table show that there is lack of nutritional supplements for HIV positive patients as majority of patients 28 (40%) agree and 17 (24%) confirmed by strongly agreeing that there is lack of nutritional support for HIV positive patients. The study results further reveal that 7 (10%) of the respondents strongly disagree, with 2 (3%) indicating that there is lack of nutrition supplements for HIV positive. However about 16 (23%) disagreed that patients do not have nutritional supplements. This confirmed that there are no nutritional supplements for HIV positive patients; this calls the government to provide nutritional supplements for HIV positive patients.

Table 4.26: There is support, Supervision and mentorship for home based care givers

	Frequency	**Percentage**
Strongly agree	6	9%
Agree	29	41%
Disagree	23	33%
Strongly disagree	7	10%
Not sure	5	7%
TOTAL	70	100%

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The above table show home based care givers are receiving support as 29 (41%) agreed with 6 (9%) strongly agreed. The study results shows that 7 (10%) strongly disagree, with 5 (7%) not sure that there is support, supervision and mentorship. However about 23 (33%) of care givers disagreed that they are receiving support, supervision and mentorship. This can be confirmed that care givers are receiving support, however much work need to be done to support care givers who disagreed with the statement.

Table 4.27: Home based care givers are provided with emotional support

	Frequency	Percentage
Strongly agree	9	13%
Agree	22	31%
Disagree	24	34%
Strongly disagree	11	16%
Not sure	4	6%
TOTAL	70	100%

The result show that home based care givers are not provided with emotional support as 24 (34%) disagree, 11 (16%) strongly disagreed. However, 22 (31%) of the respondents agreed, with 9 (13%) strongly agreed that care givers are provided with emotional support. The study results further show that 9 (13%) strongly agree, with 4 (6%) not sure that home based care givers are provided with emotional support. This confirm that care givers are provided with HIV care and support, however much effort needs to be done to ensure that all care givers are provided with emotional support such as debriefing and counselling.

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Table 4.28: The services rendered are benefiting the surrounding communities which the project situated

	Frequency	Percentage
Agree	56	80%
Agree	0	0%
Disagree	13	19%
Strongly disagree	0	0%
Not sure	1	1%
TOTAL	70	100%

The above table showed significant results as about 56 (80%) of the respondents indicated that their services are benefiting the surrounding communities, however about 13 (19%) disagreed with the statement that communities are benefiting from care and support services rendered by care givers. The study further show that 1 (1%) of the respondents were not sure that services rendered are benefiting the surrounding community. This show that care givers are managing to reach communities at large with their services though their stipend are not satisfactory.

Table 4.29: Home based care are trained on related home based care trainings received

	Frequency	Percentage
Agree	40	57%
Strongly Agree	7	10%
Disagree	13	19%
Strongly disagree	9	13%
Not sure	1	1%
TOTAL	70	100%

The above figure shows that care givers in Ratlou sub-district are more likely to have received training in home based care related trainings as 40 (57%) of the respondents indicated they agree with 7 (10%) strongly agree.. The study results show that 13 (19%) disagree, with 9(13%) strongly disagree and 1 (1%) not sure that care givers are trained on

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related home based care trainings received. The CHW training should involve an initial orientation course and short specific courses e.g. Home-Based Care Training-59 days and an intensive course completed over a few years e.g. Ancillary Health Care – 2 years with the CHWs functioning during this time, gradually extending their range of work as they become more competent (Ognmefun and Madale et al.,2011: 38).

Table 4.30: Home based care givers have knowledge on HIV and AIDS management

	Frequency	Percentage
Agree	26	37%
Strongly Agree	7	10%
Disagree	30	43%
Strongly disagree	6	9%
Not sure	1	1%
TOTAL	70	100%

The study highlighted that there was no knowledge on HIV and AIDS management as 26 (37%) agreed and 7 (10%) strongly agreed. The study 30 (4%) disagree, with 6 (9%) strongly disagree and 1(1%) not sure that care givers have knowledge on HIV and AIDS management. Specific training is requested on bereavement and family counselling. Training is also required on how to handle stigma and discrimination relating to HIV and AIDS. Knowledge that treatment for AIDS is available may help to reduce the stigma around being HIV positive, and encourage prevention behaviours. Also, the new information that AIDS drugs (ART) are available should be incorporated into prevention messages to ensure that people are fully informed about the nature and extent of treatment, and its implication for further health.

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Table 4.31: Home based care givers are trained on reporting, Monitoring and Evaluation tools

	Frequency	Percentage
Agree	36	51%
Strongly Agree	30	43%
Disagree	2	3%
Strongly disagree	1	1%
Not sure	1	1%
TOTAL	70	100%

Majority of respondents 36 (51%) agreed that they received relevant training related to reporting, monitoring and evaluation with 30 (43%) strongly agreed that they have received such training. The study results reveal that 2 (3%) disagree, with 1 (1%) strongly disagree and 1 (1%) not sure that home based care givers are trained on Monitoring and Evaluation. According to the South Africa Department of Social Development report (2006: 21) the creation of a monitoring and evaluation (M&E) system if community-based care is to become effective and sustainable. The report further highlighted that guidelines for a minimal package of care along with basic monitoring and evaluation tools should be developed and implemented.

Table 4.32: Home based care givers were trained on Home Based Care (59-day) training

	Frequency	Percentage
Agree	36	51%
Strongly Agree	26	37%
Disagree	5	7%
Strongly disagree	2	3%
Not sure	1	1%
TOTAL	70	100%

The results show that about 36 (51%) agreed that care givers have received 59 days Home Based Care training with 26 (37%) strongly agreed. The study results show that 5 (7%) disagree, 2 (3%) strongly disagree and 1 (1%) not sure if care givers were trained on home

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based care 59 day training. According to Ognmefun and Madale et al.,2011: 38) training should involve an initial orientation course and short specific courses e.g. Home-Based Care Training-59 days

Table 4.33: Home based care givers have relevant knowledge of home based care

	Frequency	Percentage
Agree	36	51%
Strongly Agree	26	37%
Disagree	5	7%
Strongly disagree	2	3%
Not sure	1	1%
TOTAL	70	100%

The above table show that most of the respondent's 36 (51%) agreed that they have knowledge of home based care for patients infected by HIV/AIDS in need of care with 26 (37%) strongly agreed. The study show that 5 (7%) disagree, 2 (3%) strongly disagree and 1 (1%) not sure that care givers have relevant knowledge of home based care. This includes having knowledge of Home community based care policies and guidelines. This also include knowledge of Health promotion, Education and HIV and AIDS awareness, bereavement counselling, and Feeding adults infected by HIV and AIDS, baby feeding and condom demonstration.

Table 4.34: There are Supplies such as food parcels provided to care givers

	Frequency	Percentage
Agree	6	9%
Strongly Agree	50	71%
Disagree	5	7%
Strongly disagree	7	10%
Not sure	2	3%
TOTAL	70	100%

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The table above show that that there are Supplies such as food parcels provided to home based care givers by the department of health as 50 (71%) strongly agreed with 6 (9%) agreed. The study results show that 5 (7%) disagree, with 7 (10%) strongly disagree and 2 (3%) not sure that there are supplies such as food parcels provided to care givers. The Departments should consider the provision of supplies to all HCBCs irrespective of whether they are funded or not (South Africa of Department Social Development, 2006: 59). However, home based care givers must be ensuring that supplies are available on time by identifying as early as possible.

