

**THE ROLE OF THE FARM LAY HEALTH WORKER IN THE  
RURAL WESTERN CAPE PROVINCE**

by

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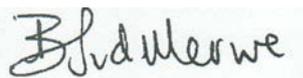
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November 2013

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### **DECLARATION**

I declare that **THE ROLE OF THE FARM LAY HEALTH WORKER IN THE RURAL WESTERN CAPE PROVINCE** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged, by means of complete references and that this work has not been submitted previously, for any other degree at any other institution.



**SIGNATURE**

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30 November 2013

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# **THE ROLE OF THE FARM LAY HEALTH WORKER IN THE RURAL WESTERN CAPE PROVINCE**

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## **ABSTRACT**

Public demands have forced countries to explore new ways of rendering primary health care to reach the poor who are not within reach of the modern health care systems. New categories of health care personnel, like lay health workers emerged. There are vast differences in the roles of these lay health workers as was revealed with an extensive literature search. The phenomenology qualitative research method was used to investigate perceptions of farm lay health workers regarding their roles in rural areas. A convenience, non-random sample (N=5) was used for focus group discussions and in-depth interviews to collect data. The latter revealed five main themes associated with the role of farm lay health workers: (1) community link; (2) carer; (3) community developer; (4) counsellor and (5) role model. Guidelines were formulated to enhance the role of lay health workers in the rural Western Cape Province and to improve the quality of care to rural communities.

## **KEY CONCEPTS**

Primary health care; lay health workers; farm lay health worker; rural areas; community link; carer; community developer; counsellor; role model; guidelines.

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## *Dedication*

*To my daughters, Natalie and Lynn*

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### LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti-Retroviral
CHIP	Community Health Intervention Programme
CHW	Community Health Worker
CNP	Clinical Nurse Practitioner
DOTS	Direct Observation of Treatment Short course/support
FHW	Farm Health Worker
HIV	Human Immunodeficiency Virus
ICU	Intensive Care Unit
IMCI	Integrated Management of Childhood Illnesses
LHW	Lay Health Worker
NGO	Non-Governmental Organisation
PHC	Primary Health Care
RSA	Republic of South Africa
TB	Tuberculosis
VCT	Voluntary Counselling and Testing
VHW	Village Health Worker
WHO	World Health Organization

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# CHAPTER 1

## INTRODUCTION AND OUTLINE OF DISSERTATION

### 1.1 INTRODUCTION

People discuss their symptoms with some other person before seeking professional help. In the same way the doctor or nurse has his/her “referral system” – so the potential patient has his “lay referral system”. The whole process of seeking help involves a network of potential consultants which might range from immediate family members, to more select, distant and authoritative laymen, until the “professional” is reached.

Public demands have forced countries to explore new ways of rendering health care, with special emphasis on primary health care in a holistic manner. Citizens can both influence and control programmes in health care delivery. As a result of this, new categories of health care personnel emerged, neighborhood health centres were established and self-help groups came into being during the past two decades. This includes community health workers, lay health workers, village health guides/workers and multipurpose workers. In some countries emphasis is being placed on the use of traditional healers or herbalists.

The poor are largely not within reach of modern health care systems and it will remain so for the foreseeable future, despite the best efforts of countries to expand their health systems. Alternative approaches with existing resources, like lay health workers are needed - both urban and rural – in ways that will mobilise the abilities of the poor and stimulate their interest in improved health, as part of a movement towards a better future for all.

The researcher works in a primary health care setting and interacts with various groups of lay health workers (LHW). The researcher realised that there are vast differences in the roles of these lay health workers. LHWs can mobilise communities they serve in various ways.

Primary health care clinics and mobile units also extend their services by making use of available LHWs. The researcher in this study was interested to know what the extent of the role of the LHW is, as perceived by the LHW him/herself. This chapter provides in detail the background and motivation for conducting the research, as well as the problem statement. The research objectives and paradigmatic perspective of the research are also discussed.

## **1.2 BACKGROUND AND MOTIVATION**

The Cape Winelands, which has a population of 712 402, covers 22 000 square kilometers. This translates to a population density of 32.4 people for every square kilometer. The Cape Winelands is known for viniculture and agriculture and farming contribute to the growth of the region which currently contributes 7.9% to employment. The literacy rate of farm workers is low and this contributes to the lack of health care knowledge. The health care services are provided from 5 community day centers, 44 clinics, 8 satellite clinics, 20 mobile clinics, 4 district hospitals and 2 regional hospitals. There is an ambulance and emergency service available in the district (Regional Development Profile Cape Winelands District 2011:4).

Although these facilities are available, they are not within reach of all the inhabitants. The ARV patient load is 8 477 and the Human Immunodeficiency Virus (HIV) transmission rate was 3.4 percent in 2011. The dual infection with tuberculosis places an extra burden on the health care services. To address the burden of HIV disease, this district erected 23 ARV distribution sites. The population under one year of age, who is fully immunised, represents 86.8 %. There are still children with severe malnutrition and 206 cases were reported in 2011. Out of the total of 13 856 live births 4 maternal deaths occurred. There were 1 136 teenage deliveries in 2011 in this district. Drug related crime is high and contributes to the burden of disease and the case load on available facilities. Poverty levels are high with 42 333 indigent households in the area. There is an unemployment rate of 16,2% and 197 000 people living in poverty in this rural area (Regional Development Profile Cape Winelands District 2011:15).

Reaching out into homes and the community to promote healing and wellness as an integral part of health practice, is as old as health care itself (Treadwell 2003:3).

Currently the health care system, if measured by the ultimate benchmark of equity or lack of disparity, is an extremely poor performer, particularly when one considers the fiscally intense resourcing of facilities and of the current first tier providers. Many people in rural areas cannot access the services that they need to remain well (Treadwell 2003:2) due to various problems. These range from the topography of the place to the inclusion of the lack of properly trained health professionals in areas where they stay.

Shortage of health human resources is a world-wide concern. In North America shortage of nurses results in poor or substandard nursing care in some of the rural regions (Bushy & Leipert 2005:1; Eygelaar & Stellenberg 2012:1). This view is supported by Hegney and McCarthy (2006:347) who also reported shortage of nurses and midwives in the remote rural areas of Australia. In various provinces of the Republic of South Africa, especially in Mpumalanga and the Eastern Cape province, Madigage (2005:72-73) and Xego (2006:31, 44), suggested the need for more nursing staff in some of the rural hospitals. Earlier studies found a shortage of nurses and overcrowding of patients to be seen by nurses in the rural districts of the Eastern Cape (Thiphanyane & Mavundla 1998:28). A shortage of nurses is not an issue for rural health services only Gilliomme (1999:103) revealed that Intensive Care Units (ICU) in Gauteng were also in dire need for adequate nursing personnel.

According to Blaauw, Erasmus, Pagaiya, Tangcharoensathein, Mullei, Mudhune, Goodman, English and Lagarde (2010:353), in a study conducted in Thailand, Kenya and South Africa, revealed that patients with the greatest health needs tend to live in remote rural areas. As a result, health services in rural remote areas experience difficulties in attracting and retaining skilled health care workers (nurses included). The researcher is of the opinion that such a lack of trained nursing personnel leads to strain among nurses. As such, support personnel including the use of LHWs in rural areas where nurses are not available to provide nursing care are important.

In the Winelands, where this study was conducted, access to basic services is good in the surrounding towns and 93,6% of households have electricity, flush toilets and piped water. Refuse removal is available to 72,9% of households. These services are not well established on farms. The roads are tarred in the towns, but mostly gravel in the rural areas with some of the patients having to cross rivers to reach the nearest Health Care

Service (Regional Development Profile Cape Winelands District 2011:11). Bassett (2004:21) concurs with this view and further argues that rural remote areas in South Africa lack the basic infrastructure such as telephones and roads which contribute negatively to the provision of health services in such areas. Due to lack of telephones in remote rural areas, there may be lack of physical interaction (communication) from other stakeholders with the health care providers especially the nursing personnel.

In addition to poor infrastructure is work overload. According to Regional Development Profile Cape Winelands District (2011:22), the staff is overworked and cannot adhere to the service demands. The PHC service at each facility renders a full package of care that includes preventative, promotive, curative and rehabilitative care. Patients have to be referred to the nearest service. The community based service is provided by non profitable organisations in this district and subsidised by the Provincial Government. As a result of the burden of disease and the socio-economic circumstances of patients in rural areas, this requires that the formal health care service expands services to make use of LHWs to provide care to the community members that cannot be reached by nurses. According to Regional Development Profile Cape Winelands District (2011:22), a total of 525 community health workers (CHW) are deployed in the district of which 201 are farm health workers (FHWs). These FHWs are employed by the farmers who determine the hours that they can be involved in health related matters.

The more technical focus of current CHW programmes under-utilise available human resources in South Africa, which previously had a much wider social and health impact (Van Ginneken, Levin & Berridge 2010:1). As a result, a qualitative research was therefore undertaken to explore the role of the LHW in the rural area of the Boland in the Western Cape Province of South Africa with the purpose of describing their role as they perceive it. The research was conducted on the farms in the area of the Cape Winelands District Municipality, in the Western Cape Province.

### **1.3 STATEMENT OF THE PROBLEM**

As observed in the literature there are vast differences in the roles of LHWs in particular settings. They are used as counsellors, health promoters, research participants, primary care workers, home carers, and etcetera. Overall they tend to serve as role models for their peers. The researcher was curious of what the perception was of the farm health

workers in the Boland about their particular role as LHWs. Much is written on the topic, but no researcher was found that describes the role of the farm health worker as it is perceived by him/herself in the community and especially on the farms in the rural areas. The researcher wanted to know what was similar or different in this group of people who were doing lay health work on farms, in accordance to what was noted in the literature on the roles of lay health workers.

#### **1.4 RESEARCH QUESTION**

The researcher observed that there are overlaps and differences in the roles of various groups of lay health workers and not much is written on how the LHW perceives his/her role in the community. This recognition led to the following research question which was the focus of this research:

- What is the role of the farm lay health worker?

Answering this question would mean that guidelines regarding the role of farm LHW would be described and understood within the context of rural areas of the Boland Winelands.

#### **1.5 PURPOSE OF THE RESEARCH**

In accordance with the research question, the main purpose of this research was to describe the role of the lay health worker practising in the rural areas.

#### **1.6 RESEARCH OBJECTIVES**

In line with the purpose of research, the following research objectives were formulated by the researcher for this study to

- explore available literature to identify what is already known regarding the role of the lay health worker within rural context (Phase 1)
- explore and describe LHWs' perception of their role in the rural Western Cape Province (Phase 2)

- formulate and describe the guidelines for the role of lay health workers in the rural Western Cape Province (phase 3)

## 1.7 PARADIGMATIC PERSPECTIVE OF RESEARCH

All research should be based on philosophical beliefs about the world, also called worldview or paradigm. The word paradigm is from a Greek word meaning “pattern”. The perceived paradigm is the basis for most qualitative research (LoBiondo-Wood & Haber 2002:127).

A paradigm is a general perspective on the complexities of the real world. Paradigms for human inquiry are characterised in terms of ways in which they respond to basic philosophical questions (Polit & Beck 2004:13).

The pattern of this research and the philosophical beliefs about the world are therefore discussed in this section. Using the naturalistic paradigm this research addresses the basic philosophical questions as outlined by Polit and Beck (2004:14) (see table 1.1 below).

**Table 1.1 Major assumptions of naturalistic paradigm**

<b>Assumption</b>	<b>Naturalistic paradigm</b>
<b>Ontological</b>  What is the nature of reality in this study?	Reality of the life-world of persons acting as farm lay health workers and their own perception of their roles were investigated.
<b>Epistemological</b>  What is the relationship between the inquirer and that being studied?	The researcher conducted a focus group discussion. Subjective interaction was thus facilitated and it was assumed that knowledge would be maximised in the findings.
<b>Axiological</b>  What is the role of values in the inquiry?	Subjective interaction and values were inevitable and essential in this research.
<b>Methodological</b>  How should the inquirer obtain knowledge?	The research design, method, data collection and analysis were described. A phenomenological qualitative inductive and descriptive method was used. Participants related their lived experiences.

The naturalistic paradigm is the outgrowth of pervasive cultural transformation that is usually referred to as postmodernism. According to Polit and Beck (2004:14), postmodern thinking emphasises the value of **deconstruction** – that is taking apart old ideas and structures, and **reconstruction** that is, putting ideas and structures together in new ways (Polit & Beck 2004:14).

According to the post-modern thinking, the findings of this research were utilised to describe the content of the role of the farm lay health workers as they described it themselves. The naturalistic paradigm perspective of this research is further discussed under meta-theoretical assumptions; theoretical assumptions, and methodological assumptions.

### **1.7.1 Meta-theoretical/meta-paradigm assumptions**

A concept is a word or phrase that provides a visual image of a phenomenon. Meta-paradigm refers to the major concepts that identify the phenomena of interest to a discipline. These concepts are agreed on by the members of the discipline of nursing. They provide the boundaries for the subject matter of the discipline. Meta-theoretical/meta-paradigm concepts for nursing are defined as person, environment, health and nursing. When translated to community oriented practice **person** (client) is usually an aggregate, a population or an entire community. **Environment** is the physical, social and political surroundings and settings for the aggregate populations and entire community. **Health** is interpreted as the health state of the community or aggregate population. The concept of **nursing** includes the process or practice interventions that are used to care for this community or the aggregates within it (Stanhope & Lancaster 2004:195). Neuman linked the four concepts of nursing paradigm, namely person, environment, health and nursing in the systems model (Stanhope & Lancaster 2004: 201) (also see figure 4.1).