Table 4.35: Care givers are provided with protective clothes to use when they see patients

	Frequency	Percentage
Agree	5	7%
Strongly Agree	25	36%
Disagree	38	54%
Strongly disagree	1	1%
Not sure	1	1%
TOTAL	70	100%

The above figure show that majority of care givers are not provided with protective clothes as 38 (54%) they are not provided with protective clothes, with about 25 (36%) strongly agree that they are provide with protective clothe. lack of protective clothe can lead them to be exposed to diseases. The study results show that 5 (7%) agree, 1 (1%) strongly disagree and 1 (1%) not sure that care givers are provided with protective cloths to use when they see patients. This confirm that measures should be taken focusing of ordering supplies such as kits, N95 masks and safety and policies should be emphasised to ensure that care givers are wearing protective clothe when dealing with patients infected by both HIV and TB this will reduce the risk of TB co-infection and contacting infectious diseases.

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Table 4.36: Home based care givers are provided with home based care kits

	Frequency	Percentage
Agree	2	3%
Strongly Agree	49	70%
Disagree	0	0%
Strongly disagree	18	26%
Not sure	1	1%
TOTAL	70	100%

Table above confirm the availability of home based care kits as 49 (70%) strongly agree to confirm the availability of care kits and only about 18 (26%) The results show that 2 (3%) of the respondents agree and 1 (1%) not sure that care givers are provided with home based care kits. This means that care givers are provided with home based care kits.

Table 4.37: supplies such as food parcels are available to care givers within the expected period

	Frequency	Percentage
Agree	2	3%
Strongly Agree	15	21%
Disagree	22	31%
Strongly disagree	30	43%
Not sure	1	1%
TOTAL	70	100%

Table above shows the availability of supplies within specific periods of time. The results reveal that majority care givers 30 (43%) strongly disagree that they never receive food parcels groceries within the specified period, with 22 (31%) disagree, o 15 (21%) strongly agree that supplies are supplied within the expected period. The study results show that 2 (3%) agree, with 1 (1%) not sure that supplies such as food parcels are available to care

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givers. The results show that home based care supplies took more than the time expected to be supplied. This includes minerals such as protein, vitamins which are not available.

SECTION C: PROJECT SUSTAINABILITY AND ACCESSIBILITY

Table 4.38: Home based care givers have business plan which guide their activities

	Frequency	Percentage
Agree	3	4%
Strongly Agree	50	71%
Disagree	6	9%
Strongly disagree	10	14%
Not sure	1	1%
TOTAL	70	100%

The table above show that most home based care project have a business plan which guide their activities with 50 (71%) respondents strongly agreed, 3 (4%) agreed, 6 (9%) disagreed, 10 (14%) strongly disagreed. The study results also reveal that 3 (4%) agree and 1 (1%) were not sure that care givers have business plan which guide their activities. This shows that there are few projects which are without a business plan. Further steps need to be taken to ensure that all home based care projects have a business plan.

Table 4.39: Home based care givers have sustainable income generating projects

	Frequency	Percentage
Agree	4	6%
Strongly Agree	30	43%
Disagree	5	7%
Strongly disagree	30	43%
Not sure	1	1%
TOTAL	70	100%

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The above table show that about 30 (43%) of the facilities strongly agree that their projects have sustainable income generating projects, with 5 (7%) disagree, and with 30 (43%) strongly agree. The study results reveal that 4 (6%) agree, 1 (1%) not sure that they have sustainable income generating projects. This confirms that most home based care projects don't have sustainable income generating project. This need to be addressed with home based care projects in order to ensure that projects have sustainable income generating projects; this can help projects to sustain themselves in the absence of funds.

Table 4.40: There is a means of transportation for care givers available to access patients home

	Frequency	Percentage
Agree	4	6%
Strongly Agree	0	0%
Disagree	60	86%
Strongly disagree	5	7%
Not sure	1	1%
TOTAL	70	100%

Majority of the respondents felt that there is no means of transportation for home based care givers to visit patients as 60 (86%) disagree with the statement with 4 (6%) agree. This means only 4 (6%) felt that care givers have access to means of transportation. Furthermore the study results show that 5 (7%) strongly disagree and 1 (1%) not sure if there is a means of transport for care givers. It can be concluded that patients are still struggling to access clinics for referral and follow up visits. Some HCBC organisations noted that they face operational challenges due to the lack of transportation.

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Table 4.41: The home based cares have sufficient funding from other institutions to can sustain the project

	Frequency	Percentage
Agree	5	7%
Strongly Agree	40	57%
Disagree	20	29%
Strongly disagree	4	6%
Not sure	1	1%
TOTAL	70	100%

The respondents 40 (57%) strongly agree that their project have sufficient funding from other institutions to sustain the project and of which 20 (29%) disagree as they don't have the chance of sustaining itself in the absence of funds. The study results show that 5 (7%) agree, with 4 (6%), strongly disagree and 1 (1%) not sure that home based care have sufficient funding from other institutions. Further action need to be done to train care givers on how to apply for funds. Similar findings conducted by Mbatha, (2011:2) reveal that some organisations were in need of funds for stipends of their community caregivers. The majority of the respondents agreed with the statement that there is lack of funds within the organisation, of which also confirm by strongly agreeing that there is lack of funds within their home and community based care project. This shows that there are large numbers of projects which are not funded and this might leave project to lapse due to lack of funds to sustain themselves.

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SECTION D: INTEGRATION WITH HEALTH SYSTEMS AND COMMUNITY PARTICIPATION

Table 4.42: Home based care workers have a good knowledge and participation of Primary Health care re-engineering

	Frequency	Percentage
Agree	7	10%
Strongly Agree	40	57%
Disagree	20	29%
Strongly disagree	3	4%
Not sure	0	0%
TOTAL	70	100%

Table above show that about 40 (57%) (67%) of home based care givers strongly agreed, 7 (10%) agreed that they have a good knowledge of Primary Health care re-engineering. The results show that 20 (29%) disagreed with 3 (4%) strongly disagree that they have never been trained on Primary Health care re-engineering. The results confirm that home based care givers are not trained on PHC re-engineering. Further steps need to be taken to ensure that all home based care givers are capacitated on all activities which include PHC re-engineering.

Table 4.43: Home based care workers have a good relationship with HIV and AIDS counsellors within local clinics

	Frequency	Percentage
Agree	60	86%
Strongly Agree	2	3%
Disagree	4	6%
Strongly disagree	4	6%
Not sure	0	0%
TOTAL	70	100%

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The above table shows that Home based care givers have a good relationship with HIV and AIDS counsellors within local clinics with 60 (86%) agreed, 2 (3%) strongly agreed, 4 (6%) disagreed, and 4 (6%) strongly disagreed. This confirms that care givers have a good relationship with counsellors who are placed at facility level.

Table 4.44: The project received official visits from project funders for project monitoring and support

	Frequency	Percentage
Agree	3	4%
Strongly Agree	50	71%
Disagree	15	21%
Strongly disagree	2	3%
Not sure	0	0%
TOTAL	70	100%

The above table illustrate that 50 (71%) strongly agree, 3 (4%) agreed that the project receives official visits from project funders for project monitoring and support. The results show that 2 (3%) strongly disagree that project received official visits from funders. The table also show that 15 (21%) disagree that they receive official visit for monitoring and evaluation on project activities. This reveals that project funders are able to visit some of the home based care projects, however further steps need to be conducted to ensure that other home based care projects are visited.