#### **1.7.1.1 Person/client**

Client individuals are viewed holistically by Neuman and are composed of the variables (physiological, psychological, sociocultural, spiritual and developmental) which occur simultaneously, comprehensively and are always present. The client system may refer to individuals, families, groups or communities where the client is in constant interaction

with the environment (Stanhope & Lancaster 2004:201). In this study the client system comprises of individuals who are doing lay health work on farms in the Boland area and are in constant interaction with their environment.

### **1.7.1.2 Environment**

The environment is defined as all the internal and external factors that surround the client system and affect life and development. Three types of environments are identified namely internal, external and created environment. The created environment includes intra-, inter, and extra-personal stressors which occur within the internal and external environments. Stressors are defined as stimuli that produce tensions and have the potential for causing system instability (Stanhope & Lancaster 2004:203).

- **Internal environment** exists within the client system and is made up of all forces and interactive influences that are within the boundaries of the client systems. This will include the values and beliefs of the lay health workers in this research (see figure 4.1).
- **Intrapersonal stressors** also occur within the client system and correlate with the internal environment, for example the different personalities of lay health workers and how that influences their role in the community.
- **External environment** exists outside the client system and is made up of forces and interactive influences that are outside the boundaries of the client system.
- **Interpersonal stressors** correlate with the external environment and occur outside the client boundary as well, for example possible conflicts between the patient and the lay health worker on expectations about the role and function of the lay health worker.
- **External stressors** also correlate with the external environment and occur outside the client boundary, but are at a greater distance from the system than are interpersonal stressors. As an example in this study the political environment in a community can be used, as well as the policies and *acts* which prescribe the role and function of lay health practice.

- **Created environment** is developed unconsciously by the client and is symbolic of system wholeness. According to Neuman, the created environment is dynamic and depicts especially the unconscious mobilisation of the psychological and sociocultural variables. The purpose of the mobilisation is the integration, integrity and stability of the system. A major objective of created environment is to provide a positive stimulus towards health for the client (Stanhope & Lancaster 2004:203). In this research the created environment is viewed as the correct interpretation of the role of the farm health worker and the application of that role in the community.

### **1.7.1.3 Health**

Health is seen as a continuum from wellness to illness and is a manifestation of living energy available to the client system, so that system integrity is enhanced. Neuman describes health as dynamic, with changing levels occurring within a normal range for the client system over time (Stanhope & Lancaster 2004:203).

In this research health depicts the total physical, mental, psychological health of the lay health worker as he/she applies her/himself to their role in the community.

### **1.7.1.4 Nursing**

Nursing is seen as the action to keep the client system stable through accurate assessment of actual and potential stressors, followed by implementing appropriate interventions (Stanhope & Lancaster 2004:201).

The application of their knowledge and skills to enhance the health of their clientele is the “nursing” action of the lay health workers. These meta-theoretical assumptions deal with human beings and society and provide an essential framework for the theoretical assumptions of this research.

## 1.7.2 Theoretical assumptions

The systems theory can be used to describe and explain the behaviours of individuals, groups and communities. Neuman defines, describes and links together the four concepts of the meta-paradigm, as described previously, within the model using the worldview of reciprocal interaction. The intent of the Neuman system model is to set forth a structure that shows the parts and sub-parts of the client (lay health worker) and their relationships to one another and the environment. The Neuman system model depicts on an open system in which persons and their environments are in dynamic interaction. The client system is composed of five interacting variables (refer to table 1.2 below), namely: physiological, psychological, socio-cultural, developmental and spiritual (Stanhope & Lancaster 2004:203).

These variables have a basic core structure unique to an individual, but with a range of responses to all human beings. In this study, these variables are considered basic needs of persons doing lay health work.

**Table 1.2 Definition of systems variables**

<b>Variable</b>	<b>Definition</b>	<b>Examples</b>
Physiological	Structures and functions of the body.	<ul style="list-style-type: none"> <li>• Personal genetic composition of lay health worker</li> <li>• Health status</li> <li>• Physical strength and endurance</li> </ul>
Psychological	Cognitive and affective characteristics.	<ul style="list-style-type: none"> <li>• Happy/depressed</li> <li>• Intelligence level</li> <li>• Caring capabilities</li> <li>• Emotional strength</li> </ul>
Sociocultural	Social, economic, demographic, political, recreational, cultural, health characteristics and communication patterns among subsets.	<ul style="list-style-type: none"> <li>• Poor/middle class/affluent</li> <li>• Communication skills</li> <li>• Cultural diversity</li> <li>• Liberal/conservative</li> <li>• Role expectancy</li> <li>• Support system like clinics and hospitals</li> </ul>
Spiritual	Moral, religious and value systems of the LHW.	<ul style="list-style-type: none"> <li>• Spiritual beliefs on health factors</li> <li>• Role of churches</li> <li>• Moral and ethical values of LHW</li> <li>• Traditional beliefs</li> </ul>

Variable	Definition	Examples
Developmental	<p>Refers to the process related to development over lifespan.</p> <p>History, stage and evaluation of subsystems and aggregates in community.</p>	<ul style="list-style-type: none"> <li>• National registry of LHW programmes</li> <li>• Aging or adolescent populations</li> <li>• Poverty and deteriorating health in community</li> <li>• Educational level of community</li> <li>• Morbidity/mortality rate in community</li> </ul>

(Adapted from Stanhope & Lancaster 2004:203)

Optimal system stability is the best possible health state at any given time, occurring when all system variables are in balance and are functioning within the client system. Three intervention strategies are suggested:

- **Primary prevention strategies** are implemented to strengthen the lines of defense by reducing risk factors and preventing stress. Clarity on their role can help reduce stress for LHWs and the correct application of their role can reduce risk factors like malpractice.
- **Secondary prevention** begins after occurrences of an incident; relevant goals and interventions about the role and functioning of lay health workers should be set to prevent similar incidents from occurring.
- **Tertiary prevention** can be initiated at any point after system instability has occurred, for example re-applying a lay health worker in another role in the community to prevent further stressors, reaction or regression.

Within the systems perspective all strategies lead back toward primary prevention in a circular fashion and health promotion becomes a specific goal for nursing action (Stanhope & Lancaster 2004:202).

These intervention modalities were taken into account when exploring the role of the lay health worker with the aim of getting role clarity on the farms. The systems variables (see table 1.2) were also considered when working with the group of lay health workers to describe their perception of their role in the community. The role of the lay health

workers was assessed, their responses analysed and then the role of the farm lay health worker was formed and described. The postmodern thinking of putting new ideas and structures together in new ways was therefore applied in this research, and the support strategy used accordingly to improve the knowledge of the community and health care providers on the role of the lay health worker on farms.

### **1.7.3 Theoretical definition of terms**

For the purpose of this research the following definitions and descriptions were applied.

- **Lay health worker**

According to Lewin, Dick, Pond, Zwarenstein, Aja, Van Wyk, Bosch-Capblanch and Patrick (2005:1) the lay health worker is seen as any health worker carrying out functions related to health care delivery, trained in some way for the specific intervention and having no formal professional or para-professional certificated or degreed tertiary education.

- **Community health worker**

According to a WHO study group of 1989, cited in Lehmann and Sanders (2007:1) community health workers should be members of the communities where they work, should be selected by the community, should be answerable to the community for their activities, should be supported by the health system, but not necessarily part of its organisation, and have shorter training than professional workers.

A definition for CHW was also formulated by Lewin et al (2005) , cited in Lehmann and Sanders (2007:14) as being “any health worker, carrying out functions related to health care delivery, trained in some way in the context of the intervention, and having no formal professional or paraprofessional certificated or degreed tertiary education”.

According to Schneider, Hlophe and Van Rensburg (2008:179), the term CHW was introduced in 2004, as the umbrella concept for all the community/lay health workers in the health sector and a national framework was adopted. Rapid growth of HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome) funding in

South Africa has been responsible for the emergence of a large lay health worker infrastructure (Schneider et al 2008:179).

- **Community**

For the purpose of this study “communities” will be a social group determined by geographical boundaries and with common values and interest. Its members know and interact with one another. The community functions within a particular social structure and exhibits and creates norms, values and social institutions (Stanhope & Lancaster 2004:205).

- **Primary health care**

Primary health care is essential health care made universally accessible to individuals and families in the community, by means acceptable to them, through their full participation and at a cost the community and country can afford.

#### **1.7.4 Methodological assumptions**

Methodological assumptions concern the researcher’s view of the nature and structure of science and research in the relevant discipline and direct the research design. The methodological assumptions for this research will be discussed in short as a detailed discussion is presented in chapter 3.

##### **1.7.4.1 Research design**

A qualitative research design which is explorative, descriptive and contextual was used. An exploratory qualitative design was ideal for this research study, because the role of the farm lay health worker is not well understood by the community and health professionals. The researcher developed a comprehensive understanding of the content of the role of the lay health worker on farms by exploring their perception of their role. The collaborative and participatory nature of this design minimised suspicion and distrust of research with a concomitant increase in trust and credibility (Mouton 2001:162). The design used in this study is comprehensively discussed in chapter 3.

### **1.7.4.2 Research methodology**

The research was conducted in three phases. In phase one a literature review was conducted, in phase two the researcher explored the role of the lay health workers and in phase three the guidelines to facilitate the role of LHWs in a rural community in the Western Cape Province were developed and described using the findings and literature as the basis.

#### *1.7.4.2.1 Phase 1: The exploration of available literature to identify what is already known regarding the role of a LHW worldwide*

In order to develop a comprehensive understanding of the role of LHWs in the rural context, the researcher in this study had to conduct an in-depth exploration of available literature. The researcher utilised a deductive reasoning strategy to identify what the role of LHWs was in other parts of South Africa and the world. This knowledge helped the researcher to base the findings of this study and in developing guidelines to facilitate the role of LHWs in a rural community, in the Western Cape Province.

#### *1.7.4.2.2 Phase 2: The exploration and description of LHWs' perception of their role in the rural Western Cape Province*

Qualitative research was used to investigate the perception of the LHWs with regard to their roles on the farms. The qualitative research approach is the process of learning and constructing the meaning of human experience through intensive dialogue with persons who are living the experience (Streubert-Speziale & Carpenter 2007:76). The researcher's goal was to understand the meaning of the experience as it is lived by the participant. The meaning is pursued through a dialogical process and requires the thoughtful presence of the researcher (LoBiondo-Wood & Haber 2002:143). The researcher used an inductive process to integrate information from persons doing lay health work on farms to understand their lived experiences about their role (Polit & Beck 2004:17). The methods used in his study are described briefly below. A comprehensive description of these methods is dealt with in chapter 3.

- **Population**

The study population was all the LHWs who practise on farms in the Boland area of the Western Cape. This population will be fully discussed in detail in chapter 3.

- **Sampling**

A convenience, non-random, purposeful sample was used. The sample size comprised of five people who were willing to engage in a focus group discussion. Further details regarding this sample are discussed in chapter 3.

- **Data collection process**

A single focus group discussion (FGD) and in-depth interviews were used as methods for data collection in this research (Liamputtong 2009:53).

During a focus group discussion data are collected that are in the words of a group of participants. Verbal data need to be collected in a relaxed atmosphere with sufficient time allowed to facilitate a complete description by the participant. The researcher observes verbal and non-verbal behaviour; the environment and his/her own response to the situation (Burns & Grove 2005:544).

The focus group is inexpensive, flexible, stimulating and rich data are collected. This method is particularly ideal for this research as it promotes a relaxed, non-threatening atmosphere to facilitate free expressions of opinions and perceptions with regard to the roles as LHWs (Liamputtong 2009:68). A full discussion of this approach to data collection follows in chapter 3.

A **pilot study** is a smaller version of a proposed study conducted to refine the methodology. A pilot study was conducted using the draft data collection tools. The aim of the pilot study was to determine the clarity of questions, effectiveness of the instructions, the time required to complete the interviewing process, sequencing of questions and the procedure to record responses. The success of using the FGD as a data collection method was determined. Problems encountered during the pilot study were rectified (Burns & Grove 2005:544).

- **Methods of data analysis**

The search for important themes and concepts begins with data collection. There are no universal rules for analysing and presenting data. It might entail an enormous amount of work. The researcher edited the data using the analysis style and read through the data in search for meaningful segments and units. Then a categorisation scheme was used and corresponding codes were used to sort and organise data. The researcher searched for patterns to connect the content of the role of the farm lay health worker as perceived by them (Polit & Beck 2004:571). The data analysis method is discussed in more detail in chapter 3.

#### *1.7.4.2.3 Phase 3: Development and description of guidelines to facilitate the role of LHWs in the rural Western Cape Province*

The researcher utilised literature and research findings as the basis for the development of guidelines to facilitate the role of LHWs in the rural Western Cape province. A deductive reasoning strategy was employed by the researcher for this purpose. The guidelines are comprehensively discussed in chapter 5 of this study.

## **1.8 REASONING STRATEGIES**

Various reasoning strategies were employed by the researcher in the execution of various phases of the research process. The reasoning strategies that were used in this research are, namely: analysis, inductive reasoning, deductive reasoning and synthesis. The reasoning strategies helped the researcher in exploring and describing the roles of LHWs on farms in the rural Western Cape Province. The intellectual capacity and the experience of the researcher added to the formal system of thought.

## **1.9 ETHICAL CONSIDERATIONS**

The personal nature of this research made it difficult to predict what might transpire during the FGD, but an informed consent from the participants was obtained (Appendix D). Participants knew that they were free to withdraw from the study without prejudice and they were protected from physical harm and mental discomfort that might have

arose from the research process. They had a right to remain anonymous and the confidentiality of participants and data were protected (De Vos, Strydom, Fouche & Delpont 2005:58).

This study was approved by the University of South Africa's Health Studies Research Ethics Committee (Appendix A). Permission was granted by the Cape Winelands District Municipality to conduct the research in their area of jurisdiction (Appendix C). The protection of human rights according to LoBiondo-Wood and Haber (2002) and Burns and Grove (2007), will be described in chapter 3 in detail.

## **1.10 TRUSTWORTHINESS OF THE RESEARCH**

Guba's model for trustworthiness was utilised to ensure the validity and reliability of this research (Lincoln & Guba 1985:12). The four criteria for trustworthiness utilised in this study are: truth value, applicability, consistency and neutrality. The truth value was ensured by applying the strategy of credibility, and applicability by applying strategies of transferability. Consistency was ensured by strategies of dependability, and neutrality by strategies of confirmability (Mavundla 2000:1572). These strategies are briefly explained below.

### **1.10.1 Credibility**

Credibility refers to the correctness and truthfulness of the data and information supplied by the participants. The credibility of the data and information were established by ensuring that the recording and note-taking were done simultaneously. The researcher also ensured that the notes taken are extensive and reflective of the content of the discussions, as well as the non-verbal behaviours displayed during the discussions by the participants; and finally by compiling and reading the final written reports of the FGD (focus group discussion) in order to confirm and verify whether the reports are a true account and a true reflection of what was said by the participants during data collection.

### **1.10.2 Dependability**

Dependability refers to the consistency and stability of the data and information supplied by the participants. The researcher established the dependability of this study by documenting real life experiences and real personal stories of the participants. Consequently, the findings of this study are the result of the experiences and ideas of the participants, rather than the researcher's own ideas, preferences and assumptions.

### **1.10.3 Confirmability**

Confirmability refers to the degree to which the results and findings of the study are confirmed or corroborated by others. To ensure this, the researcher substantiated the report of the FGD by reviewing other similar studies previously conducted to see if the participants' responses match the literature reviewed in this study.

### **1.10.4 Transferability**

Transferability refers to the degree to which the results and findings of a study can be applied to other similar contexts or settings. The researcher established transferability in this study by using purposive sampling whereby selecting participants whom she knew would provide rich and relevant information pertaining to the phenomenon investigated in this study. The researcher also ascertained that all the participants met the inclusion criteria set at the beginning of the fieldwork.

The trustworthiness of data collected in this study is comprehensively discussed in chapter 3.

## **1.11 USE OF LITERATURE IN THIS STUDY**

The qualitative design is ideal to explore the perception of the role of the lay health workers on farms and therefore the use of literature was planned as follows:

- The researcher conducted an extensive literature review to develop the background and motivation for this research. This verified the need for the

investigation and helped the researcher to focus during this study. This literature is discussed in both chapters 1 and 2.

- Another literature search (literature control) was done after analysing the data to place the findings in the context of what is already known on the perception of the LHWs about their role on the farms. This is discussed in chapter 4.
- Chapter 5 is used as an avenue to develop and describe guidelines to facilitate the role of LHWs in the rural Western Cape Province.

## **1.12 ORGANISATION OF THE REPORT**

The structure of the dissertation is as follows:

**Chapter 1:** Introduction and outline of the study

**Chapter 2:** Literature review

**Chapter 3:** Research design and methodology

**Chapter 4:** Discussion of research findings and literature control

**Chapter 5:** The descriptions of guidelines to facilitate the role of LHWs in the rural Western Cape Province.

**Chapter 6:** Conclusions, limitations and recommendations

## **1.13 CONCLUSION**

The need for this research was clear and the problem was stated. The background information guided the way to the statement of the research questions that had to be answered by way of studying the literature and conducting the actual research. This chapter discussed in detail the background and motivation of the research, as well as the paradigmatic perspective of the dissertation. Chapter 2 covers the literature review.

## **CHAPTER 2**

### **LITERATURE REVIEW**

#### **2.1 INTRODUCTION**

In this chapter, a wide range of literature relating to this study was reviewed. The main concepts in which this study is rooted were also discussed. An extensive literature search was done, using books, the internet, abstracts, journals and other sources to explore the information about the role of the LHW. This served as phase one of the study. This chapter gives an overview of what the researcher found in the literature on the role of the lay health worker. The research findings are discussed in chapter 4.

#### **2.2 PURPOSE OF THE LITERATURE**

According to Babbie and Mouton (2007:565) in Tshibumbu (2006:22), every research report should be put in the context of the existing general body of knowledge. As such, the general purpose of reviewing literature is to gain an understanding of the current state of knowledge about the research topic of interest. In this study, literature review assisted the researcher to identify the gaps in the body of knowledge about the role of LHWs. The research topic was thus refined based on this knowledge. An understanding of the relationship between the main concepts in the research topic was also obtained from literature review. In addition, the identification of an ideal methodology to address the research objectives was also done through literature review. This has guided the structuring of the grand tour question, as well as the pre-conceived scope of the probing questions. In order to ensure that this purpose is successfully accomplished, the reviewed literature was interrogated to a significantly wide scope as elaborated in the next section.

#### **2.3 DEFINITION OF A LHW**

Despite the multifaceted roles and functions of CHWs no single accepted definition exists or any of the other associated titles commonly applied to lay health workers. Over the past 40 years, at least 30 synonyms have been used to describe CHWs in

various health promotion programmes and research studies. The usual assumption is that the CHWs are part of the community in which they work ethnically, linguistically, socioeconomically and experientially.

The community health worker is a person who, with or without compensation, provides cultural mediation between the community of which he/she is part of and the health and human services systems. They provide informal counselling and social support, as well as culturally and linguistically appropriate health education. They advocate for the needs of individuals and the community and assure that people get the services they need. The latter builds on individual and community capacity. CHWs also provide referral and follow-up services.

## **2.4 COST-EFFECTIVENESS**

Since the Alma-Ata Conference in 1978 reiterated the goal of “Health for all by the year 2000”, health service delivery programmes promoting the primary health care approach using CHWs have been established in many developing countries. These programmes are expected to improve the cost-effectiveness of health care systems, by reaching large numbers of previously underserved people, with high impact basic services at low cost (Walker & Jan 2005:222).

Conventional approaches to economic evaluation, particularly cost-effectiveness, tend not to capture the institutional features of CHW programmes. Services provided by CHWs are seen to be more appropriate to the health needs of populations than those of clinic-based services, to be less expensive and to foster self-reliance and local participation. Economic evaluations that have been undertaken tend to be conventional cost-effective studies and therefore based on narrowly defined endpoint e.g. vaccinations administered and patients treated. The value of such measures is that they provide decision makers with explicit basis for comparing programme alternatives in terms of inputs and outputs. The key elements of a programme can be missed through this reductionist perspective. The study by Walker and Jan (2005:223) aims to examine means by which economic methods can be extended to provide evidence regarding the cost-effectiveness of CHWs in developing countries. This manuscript has evaluated the importance of the institutional context in defining its value or benefit and

found that the more holistic institutional approach offers a potentially useful framework for evaluating CHWs (Walker & Jan 2005:223).

## 2.5 PROFILE OF A LHW

In addition to the cost-effectiveness of the LHW programme, is their profile. It is therefore important to be aware of the profile of CHWs when considering the indigenous population in terms of culture, language and gender issues.

In a study undertaken in rural KwaZulu-Natal where a participatory intervention was used to improve the nutritional status and to influence dietary practices of the community, the findings revealed that the LHWs were women elected by their communities with a mean age of 46 years, who lived in their area for an average of 26,9 years and were all married with an average of 5 children. They had 5 - 6 years of schooling. In this study it was also revealed that they learned about nutrition, how to ask questions logically and to identify problems in their communities. They were of the opinion that their work was appreciated (Taylor & Jinabhai 2001:125).

In a similar study conducted to describe the profile of CHWs in Peru, it was reported that the majority were men with limited education who worked voluntarily. They were young and high school graduates, but there was a high drop-out rate among them. In contrast, traditional healers and birth attendants were older and not prone to drop out. At community level, the health promoters were the most visible CHWS (Brown, Malca, Zumaran & Miranda 2006:2). Lehmann and Sanders (2007:7) confirmed that the majority of health promoters in Peru were male and that they skew the gender equality in community leadership positions.

Research also revealed that the issue of gender was not addressed in policy-making (Daniels, Clarke & Ringsberg 2012:8).

## 2.6 GOALS OF LHW PROGRAMME

Apart from the profile of LHWs, it is also necessary to present the goals of the programme that govern their work. There are three interrelated goals for the use of LHWs in the community, namely **therapeutic alliance**, – stronger relations between

health care professionals and lay persons in the community; to **improve appropriate health care utilisation** – this can cut costs with early access, prompt diagnosis and treatment, greater use of primary care providers and fewer urgent care units; and **reduced health risks** – by educating the community about prevention, early diagnosis and treatment. These three goals depend on one another for maximal effectiveness (Nemcek & Sabattier 2003:261).

The LHWs act as health promotion role models, mentors and health advocates in reducing health risks for their peers. This duty may be performed directly or indirectly when transporting peers to health services or visiting peers in their homes. According to Nemcek and Sabattier (2003:263) CHWs are used in different programmes, i.e.

- Outreach e.g. case finding, conduct health screening, referrals and staffing of mobile units.
- Culturally sensitive care – e.g. to translate, liaison and establish links between peers and professionals, to develop culture specific health materials or train health professionals on culture.
- Health education/counselling, i.e. to educate or counsel groups or one-on-one; take part in mass media campaigns and to develop and distribute resource guides.
- Health advocacy, i.e. to act as role models, mentors, to do crisis intervention or lobbying.
- Home visits to evaluate home environment and for social support.
- Health promotions/lifestyle changes as leader or coach.
- Perinatal care for outreach and early prenatal care, nutrition, parenting and child care.
- Transportation/homemaking – e.g. to drive/arrange for travel, cleaning and food preparation (Nemcek & Sabattier 2003:263).

## 2.7 TRAINING OF LHWs

As seen in the paragraphs above, the CHWs have diverse roles. To address some of these roles the ABE Trust developed outcome based educational material for farm health workers which included a guide for community health workers, reproductive

health, child health and prevention of diseases. These guides in a modular set-up are worked through with farm health workers and teach them step-by-step to fulfill their roles as health workers on primary level in a rural community (Clarke, Knight, Prozesky & Van Rensburg 2003:5).

In “The guide for community health workers” (Clarke et al 2003:1) a nomphilo is the word used for a “women of love, health and care”. This is how the CHWs are called in KwaZulu Natal. Their training was based on this guide and included needs assessment and referral; assuring people from groups to talk about health problems; to develop health education and special events for projects like AIDS; to start vegetable gardens; to visit and care for people that are sick, old, disabled, to empower individuals, families and communities by sharing knowledge and skills, information and resources (Clarke et al 2003:11). This guide can be applied to various groups of CHWs according to their roles in the community.

In the Free State in South Africa, the CHWs were trained as single purpose workers, namely lay counsellors, home-based carers or DOTS supporters. The results were that there was shifting of tasks from professionals to CHWs; patients presenting with social problems; nurses were positive about the CHWs’ role as mediator between family and the community. This was an empowering role that served as a bridge between the patient/community and the health system (Schneider, Hlophe & Van Rensburg 2008:182).

In El Salvador It was found that non-governmental promoters received more training than government promoters (Lewis, Eskeland & Traa-Valerezo 1999:4). In El Salvador LHWs were trained to prescribe and have available simple medication and antibiotics. The communities were positive on the role of all promoters in the immunisation campaigns (Lewis et al 1999:5).

Lay health workers were trained as “AjariSanteMantal” (Lay Mental Health Workers) to aid earthquake survivors in coping with disaster and displacement related distress (James, Noel, Favorite & Jean 2012:117).

Andrews, Felton, Wewers and Heath (2004:360) coded the roles of CHWs as educators, outreachers, case managers and data collectors. The author found that their

roles varied as well, with regards to their training, payment, recruitment and supervision. The training was often dependant on the nature of services they provided. Common traits included literacy, motivation, trustworthiness, credibility and high self-esteem. In several studies the CHWs were required to have experience with the targeted behaviour or outcome, such as breastfeeding or having had a mammography. Andrews found that procedures for supervising the CHWs' retention rates and procedures to retain CHWs during study periods were rarely described (Andrews et al 2004:360).

According to O'Brien, Squires, Bixby and Larson (2009:262), a standard approach to reporting the selection and training processes will more effectively guide the implementation of future CHWs programmes.