Table 4.45: The project well known in the community in which it is operating

	Frequency	Percentage
Agree	9	13%
Strongly Agree	51	73%
Disagree	5	7%
Strongly disagree	5	7%
Not sure	0	0%
TOTAL	70	100%

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The results show that about 51 (73%) of the respondents strongly agree with 9 (13%) agree that that the project is well known in a community in which it is operating and with believe that services they are rendering are benefiting the surrounding communities which the project situated. The study results also reveal that 5 (7%) disagree and 5 (7%) strongly disagree the project is well known in a community in which it is operating. The response shows that their project has a good relationship with other organizations within the community which they operate.

Table 4.46: Home based care givers receive supporting networks from the community where it is situated

	Frequency	Percentage
Agree	10	14%
Strongly Agree	50	71%
Disagree	6	9%
Strongly disagree	4	6%
Not sure	0	0%
TOTAL	70	100%

The results show that about 50 (71%) of the respondents strongly agree with 10 (14%) agree that that home based care givers receive supporting networks within communities which it is operating as the services which they are rendering are benefiting the surrounding communities where the project situated. The study result show that 6 (9%) disagree and 4 (6%) strongly disagree that the home based care givers receive supporting networks from the community where it is situated. The response shows that their project has a good supporting networks within the community which they operating.

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Table 4.47: Patients are provided with a detailed referral form when referred to clinics

	Frequency	Percentage
Agree	9	13%
Strongly Agree	51	73%
Disagree	5	7%
Strongly disagree	5	7%
Not sure	0	0%
TOTAL	70	100%

There above table show that 9 (13%) agreed, with 51 (73%) strongly agree that patients are provided with a detail referral forms when they are referred to clinics, however about 5 (7%) disagreed, with the other 5 (7%) strongly agreed. The results confirm that patients are provided with referral forms they will ensure that patients are not poorly managed and this will ensure that patients are tracked so that there should not be loss to follow up.

Table 4.48: The role and responsibilities of the project stakeholders and members clearly defined

	Frequency	Percentage
Agree	9	13%
Strongly Agree	54	77%
Disagree	4	6%
Strongly disagree	2	3%
Not sure	1	1%
TOTAL	70	100%

The table above show that 54 (77%) of care givers strongly agreed that the roles and responsibilities of the home based care project stakeholders and members were clearly defined, with 9 (13%) agreed, 4 (6%) disagreed and 2 (3%) strongly disagreed. The table above also show 1 (1%) not sure that the role and responsibilities of the project stakeholders and members were clearly defined. This confirms that the role and responsibilities of the project stakeholders and members clearly defined.

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Table 4.49: Home based care givers has referral systems/networks (including referral forms) integrated with health systems

	Frequency	Percentage
Agree	16	23%
Strongly Agree	44	63%
Disagree	6	9%
Strongly disagree	3	4%
Not sure	1	1%
TOTAL	70	100%

Table above show that 16 (23%) of the respondents agreed with 44 (63%) strongly agreed that home based care givers has a referral forms which are integrated and standardised with the department of health systems. The table also show 1 (1%) not sure that their referral forms are integrated with health systems. The table further shows that 6 (9%) disagreed, with 3 (4%) strongly disagreed that their referral forms are integrated with health systems.

Table 4.50: The monitoring and reporting systems (such as reporting tools) are linked with the department of Health

	Frequency	Percentage
Agree	9	13%
Strongly Agree	54	77%
Disagree	4	6%
Strongly disagree	2	3%
Not sure	1	1%
TOTAL	70	100%

The table about show that 54 (77%) strongly agreed, with 9 (13%) agree that the monitoring and reporting systems (such as reporting tools) are linked with the department of Health and Social Development systems. The study results also reveal that 1 (1%) if the monitoring and

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reporting systems are linked with the department of health. The table further show that 4 (6%) disagreed and 2 (3%) strongly agreed that that the monitoring and reporting systems (such as reporting tools) are linked with the department of Health and Social Development systems. This reveals that monitoring and reporting systems are linked with department of health systems.

Table 4.51: Clinics provide Care givers with list of patients in need of care and support

	Frequency	Percentage
Agree	9	13%
Strongly Agree	54	77%
Disagree	4	6%
Strongly disagree	2	3%
Not sure	1	1%
TOTAL	70	100%

The result shows that 54 (77%) strongly agreed with 9 (13%) agree that clinics provide Care worker with list of patients in need of care and support. The results also show that 1 (1%) not sure if the clinics provide care givers with list of patients in need of care and support.The results further show that 4 (6%) of the respondents disagree, with 2 (3%) strongly disagreed. This means that clinics have a good working relationship with home based care givers at facility level.

Table 4.52: The stakeholders participate on the running of the project

	Frequency	Percentage
Agree	51	73%
Strongly Agree	8	11%
Disagree	7	10%
Strongly disagree	3	4%
Not sure	1	1%
TOTAL	70	100%

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The table above show that 51 (73%) of the respondents agreed, with 8 (11%) strongly agree that stakeholders participated in the running of the project. Only 1 (1%) not sure the stakeholders participate on the running of the project. The results further show that 7 (10%) disagreed, 3 (4%) strongly disagreed that their project stakeholders participate on the running of the project. This can ensure sustainability of the project as stakeholders influence in desertion making.

SECTION E: CARE AND SUPPORT SERVICES RENDERED BY HOME AND COMMUNITY BASED CARERS

Table 4.53: Home based care givers are providing Prevention of mother-to-child transmission (PMTCT) services

	Frequency	Percentage
Agree	53	76%
Strongly Agree	11	16%
Disagree	4	6%
Strongly disagree	1	1%
Not sure	1	1%
TOTAL	70	100%

Table above show HIV and AIDS care and support services which are rendered by care givers, of which most 53(76%) agree with 11 (16%) strongly agreed that they are providing prevention of mother-to-child transmission services. The results also show that 1 (1%) not sure if home based care givers are providing prevention of mother to child transmission. The results further reveal that 4 (6%) disagree with 1 (1%) strongly disagreed that they are not rendering prevention of mother to child transmission services. This means that most care givers are providing HIV care and support services to prevent transmission of mother to child transmission.

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Table 4.54: Home based care givers are providing Health promotion and HIV Education

	Frequency	Percentage
Agree	53	76%
Strongly Agree	11	16%
Disagree	4	6%
Strongly disagree	1	1%
Not sure	1	1%
TOTAL	70	100%

The table above show 53 (76%) respondents agreed with 11 (16%) strongly agreed that home based care givers are providing Health promotion and HIV education. The table above also show 1 (1%) not sure that home based care givers are providing health promotion and HIV education. The table also illustrate that 4 (6%) disagreed, with 1 (1%) strongly disagreed that home based care givers are providing health promotion and HIV education. This confirms that home based care givers are able to provide health promotion and HIV education.