## **2.8 FUNCTIONS OF THE LHW**

LHWs have achieved much in many countries. There is no place for discussion of whether CHWs can be key actors in achieving adequate health care. The question is how to achieve their potential. They provide the ideal bridge between the community and the health sector, however, experience in numerous countries has demonstrated that the top priority must be given to understanding and tackling the problems raised by attempting to achieve this bridging function in practice. Their function is regarded as extenders of health services and agents for educational and developmental change. The main need is to restore and resurrect socially and economically shattered community organisations so that they can make better use of available CHWs (Nemcek & Sabattier 2003:260).

The widespread difficulty in achieving the undoubted potential of this category of worker stems not from medical or other technical problems but from organisational and management issues. The wide deployment of a generalist health worker is the main avenue towards achieving primary health care in most countries. The positive and unique benefits of CHWs should be emphasised and they should not just be used because there are not enough trained professionals. These authors are of the opinion that underutilisation exists due to the lack of understanding of the LHW concept and a dearth of evaluation literature of CHWs (Nemcek & Sabattier 2003:260).

## 2.9 THE ROLE OF THE LHW

A CHW can be a generalist or specialist. The generalist performs a wide range of functions, while the specialist is used to address specific health issues, like maternal and child health, tuberculosis care, malaria control and HIV/AIDS care (Lehmann & Sanders 2007:8).

They serve a critical function in the community wherein they are working, often providing a service to the most marginalised poor communities, where none may otherwise have been available (Daniels, Van Zyl, Clark, Dick & Johansson 2004:97)

They perceived their roles which include health related activities, such as health promotion, treatment support and counselling, but it could extend beyond health to areas such as welfare, e.g. delivering of food parcels. They perceived their roles as being experienced in their training and having the qualities and skills that they needed like advocacy, interpersonal effectiveness, availability and willingness to help, trustworthiness and appropriate health care skills. There were community and personal benefits for them. The resources as mentioned were found useful in coping and sustaining themselves (Daniels et al 2004:97).

Community Health workers are included in a wide range of activities - including home visits, environmental sanitation, first aid and treatment of common ailments, health education, nutrition and surveillance, community development activities, referrals, record- keeping and collection of data (Lehmann & Sanders 2007:8).

Discussions regarding the role of LHWs in primary health care have been ongoing since the early 1990's. These discussions need to be the focus of policy-makers into a set of guidelines, which will address the principle of gaining access into communities, selection of suitable recruits, initial training, supervision and support of LHWs and these guidelines also need to address the issue of enhancing the sustainability of these important interventions (Daniels et al 2004:92).

A key element of the National South African CHW Policy of 2004 from National Department of Health, cited in Schneider et al (2008:182), is to allow CHWs to be

generalist and single purpose workers. It was stated that they must receive a stipend and belong to the NGO model (Schneider et al 2008:182).

There are vast differences in the rendering of help to people in rural and urban areas. There is a need for knowledge on the role of the lay health worker. This will assist health workers to know who, and what for, to recruit LHWs in future.

### **2.9.1 Activities performed by the LHW**

Literature highlights variations in training and preparations, roles and responsibilities and controversy associated with using community health workers. Knowledge is sought on the perception of the role of the rural lay health worker on the farms in the Boland area.

Conferences like Alma Ata (1978), Ottawa (1986) and Jakarta (1996) have declared the importance of community participation to improve health conditions (Minkler & Wallerstein 2003:32).

These LHWs had six priority activities, namely prenatal health promotion; encouraging exclusive breastfeeding during the first six months of life; weighing of children monthly and nutritional counselling; making referrals for appropriate child vaccinations; oral rehydration for children with diarrhea and the treatment of minor wounds. According to Cufino-Svitone, Garfield and Vasconcelos (2000:295), these lay health workers are also sometimes engaged in services regarding contraceptives, promotion of cancer screening, encouragement of water and sanitation improvement, screening and follow-up for treatment for locally endemic diseases (leishmaniasis and malaria), screening and follow-up for chronic diseases and death and birth notification (Cufino-Svitone et al 2000:295). The literature addressed the following aspects of the LHW role, namely: (1) nutrition promoter; (2) social support promoter; (3) promoting compliance with treatment; (4) promoting access to care; (5) promoting quality care in children.

#### **2.9.1.1 LHW as a health promoter**

In contrast, in Peru the role of LHW was to promote health (Brown et al 2006:2). There is an increase in the burden to take care of female LHWs. These female LHWs are

carrying a range of tasks, including palliative care, counselling, health promotion, treatment and support (Daniels et al 2012:8).

- **LHW as a promoter of good nutrition**

In a South African study conducted in the province of KwaZulu-Natal it became clear that LHW were responsible for improving and educating the community members on their nutritional aspect (Taylor & Jinabhai 2001:125). They could promote the use of locally available foods, encourage the development of food gardens, and emphasise the benefits of improved sanitation and hygiene to prevent disease.

LHWs engaged in community nutrition activities are promoted as a cost-effective mechanism for reaching underserved groups. Roles spanned nutrition, education, health promotion, administration and personal development (Kennedy, Milton & Bundred 2008:210). A similar study was done in Costa Rica and in India, using rural health workers for specific interventions on the nutritional status of pregnant and lactating women (Taylor & Jinabhai 2001:125).

- **LHW as a promoter of social support**

In rural African settings community members rely on one another for support. Researchers found that the use of community health workers in promoting development in the community, was in keeping with the tradition of rural communities working together and supporting each other (Taylor & Jinabhai 2001:125). The emphasis on community support in most developing countries has been on providing resources, either financial, material or human, for the establishment or improvement of the health and sanitation infrastructure (health centers, latrines, etc.) or for payment of community based health workers. Communities became involved by volunteering services. Taylor and Jinabhai (2001:125) found, in a study done in the province of KwaZulu-Natal in South Africa, that community health workers were mostly women who lived in an area where they understood the local concerns and constraints of that area.

- **LHW as in promoting compliance with treatment**

Also in South Africa in the Paarl area, farm LHWs were selected to intervene, to address the compliance problems of patients with tuberculosis on farms in the Paarl district. This was done in order for them to assist with the successful treatment completion rates among adult new smear positive TB cases (Dick, Clarke, Van Zyl & Daniels 2007:383). It demonstrated that the use of peer-selected LHWs, within a wider programme of integrated care appears essential to meet the complex health needs of the rural poor. The role and function of LHWs in the management of TB control included creating awareness about the signs and symptoms of TB – they screened the farm dwellers by weighing them and checking for other TB symptoms. In addition, the LHWs administered the anti-TB medication and did the counselling. All defaulters were referred to the nearest clinic nurse. The LHW intervention stimulated the formation of health committees within the farm areas, which led to the organisation of health promotion activities. Farmers perceived that the LHW was a “broker” between farmers and farm dwellers (Dick et al 2007:383).

- **LHW in promoting access to care**

Andrews et al (2004:358) explored the roles and effectiveness of community health workers in research with ethnic minority women in the United States of America. It was found that, despite varying roles and functions, evidence indicates that community health workers are effective in increasing access to health services, increasing knowledge and promoting behavioural change among ethnic minority women. Other advantages of using the CHW are to provide social support and culturally competent, cost-effective care (Andrews et al 2004:358).

Collective functions of CHWs are to improve access to health care, empower individual and community members, improve behavioural outcomes and decrease health costs. In carrying out these functions CHWs have been used in many types of programmes such as primary and secondary cancer prevention, immunisation, maternal and child care, smoking cessation, hypertension screening and management, diabetes management, nutrition, community mental health, sexual risk reduction, AIDS prevention and asthma management (Andrews et al 2004:359).

- **LHW in the promotion of quality care in children**

In the United States of America (USA) community health workers were used in the Community Health Intervention Program (CHIP) in Virginia, to enhance the quality of care for children, and to ensure contact and referral of sick children which can be an ongoing process (Cash 2004:1).

A systematic review was conducted to categorise and describe intervention models, involving CHWs that aim to improve case management of sick children at household and community levels (Winch, Gilroy, Wolfheim, Starbuck, Young, Walker & Black 2005:201). The authors identified seven intervention models and classified them according to the:

- role of the CHW and families in assessment and treatment of children
- system of referral to the nearest health facility
- location in the community of drug stock

Improvements in care at health facilities through the Integrated Management of Childhood Illnesses (IMCI) and other initiatives are necessary to decrease childhood mortality. The authors found that health systems need to provide CHWs with medications and other supplies, regular supervision and links to a referral system. There is a growing demand for CHWs to take on, not only the management of malaria and pneumonia, but also diarrhea treatment with zinc and oral rehydration solution, and neonatal infections.

Winch et al (2005:202) suggested that choices should be made about what responsibilities were realistic to assign to CHWs. Programmes reviewed were categorical in that CHWs manage one single disease, usually malaria. They found that CHWs assess and presumptively treat sick children for malaria only. This ignores the substantial overlap in the clinical presentation of malaria and pneumonia and puts a caregiver in the position of making a presumptive diagnosis of either malaria or pneumonia, for which then to seek appropriate care. If national policy allows both antibiotics and anti-malarias to be provided by CHWs then this problem would not exist. The authors also suggested that CHWs be trained to assess and treat children with diarrhoea or neonatal infections. These new recommendations could be included in all

intervention models, but still simultaneous efforts are needed to strengthen health systems and to ensure that the overall workload of CHWs is reasonable (Winch et al 2005:202).

### ***2.9.1.2 LHW as a liaison between the community and the health system***

Apart from the role of being a health promoter, LHW also plays a major role as a liaison person between the community and the health sector. Over the past four decades community health worker roles have evolved. They now serve as liaisons between community members and providers by promoting community advocacy and community capacity building, cultural mediation, counselling, social support, culturally appropriate health education, attendance at appointments, adherence to medication and other medical regimens to ultimately promote the delivery of direct health care services (Andrews et al 2004:359).

### ***2.9.1.3 LHW as a link between the community and the health system***

As far back as 1989, Matomora (1989:1081) described village health workers as expected to serve their communities and to establish a link between the community and the national health system. They are to deliver services, as well as be “change agents”. The author emphasised their role as engaging in simple, low cost activities, such as first aid and environmental sanitation (Matomora 1989:1081).

All these groups of lay health workers were used for a specific intervention to assist the researchers to impact on the specific community for a specific purpose. The LHWs' roles, per se, were not investigated. The impact of the specific programme had positive outcomes in the sense that the nutritional status as well as the compliance to take Tuberculosis treatment improved. Strategies to sustain these programmes were not mentioned and how these lay health workers could be engaged on a continuous basis to develop their roles and own careers, were not considered.

### ***2.9.1.4 LHW in community development***

The CHWs continue to focus on their role in community development and bridging the gap between the community and formal health services (Lehmann & Sanders 2007:5).

As natural helpers CHWs play an important role in connecting public and primary care to the communities that they serve. The natural helper roles, that include trust, rapport, understanding and the ability to communicate with the community, take on an increased significance. The CHW provides structured linkages between the community, the patient and the health care system (Heman 2011:354).

According to Kennedy, Milton and Bundred (2008:213) LHWs were increasingly having access to health care, by bridging the gap between social and cultural groups and formal health. They were reducing healthcare costs by encouraging the appropriate use of the health care systems. CHWs were improving the quality of health care, by educating health care providers to the community's health care needs and enabling patients to foster self-efficacy. These programmes are strengthening local economies, by linking families to much needed services and mobilising communities to seek resources to meet their health needs (Kennedy et al 2008:213).

#### **2.9.1.5 LHW as role model**

Community health workers attend workshops and disseminate the information gained throughout the communities they live in and work. They act as role models in attending important workshops (Vananda 2001:19).

CHWs reported that trust-based relationships with rural communities, altruistic motivation to serve rural people and sound health knowledge and skills, are the most important factors facilitating successful implementation of a CHW programme in Iran (Javanparast, Baum, Labonte & Sanders 2011:2287).

Dick et al (2007:388) reported an increased personal self-confidence with LHWs, as they gained expertise in the health field. They commented on the role of the LHW as being a "role model" in the community.

#### **2.9.1.6 LHW as care provider**

In El Salvador a qualitative study was carried out to evaluate rural health strategies employed by LHWs. It was discovered that they were meant to provide basic care to communities, with emphasis on the health of women and children (Lewis et al 1999:4).

In El Paso County, in the mornings they helped at the local clinic by taking vital signs and served as translators for patients. In the afternoons they visited the homes to offer classes to women in basic homemaking skills, parenting, first aid and sanitation. These roles expanded and the lay health promoters became involved in nutrition classes, confronted gangsters to try and stop the graffiti and even ran support groups for teenage girls to prevent pregnancy. They joined community organisations like the cancer society, got involved in burns victim-support and trained other health promotoras (Williams 2001:216).

### **2.9.1.7 LHW as an advisor**

In Mumbai, a study was conducted in the urban slum areas with female peer facilitators in a community based maternal and newborn health intervention, about their role perceptions and experiences. These people were called “sakhis”. The “sakhis” shared knowledge and experiences of pregnancy, child birth and care seeking behaviour with their peers. They visited homes, offered advice and accompanied women to health facilities. They were required to give information and were seen as a source of knowledge. These tasks brought positive changes in self-esteem and their confidence increased (Alcock, More, Patel, Porel, Vaidya & Osrin 2009:958).