Table 4.55: Home based care givers provide wound dressing for bedridden patients

	Frequency	Percentage
Agree	53	76%
Strongly Agree	11	16%
Disagree	4	6%
Strongly disagree	1	1%
Not sure	1	1%
TOTAL	70	100%

The table above show 53 (76%) respondents agreed with 11 (16%) strongly agreed that Home based care givers provide Wound dressing for bedridden patients. The results further reveal that 1 (1%) not sure that home based care givers provide wound dressing for bedridden patients. The table also illustrate that 4 (6%) disagreed, with 1 (1%) strongly disagreed that home based care givers are providing Home based care givers provide Wound dressing for

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bedridden patients. This confirms that home based care givers are able to provide Home based care givers provide Wound dressing for bedridden patients.

Table 4.56: Home based care giver provide management of client with tuberculosis (TB) services

	Frequency	Percentage
Agree	53	76%
Strongly Agree	11	16%
Disagree	4	6%
Strongly disagree	1	1%
Not sure	1	1%
TOTAL	70	100%

The table above show 53 (76%) respondents agreed with 11 (16%) strongly agreed that Home based care giver conduct services for Management of client with tuberculosis. The table above also show that 1 (1%) not sure if the home based care givers conduct services for management of client with tuberculosis. The table also illustrate that 4 (6%) disagreed, with 1 (1%) strongly disagreed that home based care givers are providing services for Management of client with tuberculosis. This confirms that home based care givers are able to provide services for Management of client with tuberculosis.

Table 4.57: Home based care givers are providing services on Baby feeding for children exposed to HIV

	Frequency	Percentage
Agree	53	76%
Strongly Agree	11	16%
Disagree	4	6%
Strongly disagree	1	1%
Not sure	1	1%
TOTAL	70	100%

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The table above show 53 (76%) respondents agreed with 11 (16%) strongly agreed that Home based care givers are providing services on Baby feeding for children exposed to HIV. The above table also show that 1 (1%) not sure if the above based care givers are providing services on baby feeding for children exposed to HIV. The table also illustrate that 4 (6%) disagreed, with 1 (1%) strongly disagreed that home based care givers are providing services on Baby feeding for children exposed to HIV. This confirms that home based care givers are able to provide Home based care givers are providing services on Baby feeding for children exposed to HIV.

Table 4.58: Home based care givers facilitate HIV/AIDS support groups

	Frequency	Percentage
Agree	41	59%
Strongly Agree	5	7%
Disagree	4	6%
Strongly disagree	19	27%
Not sure	1	1%
TOTAL	70	100%

The table above show 41 (59%) respondents agreed with 5 (7%) strongly agreed that Home based care givers facilitate HIV/AIDS support groups. The table also illustrate that 4 (6%) disagreed, with 19 (27%) strongly disagreed that Home based care givers facilitate HIV/AIDS support groups and only 1 (1%) not sure that home based care givers facilitate HIV/AIDS support groups. This confirms that home based care givers are able to provide Home based care givers are Home based care givers facilitate HIV/AIDS support groups.

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4.4 ANALYSIS OF DATA COLLECTED THROUGH INTERVIEW GUIDE

A qualitative component was conducted in this study in order to gain the in-depth knowledge and understanding of the services that are rendered by the NPOs in Ratlou Sub-district using an interview schedule. The findings in this component are intended to complement the results of the quantitative component. The themes were used to develop an interview guide for NPO Managers.

The following themes were identified: major challenges facing home based care givers; availability of equipment, supplies and resources to deliver the services available within your organization; availability of training, capacity building and knowledge for home based care givers; challenges faced by Home based care givers when they are working with Patients; challenges facing Home based care integration with Health systems and community; available supervision and support adequate for care givers; challenges facing patients at community and facility level and linking method of data collecting and reporting for community based interventions with health systems

4.4.1. Major challenges facing home based care givers

Table 4.36 below shows that all five NPO managers who were interviewed highlighted that stipend for the care givers is currently a challenge. The stipend amounts are not standardised across NPOs, they range from R1000 to R1500. While some care givers receive their stipend and others do not receive. This resulted in poor performance and lack of commitment for care givers. The discrepancies in stipend may be due to the different funders who have their own standard rates.

Table 4.36: major challenges facing home based care givers

Respondents	***What are the major Challenges facing you as home based care givers?***
A	*"Most home based care givers are leaving due to lack of stipends as we can spend three to four month without being pain stipend" "There is high absenteeism due to lack of stipends. ""*
B	*"Caregivers loss interest when there is no money and they do not work as*

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	required. There is no motivation for us to do the work.
C	*"It has been two months since we were last paid b and we are working very hard from Monday to Friday but we can't get stipends." "It can take three to four months without any stipends, but we are still working."*
D	*"We get funding from the Department of Health and Social Development but only provide funds for services, not for stipends" "the European Union (EU) fund has been exhausted and there is no money anymore. We don't know how we will maintain and pay school fees for our children. We cannot do anything with R1, 200 as things are very expensive.*
E	*Caregivers get the stipends from service provider but not every month but the only pay for two to three months, they only pay them R1, 200. "We don't get paid every other month. We don't know how much we are going to get every month"* *"Caregivers go out every day to see and give care to patients and expect to get paid with stipends at the end of month."*

4.4.2. Availability of equipment and supplies to deliver the services

Another challenge that there is shortage of home based care kits and food parcels to provide services. The shortages of these kits were common in all sub-districts home based care projects. There is a gap in the supply of resources and equipment. This include shortage of home based care kits, shortage of equipment and supplies are indicated as challenges hindering community home based care service delivery .

Respondent A: *"there is shortage of home based care kits. Sometimes treatment is not available and then we have to wait for the coming two weeks or a month"*

Respondent B: *"the other challenge is the issue of lack of funds as sometimes there are no funds this lead us not to purchase care kits internally. The department is no longer providing the home based care kit and the procumbent process is still a challenge to us."*

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Respondent C: *"As the Department of Health is not providing care kits to caregivers this makes it difficult for care givers when they conduct their home visits as patients always complain"*

Respondent D: *"There is a need for caregivers to have stethoscope and barometer to measuring blood pressure. Home base care kits are still not available and there is lack of knowledge as to where we can order care kits"*

Respondent E: *"We don't receive home based kits and food parcels for patients in time."*

4.4.3. Availability of training, capacity building and knowledge for home based care givers

All participants felt that Care givers should be trained comprehensively in order to provide TB, HIV, and PMTCT integrated care. Only few care givers received training since they join their home based care project. That care givers lack knowledge and skills in certain area which need more attention to enable them to function properly in their day to day duties thus include training such as wound dressing for HIV/AIDS infected patients in need of care, Home community based care policies and guidelines Health promotion, HIV and AIDS management, and monitoring and evaluation. The results show that only few care givers have received 59 days Home Based Care training, Education and HIV and AIDS awareness, bereavement counselling, and Feeding adults infected by HIV and AIDS, and baby feeding and more on training home care givers on Computer literacy knowledge and skills. A number of participants also mentioned the lack of training of care givers as a barrier to effective home based and other services. Respondent felt that care givers could be trained to be assistant nurses as some of them already have in-depth knowledge, skills and experiences in patient care. Respondents felt that training required include project management, monitoring and evaluation, effective writing and communication and computer literacy

Respondent A: *"The Department of health must provide training for caregivers in order for them to be nurses or social auxiliary workers because they have experience on how to care for patients" this will be sustainability for job creation as there is no promised as to what will happen tomorrow"*

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Respondent B: *"We need more training especially when it comes to reporting tools and referral forms, as most of care givers do not understand forms"*

Respondent C: *"There are only 4caregiver trained on project management and reporting, Monitoring and Evaluation, so we need Monitoring and Evaluation training and project management for managers" as not all of us were not trained.*

Respondent D: *"Caregivers also want more trainings and workshops to have more knowledge and on home based care services especial PHC re-engineering"*

Respondent E: *"We need training on computer literacy, effective writing, communication skills, Monitoring and Evaluation and project management and however project managers training should not be the same for all care givers as people cannot differentiate between the Community care givers and Health Based care workers.*

4.4.4. Challenges faced by Home based care givers when they are working with Patients

Care givers feel that patients are stopping their treatment just to get grants as they start to default when their CD4 counts pick up. There is an understanding that patients on ARVs usually default, when their health begins to pick up and they think their grants will be cut by South Africa Social Security Agency (SASSA).