In the United Kingdom community advisers are used, as part of a Community Education Training programme, to provide smoking cessation support. This community advisor is available to encourage, motivate and counsel the group. These authors are of the opinion that the advantages of community advisers were to empower members of communities in transferable skills of group work and thus build the community resource (Kai & Drinkwater 2004:106).

In El Paso County, Texas there is a programme, which uses LHWs as health promoters. Here they are called promotora de salud. Their duties were to identify those who are sick, pregnant and not adhering to prescribed medications in order that they may visit them at home and make arrangements for care. These promotoras extended their roles as health *advisers*, by trying to get patients on a medical aid, applying for indigent care at the country hospital or setting up a deal with the local pharmacy. They even went as far as buying medications with their own money (Williams 2001:216).

Kennedy et al (2008:212) commented that LHWs were also commonly employed as advisers to disseminate health related messages.

#### **2.9.1.8 LHWs as health educator and health promoter**

In Brazil, auxiliaries, called agentes de saude, have also proven commitment to social service. Their areas of work were well defined geographically. Their emphasis was on health promotion and education and they had few curative and symptomatic medicines – only anti-helminthic and analgesic. For all other problems the programme established referral mechanisms to existing public clinics. Funds for salaries came directly from routine tax revenues of state government (Cufino-Svitone, Garfield & Vasconcelos 2000:293).

Lay health advisors were used to promote community health education programmes and were trained beforehand in the knowledge on breast and cervical cancer (Saad-Harfouche, Jandorf, Gage, Thelemaque, Colon, Castillo, Trevino & Erwin 2011:219).

A LHW intervention increased awareness on the prevention of breast cancer in non-adherent Korean-American women (Han, Lee, Kim & Kim 2009:318).

A partnership between a hospital and community based organisation with “promotoras” appeared to be effective for providing chronic-disease self-management education in an urban community setting (Deitrick, Paxton, Rivera, Gertner, Biery, Letcher, Lahoz, Maldonado & Salas-Lopez 2010:386).

#### **2.9.1.9 LHW as home-carer**

Barnard (2003:32) described a home-based care intervention in Ingwavuma, to address the problems faced by AIDS patients in rural areas. These carers were chosen by the community and received their training at a hospice, doing a month’s practical at the local hospital. They are then placed in teams to work in their neighbourhoods. They travelled by bicycle or went around by foot to do home-care visits to AIDS patients. They had analgesics and other drugs to treat the AIDS victims and were very active counsellors at the same time. They used weekends to teach in churches. A nurse

visited them for ongoing support and brought their supplies. This author is of the opinion that the programme works well, but that the home-carers experience stress, because of all the orphans that they cannot give over to orphan organisations (Barnard 2003:32).

The provision of home-based neonatal care by village health workers reduced the infant mortality rate in a rural population in India by almost 50%. A study was conducted in Gadchiroli, a district of India in an extremely underdeveloped region with high rates of malnutrition and female illiteracy. Male health workers collected data from 39 villages and local women, with 5-10 years of schooling who acted as lay health workers. They had six months of training in taking histories of pregnant women, observing the process of labour, examining newborns, recording data and managing cases of pneumonia in children, including newborns. This knowledge was applied by the lay health worker in the community over a period of three years (Bang 2000:92).

The main causes of death in infants were septicemia, meningitis and pneumonia. The lay health workers provided home-based management of neonatal illness to newborns and also added the management of neonatal sepsis to their duties. During the third year of the intervention, the village health workers also educated mothers and grandmothers about providing appropriate care and nutrition during pregnancy, preventing infection, recognising symptoms and seeking immediate help. They stressed the importance of breastfeeding, temperature maintenance and infant weight gain. It was estimated that 51 deaths among 913 newborns were averted, because of the home-care from village health workers (Bang 2000:93).

A study on specific interventions with CHWs, to address problems in caring for children, found that primary health care for children in remote underserved communities, using CHWs is possible and feasible (Rennert & Koop 2009:9).

Another home-care intervention by lay health workers was initiated by SA Hospice Association in response to the HIV/AIDS epidemic. A curriculum was developed to train community health workers in rural, peri-urban and urban areas to take part in home-based care projects for people living with AIDS. Training took 58 days and theory and practical was integrated to teach lay health workers to:

- show commitment to render holistic care
- show respect for dignity and uniqueness of people living with HIV/AIDS
- provide the relevant basic home nursing skills in order to alleviate pain and suffering
- provide knowledge and caring skills in all diverse areas pertaining to HIV and AIDS, Tuberculosis and sexually transmitted disease
- provide basic education and information to people living with AIDS and their families (Duma & Cameron 2002:46)

In a similar intervention in Nyanza Province in Kenya, where the HIV prevalence is 22 % and 80% of the population resides in rural areas, community health workers were trained to provide home-based care to sick or dying AIDS clients in rural areas (Johnson & Khanna 2004:496).

Community health workers work with clients, groups, other CHWs and community leaders to address health issues, for instance chronic disease prevention and health care access (Ingram, Reinschmidt, Schachter, Davidson, Sabo & De Zapien & Carvajal 2012:529).

Safe motherhood promoters' tasks focused on promoting early and complete antenatal care visits and delivery with a skilled attendant (Mushi, Mpembeni & Jahn 2010:14).

### **2.9.2 LHW in the treatment of chronic diseases**

In addition to various roles of LHWs identified in the literature review, the researcher also identified the role of LHWs in the treatment of chronic diseases. In this study the researcher identified that the LHWs provided treatment to the community members suffering from the following chronic conditions, namely: (1) hypertension; (2) TB; (3) type 2 diabetes mellitus; (4) asthma; and (5) HIV care.

### **2.9.2.1 LHWs in the treatment of hypertension**

Community health workers were trained to identify high blood pressure and visited patients up to five times over a period of forty months to educate them about blood pressure control. Three years later the residents of West Baltimore in America experienced a drop in blood pressure of 4,5mmHg systolic and 4mmHg diastolic. The percentage of individuals controlling their blood pressure doubled. This was all due to the fact that the community health workers intervened with education and counselling, social support and community outreach. This John Hopkins study demonstrates that one home visit at least by a community health worker may be sufficient to encourage someone with high blood pressure to take measures to lower it (Levine 2003:1).

In South Africa in a study conducted in Kayelitsha in Cape Town, 43 CHWs participated in focus group discussions aimed at describing the perceptions and attitudes of CHWs on hypertension. They found that the level of knowledge of hypertension, as well as the personal attitude towards this, was crucial in the style and quality of the interventions by CHWs. The important role in health promotion can help contain and reduce the prevalence of hypertension by influencing the community to adopt healthy lifestyles. It was found that the CHWs are uncertain about the causes of hypertension and are also unsure about the risk factors. The conclusion was that the insufficient knowledge about hypertension as a chronic disease of lifestyle was affecting their role in health promotion (Sengwana & Puoane 2004:65).

### **2.9.2.2 LHWs in the treatment of TB**

LHWs were also utilised as tuberculosis treatment supporters in the Boland area of the Western Cape in South Africa. A study was done to determine what the perceptions of the lay health workers were on their role (Daniels et al 2004:92). They reflected on their role in tuberculosis care and the difficulties which come with the task (Daniels et al 2004:97).

In Barcelona, CHWs were used to improve TB contact tracing in immigrants and this proved to be very effective. The incorporation of CHWs in a multidisciplinary team can reinforce the effectiveness of Public health nurses and minimise difficulties accessing care (Ospina, Orcau, Millet, Sanchez, Casals & Cayla 2012:158).

LHWs were used in Swaziland for direct observation of treatment short course (DOTS). Community health workers and family members observed that patients with tuberculosis took their treatment daily. No significant differences in the cure and completion rates were found between DOTS by community health workers or DOTS by family members (Wright, Walley, Philip, Pushpanathan, Dlamini, Newell & Dlamini 2004:559).

A different outcome was observed in the Boland Western Cape South Africa. A cluster randomised control trial was done to evaluate the effect of LHWs on tuberculosis control, among permanent farm dwellers in an area with a high tuberculosis prevalence rate. The conclusion was that LHWs were able to improve successful tuberculosis treatment rates among adult new smear positive tuberculosis patients in a well-established health service, despite the reduction of services (Clarke, Dick, Zwarenstein, Lombard & Diwan 2005:673).

Dick (2001:19) described the same intervention of LHWs on farms in the Boland area. According to this author the LHWs also treated minor ailments and acted as important link between employees, farm management and health services. It was found that the system was successful if LHWs are supervised and supported. This programme had a snowballing effect in the sense that TB action committees were formed, capacity building events were held, recreational activities were done and health promotion activities for women, men and youth developed (Dick 2001:19).

A study to evaluate the effectiveness of a LHW intervention within a primary health care framework, aimed at improving TB case finding and case holding among permanent farm dwellers, to explore perceptions of the different stakeholders and to do a cost effectiveness analysis in order to contribute to TB control in South Africa was done. The LHW model was evaluated using an unblinded pragmatic cluster randomised control trial, while the qualitative research evaluated the perception of the stakeholders and cost-effective analysis established the cost-effectiveness of LHW's in conjunction with the standard TB control programme. The successful treatment completion rate in new smear positive adult TB patients was 18,7% higher on farms in the intervention group than in the control group. The cost-effective analysis showed a potential saving of 59 % for the public health sector in direct staff costs, for clinic based directly observed treatment of TB patients living on farms. The qualitative analysis revealed that the

farmers remained positive and desired recognition from the public health sector. The findings concluded that the resident trained LHWs in conjunction with the public health sector have the potential to substantially enhance TB control activities on farms and in similar community settings (Clarke et al 2005:673).

Apart from conducting such a study among rural dwellers, a similar study was conducted among urban dwellers in Cape Town. The aim was to compare successful TB treatment outcomes rates between self-supervision, supervision by LHWs and supervision by the clinic nurse. The conclusion was that the supervision approaches of the LHW revealed statistically significant superiority, but failed to reach it, due to study limitation and small sample size. It is possible that subgroups like new and female patients do well under LHW supervision. LHW could be offered as one of several supervision options within tuberculosis control programmes (Zwarenstein, Schoeman, Vundule, Lombard & Tatley 2000:550).

Another study described how health promoters use traditional and allopathic medicine to treat, for instance fever, diarrhoea and parasitic infections. The study suggested that these health promoters can be used to do community based TB care also (Herce, Chapman, Castro, Garcia-Salyano & Khoshnood 2010:183).

### ***2.9.2.3 LHWs in the treatment of Type 2 Diabetes Mellitus***

A study was done to assign newly diagnosed type 2 diabetes persons to CHWs' case management and the participants in the CHW group achieved greater improvement than the controls in health status, dietary habits and medication adherence. This was because of the counsellor/educator role of the CHWs (Babamoto, Sey, Camilleri, Karlan, Catalasan & Morisky 2009:2).

### ***2.9.2.4 LHWs in the treatment of asthma***

A study that was done on an asthma-related intervention found that there was a decrease in asthma-related illness – both per capita expenditures and asthma-related visits, after LHW intervention (Beckham, Kaahaaina, Voloch & Washburn 2004:121).

### **2.9.2.5 LHWs in HIV care**

The LHW has re-emerged as a significant phenomenon in health systems, largely in response to new funding for disease specific programmes and in the context of health worker shortages. They have become essential players in the provision of health care and form part of a broader mobilisation of communities and non-governmental participation in the health system, precipitated in Sub-Saharan Africa (SSA) by the HIV epidemic. LHWs can assume multiple roles and still perform adequately, but require training and support and a balance between generalist and specialist roles (Schneider & Lehmann 2010:65).

LHWs played an important role in the provision of HIV services that ranged from translation, adherence counselling, VCT and medication distribution (Joseph, Rigodon, Cancedda, Haidar, Lesia, Ramanagoela & Furin 2012:141).

### **2.9.3 LHWs in perinatal care**

A study was done in India to evaluate the feasibility and effectiveness of managing low birth weight and preterm neonates in the home setting. They compared the pre-intervention years (1995–1996) with the outcomes of the intervention years (1996–2003). Major co-morbidities like sepsis, asphyxia, hypothermia and feeding problems declined significantly where the village health workers intervened. Village health workers (VHW) attended deliveries that were conducted by traditional birth attendants and then recorded the pre-term births, weighed the newborns, re-visited the high risk neonates and weighed the babies every week until day 28. They also visited if the baby was sick. These VHWs also introduced kangaroo mother care to the villagers and referred babies to hospital if necessary. The researchers found that a majority of low birth weight infants can be managed at home and that only a small percentage would need referral (Bang, Baitule, Reddy, Deshmukh & Bang 2005:72).

### **2.10 LHW AS RESEARCH PARTICIPANT**

LHWs can be valuable assets as part of a research team, as their insights provide important information and perspectives that may not be accessible via other data

collection methods (Peacock, Issel, Townsell, Chapple-McGruder & Handler 2011:2275).

The most important issue for community-based participatory researchers is the relationship between outside researchers and community members. Both outside researchers and community members have needs and agendas, which may sometimes be shared and other times be divergent or conflicting, especially if professional researchers pursue their career advancement at the expense of the community. Investigators should carefully consider the role of CHWs in their communities, before creating research programmes that depend on the CHWs' existing social networks and their propensity to be natural helpers. These strengths could lead to compromises in research requirements for random assignment, control groups and fully informed consent (Terpstra, Coleman, Simon & Nebeker 2011:86).

Souder and Terry (2009:235) used the lay educators' approach to bridge the gap between the community and university-based research center. The Lay educator programme increased the progress in research efforts (Souder & Terry 2009:235).

A study was done in the Kalabo district in Zambia to determine the factors contributing to the low performance of community health workers. The results were, that it was the irregular and unreliable supply of drugs and the selection of the wrong people to be trained as CHWs, that caused the programme to be unsuccessful (Stekelenburg, Kyanamina & Wolfers 2003:109). The researchers suggested that the programme must be rehabilitated and also found that the community support and supervision was inadequate.

Community health workers' positive role as key agents in improving health has been widely documented. Because of their understanding of the social environment, they are able to work closely with families to enhance active patient participation – thus help to reduce the prevalence of hypertension and assist in the workload in primary health care facilities. For the latter it is essential that CHWs have the correct knowledge on the disease and not to spread around wrong beliefs (Sengwana & Puoane 2004:66).

Obesity was found to be a problem amongst urban black population groups. Community health workers were targeted as participants in a study, because they could

be used as change agents in their community. A participatory approach of assessment, analysis and action was used to collect baseline data from CHWs on barriers they experienced to health living, including risks factors, prevention and treatment of diabetes. The goal was to make participatory CHWs aware of their own need for behavioural changes and in assisting them to make these changes. They then could be used as change agents in their community (Puoane & Bradley 2003:29).

In the above two scenarios CHW were the participants, because if change regarding lifestyle took place for them, they could pass that on to their communities and integrate their own behavioural change into their health promotion activities.

Research was done in Detroit east USA, to address the social determinants of health, using a lay health adviser intervention approach. This partnership was used as an initiative that seeks to reduce the disproportionate health risks experienced by residents of Detroit east. The data describes improvements in research methods, practice activities and community relationships that emerged through this academic practice community linkage. Through the participation in research on partnership, the village health workers strengthened their relationships with each other. The community-based participatory research approach used in Detroit east offered opportunities for community academic and practice partners to work together to develop research questions, collect data, interpret that data and apply the study results to address jointly determined priorities for health (Schultz, Israel, Parker, Lockett, Hill & Wills 2001:549).

## **2.11 CONCLUSION**

This review of literature revealed various aspects regarding LHWs, namely: (1) definition of LHW; (2) cost-effectiveness of the LHW programme; (3) profile of the LHW; (4) goals of the LHW programme; (5) training; (6) functions and (7) the various roles performed by LHWs in various countries including South Africa.

It is clear that the role of the lay health worker may range from promotive activities, advocating simple preventative measures, to fostering wider community development. Activities on the curative pole represent the furthest outreach of conventional health services, while those that are at the promotion pole are expressions of broader concepts of health care. The particular position of each country's lay health worker

along this continuum will vary according to the level of development and penetration of conventional health services. The curative role may be less relevant where such demands are readily met by the formal health sector and the promotive role potentially relevant to countries at all levels of development.

The next chapter will be a discussion on the research design and methodology.

## **CHAPTER 3**

### **RESEARCH DESIGN AND METHODOLOGY**

#### **3.1 INTRODUCTION**

In chapter 1, the researcher gave a full outline of this dissertation and a brief orientation to the research design and methods. In chapter 2, a literature review was done. In this chapter, the researcher gives a complete discussion of the research design and methods used to collect and analyse the data. This study was carried out in three phases – phases 1, 2 and phase 3. In phase one the researcher explored the literature to obtain knowledge of the role of the lay health worker. In phase two the researcher explored and described the lay health workers' perception of their role in the rural Western Cape Province. Phase three entails the formulation and description of the guidelines for the role of lay health workers in the rural Western Cape. These guidelines may be used in any other rural area.

#### **3.2 PURPOSE OF THE STUDY**

In order to address the research question formulated in chapter 1 of this dissertation, the researcher stated her purposes therein as well, in the following manner.

##### **3.2.1 Purpose of phase 1**

The purpose of phase one was dealt with in chapter 2 of this dissertation as follows:

- To explore the literature in order to study the role of the lay health worker.

##### **3.2.2 Purpose of phase 2**

The purpose of phase two will be dealt with in chapter 4 of this dissertation as follows:

- To explore and describe lay health workers' perception of their role in the rural Western Cape Province.

### **3.2.3 Purpose of phase 3**

The purpose of phase three was dealt with in chapter 5 of this dissertation and stated in this manner:

- To formulate and describe guidelines for the role of lay health workers in the rural Western Cape Province.

The above-mentioned purposes of the research were achieved by utilisation of the appropriate research design as indicated in the following headings.

## **3.3 RESEARCH DESIGN**

The research design guides the researcher in planning and implementing the study in a way that is most likely to achieve the intended goal. The research design followed in this study is qualitative, explorative, descriptive and contextual as indicated in chapter 1. Each aspect of the design is dealt with fully in the following subheadings:

### **3.3.1 Qualitative aspect of the design**

A qualitative research design was chosen to explore the role of the lay health worker on farms. Qualitative research is a systematic, subjective approach used to describe life experiences and give them meaning. Insight was gained through the discovery of what the role of the lay health worker is, as they experienced it in their real world. The meaning of that role was discovered through their experiences. These insights were obtained, not through establishing causality, but through improving the comprehension of the researcher of the whole issue within a holistic framework. This design explored in-depth, the richness and complexity of the phenomena. Insight from this process guided the researcher and aided in the important process of building knowledge.

Specific philosophical orientations differ with each qualitative approach. The Phenomenology guided the methodology of this research. This qualitative approach is

based on a world view that is holistic and the researcher believes that there is no single reality in exploring the role of the lay health worker, but that this reality, based on perception, is different for each person and can change over time. What we know has meaning only within a given situation or context (Burns & Grove 2005:27).

### **3.3.2 Explorative aspect of the design**

One of the characteristics of a qualitative research design is that it is bound to be explorative by nature. The researcher did not know how the lay health worker on a farm sees his/her role and used a reasoning process, which involves perceptually putting pieces of information together, to get an idea of the whole picture. From this process, meaning was produced and the role of the lay health worker on farms was described. The researcher is open-minded to new gestalts that might emerge through the abstract thinking process and would actually “get outside” the theory to get a different perspective. With this design the researcher experienced the situation to best understand it. In order to see an alternative view of the role of the lay health worker, the information is deconstructed and then later in the process, reconstructed to describe the role in full. The intuition of the researcher was used and by becoming more open and receptive to experiencing the phenomenon, deeper layers of the phenomenon were explored (Burns & Grove 2005:27).

Viewing deeper layers requires second-order deconstruction and an additional increase in openness (ascendance) to open the context according to Ihde (1977) in Burns (2005:56). It allowed the researcher to see more depth and complexity within the phenomenon that was examined - thus the capacity for insight had been enlarged. Ihde (cited in Burns 2005:56) suggests that ascendance to the open context gives the researcher multi-stability and greater control than a sedimented view. Qualitative research provides a process through which the researcher can examine a phenomenon outside this sedimented view (Burns & Grove 2005:56).

### **3.3.3 Descriptive aspect of the design**

Apart from the explorative nature of qualitative research, it is important for the researcher to describe what she has observed during the fieldwork. Many different roles have been described for lay health workers according to the literature and because of

the dynamic content of this role, openness regarding the role of the LHW is needed, and this requires discipline by the researcher

The qualitative design was selected for this study, because of the flexibility and “open-hand” it gives the researcher to explore the phenomena of interest. The title of the study, namely the role of the lay health worker in a rural area, lends itself to discussions, one-on-one contact, subjectivity of the researcher and the participants, as well as connotations of deeper meaning to the content, than a list of statistics to be obtained as in quantitative studies. It was not the aim of the researcher to discover connections between variables, but rather to use creativity to explore, analyse and describe the specific content of the role of the farm lay health worker. The goal of most qualitative studies is to develop a rich understanding of phenomena as it exists in the real world and as it is constructed by the individuals in the context of their world (Polit & Beck 2004:247). This aspect of the design was used in this study to describe:

- LHWs' perception of their role in the rural area of the Western Cape
- Guidelines for the role of LHWs in the rural Western Cape.

### **3.3.4 Contextual aspect of the design**

Once the LHWs' perception of their role were described, it was important to contextualise the findings. Researchers in naturalistic tradition emphasise the inherent complexity of humans, their ability to shape and create their own experiences and the idea that truth is a composite of realities. The emphasis of this approach was on understanding the human experience as it is lived by the lay health workers, through the collection of qualitative materials that are narrative and subjective. Naturalistic inquiry always takes place in the field and collection of information and its analysis typically progresses concurrently. As researchers sift through information, insight is gained, new questions emerge and further evidence is sought to amplify or confirm insights. Through the inductive process the researcher integrated information to develop a description of the role of the lay health worker that helped to explicate the process under observation. Natural studies result in rich, in-depth information that has the potential to elucidate varied dimensions of a complicated phenomenon (Polit & Beck 2004:16).

Phenomenology is rooted in the philosophical tradition developed by Husserl and Heidegger. This is an approach to discover meaning of people's life experiences (Polit & Beck 2004:253).

This approach investigated subjective phenomena in the belief that critical truths about reality are grounded in people's lived experiences. There are four aspects of lived experience, namely lived space (spatiality); lived body (corporeality); lived time (temporality); and lived human relation (relationally). Phenomenologists believe that human existence is meaningful and interesting, because of people's consciousness of that experience. The person is an integral part of the environment and the worldview is shaped by the self and also shapes the self. The person is a "self" within a body - embodied - and has a world which is the meaningful set of relationships, practices and language that we have by virtue of being born in a culture. The person (lay health worker) is situated in the world as a consequence of being shaped by his/her world and thus is constrained in the ability to establish meanings through language, culture, history, purposes and values. This person has only situated freedom, not total freedom (Burns & Grove 2005:55).

Each lay health worker's world is different and each person's concerns are qualitatively different. The context in which each lay health worker perceived his/her role was different – the body, world and concerns were unique to each person. Heideggerians believe that the person experiences being within a framework of time - this is referred to as being-in-time. The reality of the lay health worker is unique to that person. The researcher also experienced the research experience in collecting data for the study and analysing it, as unique to the situation (Burns & Grove 2005:56).

### **3.4 RESEARCH METHODS**

The methodology of this research was based on understanding the experience of the lay health worker in his/her role. The researcher interpreted the explanation of their experience as described by the lay health worker. The research questions will supply answers to the necessary and sufficient constituents of the experiences of the lay health workers and what the existence of these feelings indicate, concerning the nature of their being. The sampling sought individuals who were willing to describe their experiences

about their perceptions of their role as lay health workers on farms (Burns & Grove 2005:55).

To apply the qualitative research design in this project, the study was conducted in three phases. During phase one a literature study was done to gain knowledge on the content of the role of the lay health worker. Phase two entailed the exploration of the perception of the lay health workers on their roles and phase three dealt with the description of guidelines for the role of lay health workers in the rural Western Cape Province.

A combination of data collection methods were used namely, focus group discussions and in-depth interviews where the researcher was involved personally. The researcher focused all awareness and energy on the subject of interest, to allow an increase in insight into the role of the lay health worker on farms. This process required absolute concentration and complete absorption with the experience. The context required the researcher to incline toward a nomothetical approach which searches for similarities, regularity and commonality.

#### **3.4.1 Phase 1: In-depth exploration of available literature**

An extensive search of the literature was done to obtain knowledge on the content of the role of the lay health worker. Some older sources mentioned a list of tasks that lay health workers need to do, but there was a decline towards the 1995–2004 period in new sources on lay health workers' roles. Different terms were used in the literature for lay health workers, home-carers, and etcetera. Chapter 2 dealt with literature review.

#### **3.4.2 Phase 2: The exploration of the perception of lay health workers on their roles in the rural Western Cape Province**

This phase dealt with the exploration of lay health workers' perception on their roles in a rural area of the Western Cape Province. In order for the researcher to achieve the aim of this phase it was important to identify the population and sample for this study. This phase begins with ethical considerations as follows in detail:

### **3.4.2.1 Ethical requirements**

Permission to conduct the study was secured from the Director of Health of the District Municipality where the research was to be conducted. The researcher also sought permission from the lay health workers who were eligible to participate in the study. A letter explaining the purpose of the study was sent to the Director of Health of the Cape Winelands District Municipality (Appendix B). The researcher received a written permission from the Director of Health (Appendix C). The participating lay health workers also signed an informed consent for the interviews to be audio-taped (Appendix D). This field research took place in the rural-based venue of the Western Cape. The emergent nature of the design emphasised the need for ongoing negotiation of consent with the participant. Because of the researcher – participant interaction, the research experience may become a therapeutic one and if it is therapeutic for the participant it is an unplanned benefit for the participant. The researcher was used as an instrument and must acknowledge bias. The researcher returned to the participants at critical interpretive points and asked for clarification on aspects regarding their roles (LoBiondo-Wood & Haber 2002:156.)