4.4.5. Challenges facing Home based care integration with Health systems and community

Majority of the respondents rarely indicated that community is well consulted about the potential and results of the project activities. These results show that all management board are living in area where they are easily accessible. In this study, majority of the respondents shows that home based carers receive feedback on reports submitted and patients referred. Majority of home based care givers have a good relationship with the health care workers at the department of health and they are also receiving support.

Majority of home based care projects have monitoring and reporting tools which are linked with the department of Health and Social Development this also includes the availability of

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HBC has referral systems/networks (including referral forms) integrated with health systems in most HBC projects and availability of detailed referral form when referred to clinic.

There is lack of link between facilities and home based care givers. Shortage of mobile services in some areas was also perceived one of the big challenges. Poor mobile services was also seen as impact on treatment adherence as patients still travel distances to a mobile service in order to get treatment. There is a need to improve communication between the health facilities and the communities as well including the availability of stipend.

Respondent A: *"the mobile clinic only comes twice a week, as we are based in a rural area, and sometimes the mobile clinic does not come. It becomes a challenge when patients don't have adherence partner or family members to assist her or him to take medication"*

Respondent B: *The challenge remains is mainly when the patients have to take their medication and you find out that there is no medication at the clinics".*

Respondent C: *The caregivers always have to make their plans regarding how the clients will get treatment if there are any shortages of which they still need to travel long distance on their own"*

Respondent E: *"There is a need to establish a referral system in place for patient who move from clinic to clinic and also from hospital to clinics through down referrals"*

4.4.6. Supervision and support for system care givers

The study reveals that majority of home based care givers have a good relationship with the health care workers at the department of health facilities and they are also receiving support there is a need to strengthen supervision as they also feel that there is lack of proper supervision. The respondents felt that they still need a person at facility level who will be in charge of care givers rather than and sub-district level, as the person at sub-district cannot cover all care givers in the area every month. "Care givers felt that most of the nurses do not appreciate their work and effort, when care givers are putting for the work they do. Caregivers felt that they are not part of the health system."

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4.4.7. Challenges facing patients at community and facility level

Patients working in farms are hard to find and to trace as the always move from one area to another seasonally. Majority of the respondents felt that the main problem in the community is stigma as sometimes patients are hidden by family members when they visit a family if they know that he/she is HIV positive and sometime the patient will not disclose his/her status due to stigma attached to patients." There is still a fear among HIV infected clients regarding lack of confidentiality and \as they think that care givers are going to gossip about them or tell people about my status. Patients still believe that they are bewitched and then decide to go to Traditional doctors or drink tea from churches.

4.4.8. Method of collecting, reporting and monitoring of community based Interventions

Home based care projects are using tools such as standardised forms to collect household information, Intake forms for orphans, Daily tally sheet, health promotion forms, patient registers and duty sheets, Referrals forms are used by care givers and health facility staff for upwards and downward referral of patients. Some participants indicated that they also use notebooks to record patient information and their daily activities. They submit the information to the project officer and sub-district coordinator in the sub-district office of Department of Health (DOH) and Department of Social Development.

CONCLUSION

Based on the study findings it can be concluded that there is a good relationship between home-based care givers and health care workers. Only few home based care projects have sufficient funding from other institutions to can sustain the project and of which less than 50% of the project have the chance of sustaining itself in the absence of funds. The results show that services home based cares givers are rendering are benefiting the surrounding communities which the project situated. Majority of the home based care projects have stakeholders participate on the running of the project. The results show that monitoring and reporting systems such as reporting tools are linked with the department of Health and Social Development systems. Majority of the respondents' indicated that patients are provided with a detailed referral form when referred to clinic. The results further reveal that there is still delay on payment of stipend among care givers and payment of stipend among care givers.

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The results further reveal that there is lack of training on care givers in the field of their work. If home based care and health systems can be integrated this can smooth the process of Primary health care (PHC) Re-engineering in South Africa.

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CHAPTER 5: FINDINGS, CONCLUSION, AND RECOMMENDATION

5.1 Introduction

This chapter discusses the study findings in line with the study objectives, the recommendations drawn from these findings, and the study limitations. In this chapter the researcher presented this study's findings, conclusion and recommendations for interventions and future research. This study has shed some light to better understand the strategies that care givers (HBCGs) in a Home Based Care use to deal with the daily challenges they experience during their care giving and the type of support available to HBCGs from the HBC to assist them in coping with their work. The study has further identified possible remedies to some of the challenges experienced by HBCGs, which could complement the already existing support available at the sub-district.

5.2 Major findings of the study

In this section the following conclusions were drawn, based on the major findings categorised into these main themes, namely challenges facing home based care givers; sustainability of Home community based care project; integration with Health systems and community; training, capacity building and knowledge for home based care givers; equipment, supplies and resources to deliver the services and care and support services rendered by home and community based workers.

The results reveal that most of care givers interviewed about 61 (87%) were females with the majority of respondents being at 30 years of age ranging from 19 to 65 years. Most of the people that were included had no formal education. All community caregivers should be encouraged to go through Adult Basic Education and training or have grade 12

Majority of the respondents show that they there is a good relationship between home based care givers and patients. The above results also confirm that that there is a good relationship between home based care givers and health care workers. Majority of the respondents also indicated that there is delay in payment of stipend and about half of the respondents indicated that care givers are always not welcomed by family members. Most of response also shows

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that there is lack of resources within the organization. Some of the challenges of Care givers include political interference within their organization from the local communities as they want to interfere on funding, salaries and human resources process.

Projects have sufficient funding from other institutions to can sustain the project and of which less than 50% felt that the project have the chance of sustaining itself in the absence of funds. The majority of the respondents merely indicated that the community is well consulted about the potential and results of the project activities. These results show that management board are living in areas where they are easily accessible. In this study, the respondents show that home based carers receive feedback on reports submitted and patients referred. Majority of home based care givers have a good relationship with the health care workers at the department of health and they are also receiving support.

The majority of the respondents indicated that the services they are rendering are benefiting the communities in the area in which the project is situated and of the respondents' show that their stakeholders participate in the running of the project. Majority of home based care had monitoring systems such as reporting tools which are linked with the department of Health and Social Development systems this also includes the availability of HBC has referral systems and networks including referral forms integrated with health systems in most HBC projects and availability of detailed referral form when referred to clinic. Home based are using monitoring and evaluation tools which are linked to the department of health this include data collection tools.