- **Protection of human rights**

Human rights are the claims and the demands that have been justified in the eyes of an individual or by a group of individuals. These rights apply to everyone involved in the research project, including the research team members involved in data collection and the subjects. All these rights are applicable on the participants of this study and were adhered to (Burns & Grove 2007:203).

- **Right to self-determination**

The above-mentioned right is based on the ethical principle of respect for persons. People should be treated as autonomous agents who have the freedom to choose without external controls. Participants were informed about the proposed study and they could choose to participate or not. They had the right to withdraw from the study without a penalty. Participants with diminished autonomy were entitled to protection. They were more vulnerable because of age, legal or mental incompetence, terminal illness or confinement to an institution. Justification for the use of vulnerable subjects

will be provided, but if the project manager chooses to select five participants this will be kept in mind (Burns & Grove 2007:204).

- **Right to privacy and dignity**

This right is based on the principle of respect. The participants gave input to determine time, extent and circumstances under which private information was shared or withheld from others (Burns & Grove 2007:209).

- **Right to anonymity and confidentiality**

Participants were not linked by their individual responses and stayed anonymous. Individual identities of subjects were not linked to the information they provided and were not publicly divulged (Burns & Grove 2007:212).

- **Right to fair treatment**

Based on the ethical principle of justice, participants were treated fairly and received what they were due, or owed for example a free meal, during a break. Participants were fairly selected as explained to them by their project manager and they were treated equally during the collection of data via the focus group discussion. The researcher treated them fairly and distributed risks and benefits equally regardless of race, age or socio-economic status (Burns & Grove 2007:213).

- **Right to protection from discomfort and harm**

Based on the ethical principle of beneficence, people must take an active role in promoting good and preventing harm in the world around them, during research studies as well. The researcher dealt with, or referred participants with physical, psychological, social or economic discomfort to appropriate resources nearby. (Burns & Grove 2007:214). A form for obtaining an informed consent was developed (Appendix C).

- **Rights of the institution**

Permission was obtained from the institutions where this research was conducted. These institutions will be informed of the results of the study when available and when permission is granted to do so by the university. There were no interruptions of the daily activities of the staff at the institutions and no information regarding the institution was made known publicly, without their consent.

- **Scientific honesty**

The researcher was honest and did not interfere with the results of the study, because the researcher was just as interested to see what the results might be. There was no bias and the researcher conducted this study professionally. The research process was conducted at the cost of the researcher and no harm was done to anyone. When problems arose, the researcher informed the supervisor immediately.

### ***3.4.2.2 Research population***

According to Burns and Grove (2005:474), the “population is all the elements that meet certain criteria for inclusion in a given universe”. The study population was the lay health workers who practise on farms in the Boland area. This included all farm health workers of all race groups, culture groups, male and female. These people could be volunteers or paid workers from different training backgrounds. They met the criteria as lay health workers, because they were not professional health workers. These lay health workers were able to weave together an agenda to help change individual circumstances, while insuring access to appropriate health care services. Such workers provide a community-based system of care and social support that compliments, but does not substitute the more specialised services of health care providers.

### ***3.4.2.3 Sample and sampling techniques***

A convenience, non-random, purposeful sample was used. The aim of qualitative studies is to discover meaning and to uncover multiple realities and therefore generalisability is not a guiding criterion. The sample was selected for the high potential for information richness (Polit & Beck 2004:305).

- **Eligibility**

Purposive sampling was undertaken, because the researcher wished to understand the particular group of farm lay health workers especially well. The guiding principle was that all participants must have experienced the phenomenon (the practice of lay health work) and must have been able to articulate what it was like to have lived that experience. Farm lay health workers who have done more than three years of lay health work on farms in the Boland were selected. They could be male or female. Participants had to come from different farms, because the researcher wanted to explore diversity of individual experiences.

- **Sample size and technique**

The sample size was five people to enhance the focus group discussion and to explore in-depth discussions individually if needed and guided by the members of the group. The manager of the farm lay health worker project was asked to select a group of five participants, who were willing to engage in a focus group discussion. These participants had to have at least three years of experience as lay health workers on farms and had to be from different farms. They had to be fluent in English or Afrikaans. The programme manager had to be able to give them time off to participate in the focus group discussions.

- **Limitations to overcome**

In a study of this nature, participants are human beings who all have their own problems and perceptions regarding the research situation. Human beings are unpredictable and the researcher could not predict how the participants' behaviour would be. The Boland is an Afrikaans speaking community. If the participants spoke Afrikaans all the data would have to be translated into English to fit the research report. The chosen participants would not have been willing to share all experiences regarding their role as lay health workers, if the researcher had not used her counselling skills to enhance the discussions. Transport to the venue for discussions was arranged and was not a problem.

### **3.5 METHOD OF DATA COLLECTION**

Data were gathered using focus group discussions and in-depth interviews. Qualitative researchers go out into the field knowing the most likely sources of data, while not ruling out other possible data sources that might come to light as data collection progresses. Data collection and analysis occur simultaneously and the procedure is complex. The researcher was totally involved - perceiving, reacting, interacting, reflecting, attaching meaning and recording. The nature of the researcher – participant relationship had an impact on the data collected and the interpretation. In this study most of the researcher's time was spent observing as participant and interviewing. Less time was spent in the participation role (Burns & Grove 2005:542).

#### **3.5.1 Pilot interviews**

A pilot interview was held in the Worcester area using the same methodology, i.e. a group interview as in the main study. A focus group with a short session of two people was held to test the methodology, the equipment and the data analysis approach. Problems that were encountered were rectified before the actual study began (Botma & Greeff 2010:275). The researcher also interacted with the supervisor in an attempt to address related issues.

#### **3.5.2 Focus group and interviews**

A focus group is a type of group interview in which a moderator (researcher) leads a discussion with a small group of individuals to examine in detail how the group members think and feel about a topic (Liamputtong 2009:68). Focus groups are designed to obtain participants' perception of a narrow subject in a setting that is permissive and non-threatening (Burns & Grove 2007:379).

A focus group was held with five participants over a period of three hours in the Paarl district in a selected venue that is within reach of the lay health workers and the researcher. The researcher kept the participants focused on the topic by asking a specific question. The question that was asked to generate discussion was: *"How do you perceive your role as lay health worker on the farms in the Boland area?"* The researcher generated the discussion with open-ended questions and acted as facilitator

of the group process. Qualitative data were collected in the own words of the participants. The group was homogeneous to promote discussions and to less likely result in cliques and coalitions. The researcher has good interpersonal skills and knows how to facilitate group discussions in order to get everyone involved. The researcher did not allow one or two people to dominate and if conflict arose, brought the group back to the task at hand. The researcher knew how to probe and ask more questions, or when the topic became exhausted.

The session was recorded and transcribed. The researcher took notes on issues that needed to be followed-up with more probing questions. The setting was quiet and the equipment functioned well. No interpreters were needed as the participants spoke a language that both researcher and participant could understand. The researcher was a good listener and observer and created an atmosphere of safety for the participants. Respect and authentic caring was essential. Data were safely stored and labelled on the same day as the interview. The researcher reminded the participants of the time, date and venue, two days prior to the focus group discussion and allowed breaks during the discussions. The location was a neutral one and acoustically amenable to audiotape recording. The participants received an incentive in the form of eats and drinks during the break. The researcher noted the following aspects:

- To gain trust amongst participants and to establish credibility, the researcher dressed, spoke and acted according to the customs and schedules of the participants.
- The pace of data collection was an exhausting experience taking concentration and energy, as well as emotional strain for which the researcher was prepared. Debriefing was done with a colleague.
- Participants were emotionally involved and the researcher also became involved in this way. The researcher did not try to solve their problems, nor share her own problems with them. The participants were referred to appropriate resources when necessary.
- The researcher reflected on her own behaviour, as she was part of the data collection process (Polit & Beck 2004:332).

### **3.5.3 In-depth individual unstructured interviews**

It was necessary to do follow up using in-depth individual interviews with some of the participants to help the researcher clarify certain issues identified during the focus group discussion. In in-depth individual unstructured interviews an attempt was made to understand how individuals experience their life-world and how they make sense of what was happening to them. Questions were thus directed at the participants' experiences, feelings, beliefs and convictions about the role as lay health workers (Liamputtong 2009:53).

With the interview, careful consideration was given to the wording and slang was understood by the researcher. Sensitive questions were asked later during the discussion when rapport had been established. Central questions were memorised to keep eye contact. A checklist of what would be needed for the interview was compiled beforehand.

## **3.6 METHOD OF DATA ANALYSIS**

Analysis began when the first data were collected and then guided the decisions which were related to further data collection. Meanings attached to the data were expressed within the phenomenological philosophy. Data were collected and then transcribed. (Appendix E). The reasoning process guided the organisation, reduction and clustering of the findings and led to the development of theoretical explanations. Transcription is the process of moving descriptions from the language of participants to the levels of abstraction and ultimately to the language of science. The researcher contemplated the phenomena under study while listening to the tape, reading the transcribed dialogue and became immersed in the data (Burns & Grove 2007:81). The following steps were followed during data analysis.

### **3.6.1 Coding**

Transcriptions were written on small bits of paper. It was coded by using different colour-codes, then organised and filed. All bits of data were cross-checked and a track of connections was kept. Coding was consistent with the philosophical base of this

explorative study. While data was organised, specific categories emerged and reflected the philosophical base used for the study.

Descriptive, interpretive and explanatory coding were used. Descriptive codes were written on different colours of paper and remained close to the terms used by the participants. Interpretive codes developed later as the researcher's insight was deepened. Reflective remarks were put in double brackets and marginal remarks were put in the right margin later in the data collecting process, after the contextual ideas began to emerge. The researcher memorised as she moved towards contextualising. It was dated and titled and immediately written on a memo pad (Burns & Grove 2007:82).

### **3.6.2 Process**

The process of data analysis developed as follows:

- Essences from transcribed descriptions were extracted. A complete expression of the core idea about the role of the lay health worker was given.
- Synthesising – the transcripts were written in the researcher's language to show how it was conceptualised by the researcher.
- Propositions were formulated from each participant's description. Core ideas were joined to synthesise essences from each participant's statement.
- Core concepts were extracted from the formulated propositions of all participants. Ideas were written in a phrase that captured the central meaning of the propositions.
- A structure of lived experiences from the extracted concepts was synthesised. Statements conceptualised by the researcher were joined together as core concepts. The structure evolved to answer the research question. The results of this analysis were moved up another level of abstraction to represent the meaning of a lived experience.
- The outcome was focused on issues of truth (validity) and beauty (aesthetics). The reader was presented with both structure and texture of the experience (Burns & Grove 2005:551).

### **3.6.3 Drawing and verifying conclusions**

While organising data, themes and patterns were noted. Aspects like plausibility, clustering and etcetera were noted. Variables were split and metaphors were made up. Particulars were subsumed into the general themes and factoring was used. Note was given to relationships between variables and intervening variables were sought. This was all done to achieve the building of a logical chain of evidence and making conceptual coherence to analyse the content of the data collected (Burns & Grove 2005:553).

### **3.6.4 Literature control**

According to Burns and Grove (2007:138), it was important to conduct literature review after analysing the data. The purpose to review the literature in a qualitative study is to place the findings in the context of what is already known about the topic (Burns & Grove 2007:138). In this study the researcher discussed themes that emerged from the results in the light of relevant literature and information obtained on the role of the lay health worker. Similarities and differences between this research and previous research were discussed, as well as the contribution of this research (Burns & Grove 2007:138). The researcher applied measures of trustworthiness to ensure that results are accepted by all the members of the scientific community as authentic without reasonable doubt.

## **3.7 TRUSTWORTHINESS**

### **3.7.1 Credibility (truth value)**

To ensure valid results, the researcher used a model of trustworthiness proposed by Lincoln and Guba (1985) cited in Marshall and Rossman (2006:201). The following criteria for trustworthiness were applied in this research: truth-value, applicability, consistency and neutrality. These criteria were used according to its applicability in the context of the study.

They refer to the confidence in the truth of the data and the interpretation thereof (Polit & Beck 2004:430). Credibility involves two aspects namely: carrying out a study in a

way that enhances the believability of the findings and taking steps to demonstrate the credibility to consumers. The researcher took the following steps to enhance the credibility of this study:

- The researcher was engaged in the study for a long time and persistent observation was done of literature on the topic.
- Triangulation: The researcher visited the participants twice at different points in time. The first visit was to collect the data and the second visit was to present the data to confer whether the group supported the findings. The data was obtained at one site and from one group of participants. A pilot study was done at a different site and with a different smaller group to test the methodology. The investigation entailed the help of the study leader, as well as a colleague who checked the findings. The Neuman systems model was used. The method of this model entails the observation of verbal and non-verbal behaviour, focus group discussion, as well as one-on-one interviews if needed.
- Peer debriefing was done that involved sessions with colleagues to review and explore various ways of inquiry.
- Member checking was done when feedback regarding the emerging data was discussed with participants and their interpretations and reactions were noted.
- Participants could correct the researcher's representation of their worlds.
- Data was searched for disconfirming evidence.
- The researcher is a trustworthy person and has the qualifications to adhere to this study. She used her experience to reflect and report on personal things that have an effect on data analysis and interpretation (Marshall & Rossman 2011:41; Polit & Beck 2004:430).