The results show that majority 62 (88%) of care givers have received 59 days Home Based Care training and other training received include Education and HIV and AIDS awareness, bereavement counselling, and Feeding adults infected by HIV and AIDS, and baby feeding and more on training home care givers on Computer literacy knowledge and skills.

The results show that the majority of care givers are provided with Home based care kits, and N94 protective musk this include antiseptic soaps to protect them from infectious diseases. The study results reveal that not all Care givers are paid with their stipend on time.

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This study finding revealed that home based care givers are covering most of the work expected of them ranging from HIV and AIDS care and support services which are rendered by care givers, these include providing prevention of mother-to-child transmission; health promotion and HIV Education; and psycho-social support and defaulter tracing.

The study reveals that majority of home based care givers have a good relationship with the health care workers at the department of health facilities. Support and supervision need to strengthen s as they also feel that there is lack of proper supervision.

The study results reveal that Patients are still ignoring care givers. Patients working in farms are hard to find and to trace as they always move from one area to another seasonally. Patients still believe that they are bewitched and then decide to go to Traditional doctors or drink tea from churches to heal HIV.

Home based care projects are using standardised tools such as forms to collect household information, Intake forms for orphans, Daily tally sheet, health promotion forms, patient registers and duty sheets, Referrals forms are used by care givers and health facility staff for upwards and downward referral of patients. Some participants indicated that they also use notebooks to record patient information and their daily activities. They submit the information to the project officer and sub-district coordinator in the sub-district office of Department of Health (DOH) and Department of Social Development.

5.3 Conclusion

It can be concluded that females are more involved in home community based care. Most of home based care givers had no formal education. Majority of care givers are full time members of their projects. It can further be concluded that Home based care programme are complying with Home based care Norms and Standards as outlined in the South African public health care policies.

It can be concluded that there is a good relationship between homes based care givers and patients. The above results also confirm that that there is a good relationship between home based care givers and health care workers. There is delay in payment of stipend among home based care givers in Ratlou sub-district. It can also be concluded that care givers are always

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not welcomed by family members. Most of response also shows that there is lack of resources within the organization. Home based care givers faces challenges such as political interference within their organization from community which the work into. The results revealed that few home based care project have sufficient funding from other institutions to can sustain the project, but however of home based care projects less chance of sustaining itself in the absence of funds.

It is apparent that the home based care services which are rendered in Ratlou sub-district, South Africa are benefiting the surrounding communities which the project is situated. It can also be concluded that stakeholders are able to participate on the running of the home based care project. Furthermore, it is evident that monitoring and evaluation systems within home based care projects (i.e. reporting tools) are linked with the department of Health and Social Development systems. The results revealed that there strong referral systems/networks (including referral forms) which are integrated with health systems in most HBC projects. It shows that home based carers gives receive feedback form local clinics on reports submitted and patients referred. Results revealed that communities are well consulted about the potential and results of the home based care givers activities, hence there is also go participation by management board that are living in area where they are easily accessible. Majority of home based care givers have a good relationship with the health care workers at the department of health and they are also receiving support.

Care givers lack trainings which are relevant to their work thus include relevant trainings such are 59 days Home Based Care training, Education and HIV and AIDS awareness, bereavement counselling, and Feeding adults infected by HIV and AIDS, and baby feeding and more on training home care givers on Computer literacy. It can be concluded that care givers lack knowledge and skills in certain area which need more attention to enable them to function properly in their day to day duties thus include training such as wound dressing for HIV/AIDS infected patients in need of care, Home community based care policies and guidelines Health promotion, HIV and AIDS management, and monitoring and evaluation.

It can be concluded that safety for care givers is not compromised as not all care givers are provided with Home based care kits, and N94 protective musk and antiseptic soaps to protect them from infectious diseases. The results also show reveal supplies are not disrupted within the required specific periods of time this include majority care givers receiving food parcels

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groceries in a month, condoms and protective gloves are supplied in a month and home based care kits which took more than a month to be supplied. However it can also be concluded care givers have limited access to electricity, water, relevant health and safety policy and procedures.

The study finding revealed that home based care givers are covering most of their HIV and AIDS care and support services work expected of them these include providing services to prevent of mother-to-child transmission; health promotion and HIV education; and psych-social support and defaulter tracing, services for the children, youth, elderly and disability including those who are infected and affected by HIV and AIDS.

5.4 Recommendations of the study

Based on the findings of this study, the following recommendations are proposed to further improve and promote home and community based care services within the public and private health sector:

- HBC workers should form part of the Primary Health care team and consideration should be given to government employing them.
- Community health care (CHWs) and home based care givers (HBCs) should be professionally recognized, and a professional qualification with national accreditation should be developed for them
- The government must define the role of the Home based care givers within the context of the PHC reengineering strategy; and also redefine their scope of practice including for those who are care givers who are not doing PHC re-engineering;
- The government must co-ordinate and provide home care in terms of its defined role as an integral part of the Ward Based PHC Outreach Teams and PHC outreach teams should utilise and strengthen the important role played by the community-based services
- The government must strengthen relations between health services and stakeholders and representatives in the communities
- There is a need to strengthen referral systems between facilities, traditional health practitioners and other community structures, such as tribal authority and religious support groups

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- High demand to train family members and the about the importance of home based care givers and establish relationship in order to Improve attitude towards care givers;
- The government must strengthen the capacity of Home based care organisations to provide HBC in terms of the re-engineering of PHC outside and inside their organization this also include integration amongst those care givers who are on PHC re-engineering and those who are functioning independently;
- There should be strong monitoring and evaluation systems in place to track the role and contribution of Home based care givers within the context of the Ward Based PHC Outreach Teams;
- There is a strong need to provide training for Community care givers on identifying patients who require home based care services
- The sub-district must establish a home based care support team within the district / Sub-district and home based care givers should be encouraged to participate in health and welfare forums which facilitate collaborative home based care strategies in the sub-district
- The department of health and social development should provide continuous education, training, mentorship & supervision to partner organisations
- Much should be done to strengthen community participation and networks among home based care projects within the sub-district
- Payment of stipends should be prioritised, develop a new system to monitor payment of care givers stipends as home based care givers still travel long distances without any means of transport.
- Training should be provided focusing of ordering supplies such as kits, N95 masks, and safety policies should be emphasised to ensure that care givers are wearing protective clothe when dealing with patients infected by both HIV and TB this will reduce the risk of TB co-infection and contacting infectious diseases

5.5 Recommendation for further research:

- A study should be conducted to evaluate on the implementation of PHC re-engineering through Home and Community Based care workers (HBC) the in North West Province

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- Research should be conducted based on the experiences and exposure of care givers when dealing with TB patients;

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APPENDIX A: INFORMED CONSENT LETTER

DEAR RESPONDENT

My name is **NDIVHUHO MANGALE**; I am a master's student at the University of Venda conducting ***an assessment on Challenges facing Home and Community Based Care (HCBC) workers when rendering HIV care and support services in the process of PHC – Re-engineering, in Ratlou Sub-District District.*** You are kindly requested to participate in this research project. You will be provided with the semi-structured interview guide to complete, only if you agree to take part and participate in this project.

I would be grateful if you would spend a little time talking with me. I will not write down your name, and your answers will be treated with strict confidentiality. Your participation is voluntary, and you are not obliged to answer any questions you do not want to answer. This interview will take about an hour of your time. I greatly appreciate your taking the time to speak with me.

Your cooperation will be highly appreciated

Yours Faithfully

---------- ----------

Mangale Ndivhuho (Mr) Date

Researcher

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APPENDIX B: PARTICIPANT CONSENT FORM

By signing this consent form, you indicate that; 1) you have read or understood the consent form; 2) your questions about the research have been answered to your satisfaction, and 3) you voluntarily agree to participate in this study. A copy of this signed consent form can be provided upon request.

I, _____, agree to participate in the study. I understand the follows information provided to me by the researcher:

- The study aims to **assess the challenges facing Home and Community Based Care (HCBC) workers when they rendering HIV care and support services in the process of PHC –Re-engineering, in Ratlou-Sub District**, North West Province.
- The information that participants provide in this interview will be used solely for the purposes of the study.
- Participants can refuse to answer certain questions, discuss additional topics, or withdraw from the interview without penalty.
- All interview data will be handled with confidentiality.
- No identifying names will be associated with the interview tapes or data.
- All interview tapes and data will be destroyed at the conclusion of the study.

For any further questions, participants can contact Professor Khwashaba at the following number phone **+27 79 422 7369/+27 15 962 8000** at the University of Venda who is the supervisor for this research project

_____ _____

Participant Signature Date

_____

Interviewer Name

_____ _____

Interviewer Signature Date

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APPENDIX C: LETTER TO THE DEPARTMENT OF HEALTH

ENQ: MR N. Mangale
Cell: (076)3899120/ (084)4704936
Tel (W): (018)3818055
Fax: (086)5668178

P O BOX 798
PHIPHIDI
0994
03 November 2010

The Secretariat
The Department of Health and Social Development
Provincial Research Committee
Private Bag X 2068
North West Province
Mmabatho
2735

Dear Sir/ Madam

Re: APPLICATION FOR APPROVAL TO CONDUCT RESEARCH

I am a student for Master Degree in Public Management at the University of Venda (UNIVEN). As part of my degree requirement I would be conducting a study on "***Assessment on the challenges facing Home and Community Based Care (HCBC) workers when they rendering HIV care and support services in the process of PHC –Re-engineering, in Ratlou Sub-District***" and my subjects will be Home and Community based care workers who are rendering HIV Care and support in Ratlou clinics.

The duration of the interview will be 45 minutes to an hour. The date and time of the interview will be negotiated with you in order to avoid any interruption to the running the services. I would like to assure you that all information gathered will be utilized for the purposes of this study only.

Attached is the copy of the Ethics approval Research Proposal, Research instruments and Letter from UNIVEN showing proof of registration for a master's degree for this study.

I hope my letter will meet your approval.

Yours sincerely

Ndivhuho Mangale (Mr.)
Master in Public Management Student

Signature ..... Date.....

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APPENDIX D: LETTER OF APPROVAL FROM NORTH WEST DEPARTMENT OF HEALTH

health
Department of
Health
North West Province
REPUBLIC OF SOUTH AFRICA

2ND Floor Tirelo Building
Dr. Albert Luthuli Drive
Mafikeng, 2745
Private Bag X2068
MMABATHO, 2735

Tel: (018) 387 5757
kshoqwe@nwpg.gov.za
www.nwhealth.gov.za

POLICY, PLANNING, RESEARCH, MONITORING AND EVALUATION

To : **Mr N Mangale**

From : **Policy, Planning, Research, Monitoring & Evaluation**

Subject : **Approval Letter-The experience and challenges facing home and community based care worker on TB/HIV/Aids care and support services in Ratlou Sub – District North West Province (South Africa)**

Purpose

To inform the researcher that permission to undertake the above mentioned study has been granted by the North West Department of Health. The researcher is expected to issue this letter to the districts or health facilities as proof that the Department has granted approval of the study.

Arrangements in advance with managers at district level or facilities shall be facilitated by the researcher. The department expects to receive the final research report upon completion.

Kindest regards

Director: ~~Policy,~~ Planning, Research, Monitoring & Evaluation
Mr B Redlinghys

11/02/2012
Date

DEPARTMENT OF HEALTH
PRIVATE BAG X2068
MMABATHO 2735
2013 -02- 11
SUPERINTENDENT GENERAL

1

Healthy Living for All

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APPENDIX E: QUESTIONNAIRE

Challenges facing Home and Community Based Care (HCBC) workers on HIV care and support services in the process of PHC –Re-engineering, in Ratlou Sub-District

The overall aim of the study is to explore and describe experiences and challenges facing Home and Community Based Care workers when they are rendering HIV and Aids care and support services in Ratlou Sub-district, of North West province. Following each statement or question, please mark the box that best represent your answer. Kindly mark only one box for each question, unless other instructions are applicable. Your answers to questions about providers should express your general feelings about all of the people who have provided you with medical care. Your response will be confidential.

SECTION A: BIOGRAPHICAL INFORMATION OF THE RESPONDENTS

1.1. Age (choose)?

18 years	**01**
19- 35	**02**
36- 45	**03**
46-55	**04**
56-65	**05**
66 and above	**06**

1.2. Gender (choose)?

Male	**01**
Female	**02**

1.3. Marital Status (choose)?

Single	**01**
Married	**02**
Widow/Widower	**03**
Separated/ Divorced	**04**
Co-habiting	**05**

1.4. What is your Highest Educational Qualification(s)?

a. No formal Education	**01**
b. ABET Certificate	**02**
c. Grade 12	**03**
d. Tertiary certificate	**04**
e. Diploma	**05**

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f. Degree	07
g. Honours degree/	08
h. Other_____	09

1.5. What is your position in this project?

Item	Yes	No
Volunteer	01	02
Care giver	01	02
Ancillary worker	01	02
HCBC Project Manager	01	02
Community Health Care worker	01	02
Other (please specify)		

1.6. Are you a full-time member of the project?

Yes	01
No	02

1.7. How long have you been within the project?

Less than 1 year	01
2-4 years	02
5-10 years	03
11-15 years	04
16 years and above	05

SECTION B: CHALLENGES FACING HOME BASED CARE WORKERS WHEN RENDERING HIV CARE AND SUPPORT SERVICES

Number	Which of the following do you regard as a challenge when you are providing to HIV and AIDS care and support services?	Strongly agree	Agree	Disagree	Strongly disagree	Not sure
2.1.	There is no good relationship between home based care giver and patients	01	02	03	04	05
2.2.	There is no good relationship between home based care giver and health care workers at clinic level	01	02	03	04	05

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2.3.	HCBC workers are not receiving support from department of health	01	02	03	04	05
2.4.	Patients are ignoring caregivers	01	02	03	04	05
2.5.	Care givers are not always welcome by family members	01	02	03	04	05
2.6.	Patient are ignoring care givers when giving them support services	01	02	03	04	05
2.7.	Patience are not appreciating services	01	02	03	04	05
2.8.	Patients are not taking prescribed medicine regularly	01	02	03	04	05
2.9.	Patients refusing services	01	02	03	04	05
2.10.	There is lack of fund within the organization	01	02	03	04	05
2.11.	There is Late or delay in payment of stipends	01	02	03	04	05
2.12.	The is lack of resources within the organization	01	02	03	04	05
2.13.	There is Lack of knowledge about home based care	01	02	03	04	05
2.14.	There is political Interference from communities	01	02	03	04	05
2.15.	There is Lack of supervision and support	01	02	03	04	05
2.16.	There is no links with local clinics	01	02	03	04	05
2.17.	Nurses are not providing support to care givers	01	02	03	04	05
2.18.	There is lack of transport to visit clinics	01	02	03	04	05
2.19.	There is Stigma and discrimination attached to patients	01	02	03	04	05
2.20.	There is Lack of Nutritional supplements	01	02	03	04	05
2.21	There is support Supervision and mentorship	01	02	03	04	05
2.22	Provided with emotional support i.e debriefing	01	02	03	04	05
2.23	Supplies are available within a specific period of time	01	02	03	04	05

2.24.	**How would you rate your**	**Strongly**	**Agree**	**Disagree**	**Stron**	**Not**

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	knowledge in the following?	agree			gly disag ree	sure
a)	Home based care givers have relevant HIV and AIDS related training	01	02	03	04	05
b)	Management of client with tuberculosis (TB)	01	02	03	04	05
c)	Health promotion, Education and HIV and AIDS awareness	01	02	03	04	05
d)	Wound Dressing	01	02	03	04	05
e)	Baby feeding	01	02	03	04	05
f)	Condom promotion and demonstration	01	02	03	04	05
g)	Home Based Care	01	02	03	04	05
h)	Reporting, Monitoring and Evaluation	01	02	03	04	05

2.5.	Home based care givers are provided with the following equipment, supplies and resources?	Strongly agree	Agree	Disagree	Strongly disagree	Not sure
a)	Protein and vitamins minerals i.e. Protein porridge	01	02	03	04	05
b)	HCBC kits	01	02	03	04	05
c)	Food parcels groceries to be given to patients	01	02	03	04	05
d)	Condoms to be given patients	01	02	03	04	05
e)	Protective clothes such as Gloves	01	02	03	04	05
f)	N93 protective masks or any protective masks	01	02	03	04	05

SECTION C: HOME BASED CARE PROJECT SUSTAINABILITY AND ACCESSIBILITY

Number	Questions	Strongly agree	Agree	Disagree	Strongly disagree	Not sure
3.1.	Is the project registered as NPO?	01	02	03	04	05
3.2.	Do you know where to register as NPO?	01	02	03	04	05

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3.3.	Does the project have business plan (produce a copy)?	01	02	03	04	05
3.4.	Do you have income generating projects?	01	02	03	04	05
3.5.	Is there a means of transportation available to access patients' home?	01	02	03	04	05
3.6.	Is the funding from other institutions sufficient to can sustain the project?	01	02	03	04	05
3.7.	Does the project have the chance of sustaining itself in the absence of funds?	01	02	03	04	05

SECTION D: HOME BASED CARE INTEGRATION WITH HEALTH SYSTEMS AND COMMUNITY PARTICIPATION

Number	Questions	Strongly agree	Agree	Disagree	Strongly disagree	Not sure
4.1.	The services rendered are benefiting the surrounding communities which the project situated	01	02	03	04	05
4.2.	The stakeholders participate on the running of the project	01	02	03	04	05
4.3.	The project and its members have a good relationship with other NGOs or NPOs?	01	02	03	04	05
4.4.	The minutes of the executive management committee meeting kept all the time	01	02	03	04	05
4.5.	Clinics provide Care worker with list of patients in need of care and support	01	02	03	04	05
4.6.	The monitoring and reporting systems (such as reporting tools) are linked with the department of Health and Social Development systems	01	02	03	04	05
4.7.	HBC has referral systems/networks (including referral forms) integrated with health systems	01	02	03	04	05
4.8.	The project have the executive management committee board	01	02	03	04	05

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4.9.	The role and responsibilities of the project stakeholders and members clearly defined	**01**	**02**	**03**	**04**	**05**
4.10.	Patients are provided with a detailed referral form when referred to clinics	**01**	**02**	**03**	**04**	**05**
4.11.	The community is well consulted about the potential and results of the project activities	**01**	**02**	**03**	**04**	**05**
4.12.	All management board are living in area where they are easily accessible	**01**	**02**	**03**	**04**	**05**
4.13.	Home based carers receive feedback on reports submitted and patients referred	**01**	**02**	**03**	**04**	**05**
4.14.	The project well known in the community in which it is operating	**01**	**02**	**03**	**04**	**05**
4.15.	HCBC workers receive supporting networks from the community where it is situated	**01**	**02**	**03**	**04**	**05**
4.16.	HCBC workers provide community mobilisation	**01**	**02**	**03**	**04**	**05**
4.17.	Patients don't want to be referred to the local clinics	**01**	**02**	**03**	**04**	**05**
4.19.	The project receives official visits from project funders for project monitoring and support	**01**	**02**	**03**	**04**	**05**
4.20	Home based care workers have a good relationship with HIV and AIDS counsellors within local clinics	**01**	**02**	**03**	**04**	**05**
4.21	Home based care workers have a good knowledge and participation of Primary Health care re-engineering	**01**	**02**	**03**	**04**	**05**

SECTION E: CARE AND SUPPORT SERVICES RENDERED BY CARE GIVERS

5.1. Which of the following HIV Care and Support services are you rendering within your Organization?

		Strongly agree	**Agree**	**Disagree**	**Strongly disagree**	**Not sure**
a)	HIV/AIDS Voluntary counselling and testing	**01**	**02**	**03**	**04**	**05**

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b)	Prevention of mother-to-child transmission	01	02	03	04	05
c)	Distribution of Food parcel for people infected by HIV and AIDS	01	02	03	04	05
d)	Stigma and discrimination reduction	01	02	03	04	05
e)	HIV/AIDS support groups	01	02	03	04	05
f)	Management of client with tuberculosis (TB)	01	02	03	04	05
g)	Giving and follow up on prescribed medications (ARVs)	01	02	03	04	05
h)	Health promotion and HIV Education	01	02	03	04	05
i)	Wound Dressing	01	02	03	04	05
j)	Baby feeding	01	02	03	04	05
k)	Organization has a support group for community health workers	01	02	03	04	05

Thank you for your participation!!!

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APPENDIX F: SEMI-STRUCTURED INTERVIEW SCHEDULE

FOR HCBC PROJECT MANAGERS

Challenges facing Home and Community Based Care (HCBC) workers on HIV care and support services, in Ratlou Sub-District

The overall aim of the study is to explore and describe experiences and challenges facing Home and Community Based Care workers when they are rendering HIV and Aids care and support services in Ratlou Sub-district, of North West province.

Following each statement or question, please mark the box that best represent your answer. Kindly mark only one box for each question, unless other instructions are applicable. Your answers to questions about providers should express your general feelings about all of the people who have provided you with medical care. Your response will be confidential.

1. What are the major challenges facing home based care givers?

_____

2. Are the equipment, supplies and resources to deliver the services available within your organization?

_____

3. What means of training, capacity building and knowledge for home based care givers?

_____

4. What are the challenges faced by Home based care givers when they are working with Patients?

_____

5. What are the challenges facing Home based care integration with Health systems and community?

_____

6. Is the available supervision and support adequate for care givers?

_____

7. What are the challenges facing patients at community and facility level?

_____

8. What is the method of collecting and reporting community based information within your organization?

_____

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