### **3.7.2 Dependability (consistency)**

Dependability refers to the stability of the data over time and over conditions. A step-wise replication was done – pilot group and real groups, as well as an inquiry audit from the external reviewer (study leader). The key to qualitative research is to learn from informants rather than controlling them. The researcher conducted focus-group discussions which were audio-taped to ensure audit trail. The researcher needed a step-by-step method of data analysis and employed literature control to verify collected

data. The full method of data collection and analysis was explained (Polit & Beck 2004:430).

### **3.7.3 Confirmability (neutrality)**

Confirmability refers to the objectivity or neutrality of the data. An audit trail will be available for inspection for example the raw data, notes, process notes, reflexive notes, forms, drafts and the final report. Conformability captures the traditional concept of objectivity (De Vos et al 2005:347).

### **3.7.4 Transferability (applicability)**

It is hoped that data about the role of the lay health worker on farms in the Boland can be generalised to the description of the role of all farm lay health workers (Polit & Beck 2004:430).

## **3.8 PHASE 3: THE DESCRIPTION AND DEVELOPMENT OF GUIDELINES FOR THE ROLE OF LAY HEALTH WORKERS IN THE RURAL AREA OF THE WESTERN CAPE PROVINCE**

This phase dealt with the development and description of guidelines for the role of the lay health workers in the rural area of the Western Cape. A deductive reasoning strategy was used by the researcher to arrive at the appropriate guidelines to describe the role of the lay health worker in a rural area. According to the American Heritage Dictionary of the English Language (2009), a guideline “is a statement or other indication of policy or procedure, by which to determine a course of action”. Following a guideline is never mandatory, but these can be utilised to guide the role of the lay health worker. “Clinical guidelines are systematically developed statements to assist practitioners and clients to adopt appropriate health care practices for specific clinical circumstances” according to Thompson and Dowding (2002:148).

In this study, guidelines are regarded as a framework for lay health workers, managers and other health care professionals to understand the role of LHWs and to know what this role entails in meeting the health care needs of the community. These guidelines will also be utilised to translate recommendations into practice for appropriate service

delivery by LHWs to farming communities in the Boland area. Practice guidelines do not dictate a specific course of action, but are recommendations that are systematically developed to support LHWs to facilitate their role in the rural community. The aim of clinical guidelines is to improve quality of care by translating new research findings into practice (Wollersheim, Burgers & Grol 2005:188).

### **3.8.1 Purpose of guidelines**

Guidelines serve different purposes, but in this study the purposes of the guidelines were to:

- provide a framework for LHWs to understand their role in the community they serve and to act accordingly
- generalise the role and function for LHWs, serving in rural communities
- improve the quality of service to the rural community, to enhance their quality of life and health status
- provide district managers, health professionals and other role players, insight into the role of LHWs in rural communities

### **3.8.2 Process of developing the guidelines**

In the context of this study, the development of guidelines was guided by the survey list of Dickoff, James and Wiedenbach (1968:478), cited in Meleis (2007:155). Dickoff and colleagues recognised the value-laden nature of theory in nursing and called for an explicit recognition and naming of values, toward which theory development was proceeding. The inclusion of values within the theory structure and the recognition of that theory was more a flexible guide to practice which provided a revolutionary view of empiric knowledge. Following is a detailed exploration and application of the concepts of the survey list model.

Guidelines were externally peer reviewed by experts for clarity, internal consistency, as well as acceptability and representativeness which ensured depth and quality of the guidelines.

### **3.9 CONCLUSION**

The research design and methodology of the study of the role of farm lay health workers have been discussed, as well as the ethical requirements to conduct the study. The next section will be a discussion of the research findings and literature control.

## **CHAPTER 4**

### **DISCUSSION OF RESEARCH FINDINGS**

#### **4.1 INTRODUCTION**

In chapter 2, an extensive literature search was conducted to seek knowledge on the role of the lay health worker. This formed phase one of the study and was dealt with in chapter 2 of this dissertation. The research design and methodology was discussed in chapter 3. In-depth individual interviews were also held in the rural area of the Western Cape Province to allow farm lay health workers to describe their role in the community as they perceived it on the farms in the Boland area of the Western Cape. This chapter discusses research findings in providing an answer to the research purpose of phase two of the dissertation, which is to explore and describe lay health workers' perception of their role in the rural Western Cape.

#### **4.2 SAMPLE DESCRIPTION**

A convenience, non-random, purposeful sample was used. The supervisor of the lay health worker project chose five individuals from different farms in the Boland who were willing to describe their experiences about their role as lay health workers. Farm lay health workers, who had more than three years of lay health work on farms in the Boland area of the Western Cape were selected. Four females and one male agreed to spend time with the researcher. These five coloured people communicated in Afrikaans.

Four of the participants had a life-partner and the mean age of the group was 37. All were casually dressed and the discussion took place in a relaxed atmosphere at a venue situated between the mountains of the Western Cape. Those that had children were satisfied that the children were cared for, while their parents were taking part in the in-depth individual interviews. Four of the participants had formal schooling – the highest grade that was reached, was grade nine – but all could read and write. They all had training as lay health workers through an initiative from a rural development trust. The training differed from four weeks to six months, while all in the group had follow-up training sessions on a regular basis (see table 4.1 for the sample characteristics).

**Table 4.1 Characteristics of the sample (N=5)**

Participant	Age	Race	Gender	Language	Life partner	Children	Level of Education(grade)	Years as LHW	Training as LHW(weeks)	Follow-up training
1	36	C	Male	Afrikaans	Yes	2	7	5	24	Yes
2	43	C	Female	Afrikaans	Yes	3	8	6	8	Yes
3	42	C	Female	Afrikaans	Yes	3	9	6	12	Yes
4	26	C	Female	Afrikaans	No	1	9	4	12	Yes
5	40	C	Female	Afrikaans	Yes	2	None	5	4	Yes

### **4.3 FIELDWORK EXPERIENCE**

The researcher experienced the fieldwork as very exciting, but also challenging. As a professional primary health care nurse, the researcher felt at ease with the participants and could understand their language and level of interaction. The researcher could relate to the circumstances on farms and could identify with the group.

The challenging part was that the researcher has a soft spot for people on farms and she had to bracket prejudices, values and beliefs. The researcher wanted to solve some of the farm workers' problems immediately and to curtail this she used bracketing and memo's, for follow-up at a later stage. The participants agreed to sign informed consent to participate in the focus group discussion after the researcher explained the purpose, format and proceedings (Appendix C).

This permitted audiotaping of the entire in-depth individual interviews to take place. Only one research question was asked at all the interview sessions held with lay health workers. The researcher used facilitative communication skills to encourage participants to communicate during interview sessions. Interviewees needed reassurance that their discussions would remain confidential.

The researcher had to drive more than 200 kilometers to take some of the research participants home to the different farms where they stay. This was made pleasant by singing songs while driving this long distance to overcome the transport problem.

After each and every interview, all the tapes were transcribed verbatim and the transcriptions were read and reread. Themes and categories emerged and were marked by using coloured stickers. Patterns of repetition were seen and a consensus on these themes was reached with a colleague who acted as an independent qualitative research data analysis expert.

#### **4.4 THE ROLE OF LAY HEALTH WORKERS**

According to Andrews et al (2004:359) the lay health workers serve as liaisons between community members and health providers by promoting community advocacy and capacity building, providing cultural mediation, counselling, social support and health education and also by promoting attendance at appointments and adherence to medications.

While the researcher was deconstructing the transcribed information, it became clear that the lay health workers had multifaceted roles and that no single definition could be formulated as the lay health workers participate in many different health promoting programmes within the community (see figure 4.1).

During collection and analysis of data the researcher identified five main themes associated with the role of lay health workers in the community. These themes are discussed in detail in the following headings.

#### 4.4.1 Perception of the lay health worker as a link in the community

The LHW serves as a link in the community. According to Andrews et al (2004:358) lay health workers were effective in increasing access to health services (Andrews et al 2004:358). This was confirmed by the lay health workers in the study when saying:

“...we serve as link in the community...”; “...the sisters (registered nurses) are there to help us and they will write back to us...”.

The participants perceived this linkage to be between themselves and the professional health care services, between the employer and employee as being the first health level contact and also to be a link between the patient and other formal structures. Table 4.2 describes the categories and sub-categories associated with this theme.

**Table 4.2 Perception of the LHW as a link in the community**

<b>4.4.1.1</b>	<b><i>Link between the community and professional health care services</i></b> <ul style="list-style-type: none"><li>• First level health contact</li><li>• Referrals of patients/clients to satellite clinics</li></ul>
<b>4.4.1.2</b>	<b><i>Link between the employer and the employee</i></b> <ul style="list-style-type: none"><li>• Liaison/mediation</li></ul>
<b>4.4.1.3</b>	<b><i>Link between the patient/client and other formal structures</i></b> <ul style="list-style-type: none"><li>• Help farm workers apply for social grants</li><li>• Assist with the placement of children in need</li></ul>

##### **4.4.1.1 Link between the community and professional health care services**

The LHW is the link between the community members on the farm and the professional primary health care services. The primary health care services offered by the local district municipality entail comprehensive clinics that are open for five days a week. This is complemented by mobile units which visit the farms on an interval of two to four weeks. The patients rely on this service for all their health-related needs. The professional staff needs a specific contact person on each farm to refer patients to for follow-up care, someone who will manage the treatment of the patient. They also need to get feedback on health related problems on a farm. The LHWs are in the ideal

position to carry out this task. They also take care of the people on the farm during the intervals where the professional services are not available. This category dealt with two sub-categories (1) first level health contact; and (2) referrals of patients or clients. These sub-categories are dealt with as follows:

- **First level health contact**

According to the primary health care (PHC) definition, it is the first level contact of individuals, the family and community with a national health system (World Health Organization 1978:2-3). The findings of this study were in line with this view, in that LHW felt they look out for all the health related problems on a farm and act immediately before any other health service can reach the farm.

..."we are the eyes and ears on the ground..."

It became clear that they are very involved with the farm life, people and community and they love their peers. They act as mediators for farm workers and they listen to their problems.

"We are very involved...love the people...listen to them..."; "...we inform the farmer so he can understand why a person is not working..."; "...when crimes are involved we do not take sides, but listen to both parties..."

The LHW can become a very trustworthy person on the farm and the mere fact that there is a LHW can help solve a lot of problems. Even the police service uses the LHWs as mediators between themselves and the community. If there are absentees on the farm, the LHW can assist the farmer in controlling the production by informing him of the amount, dates, prognosis, etc. of absenteeism.

LHWs are trained to be on the lookout for health problems and can prevent catastrophes by detecting a communicable disease early. Dick (2001:19) found that LHWs who were involved in TB programmes were useful to be on the lookout for other related problems. The author cited that the LHWs became so involved, that it led to community development (Dick 2001:19).

Heman (2011:354) confirmed this statement that, as natural helpers, the CHWs play an important role in connecting public and primary care, because as natural helpers, they understand the community that they serve.

- **Referrals of patients or clients to satellite clinics**

Apart from being an entry point into the community, LHWs make referrals of patients to mobile and satellite clinics by means of written referral letters or telephone calls. They treat people with minor ailments and other problems and then refer them to the nearest primary health care service, who in turn will contact the lay health worker again for follow-up work on the farm. Patients will not go missing with this “bridge” that the lay health workers built. This ensures a constant referral source for LHW, client and primary health care service, especially where distance and transport is a problem:

“...we are the referral source for people in the community”.

Without LHWs it could take days/weeks for a farm worker to come in contact with a formal health care provider.

#### ***4.4.1.2 Link between the employer and the employee***

The LHWs perceived their role as being the contact person or link or speaker between the employee and the employer. Both parties need to know what is happening concerning health related matters on the farm. It is impossible for the farmer to know every individual's health problems, when they need to go to the clinic, when they have a serious health problem and when they need the employer's support or need to be excused from work or to go on light duty. The employees need to know where they stand about transport to the clinic, sick leave, burial assistance and compassion from the employer. This is all the information that the LHW will convey between the two parties.

- **Liaison person**

The LHW also serve as liaison person between the farmer and the farm workers. The LHW does not just serve the sick people, but also acts as link to the other people to convey their situation to the employer. All the affairs concerning the farm workers are grouped together and discussed with the farmer in a formal manner. This makes issues easier to handle on the farm and keeps the farmer, as well as all the employees informed.

The LHW will serve as a mediator between the farmer and employee should a problem arise concerning the health needs on a farm. This is very positive for labour relations and gives structure on the farm. As far back as 1989 Matomora wrote that LHWs must serve the communities they live in and that they must be “change agents” (Matomora 1989:108).

Without embeddedness CHWs will be unable to successfully perform the socially oriented tasks, such as health education and counselling (Campbell & Scott 2011:125).

The farm workers may complain about the hygiene on the farm or housing circumstances. The LHW can then lobby with the employer to explain the effect on their health so that the farmer can improve the living conditions for the people. An informed farmer will not expect sick people to do harsh jobs and the farmer can convey his condolences and support through the LHW to his workers. This was what they had to say about this:

“...peoples contact on the farm...”; “...tell the farmer what his employees are saying...”; “...people shy...do not want to talk to farmer...”.

#### **4.4.1.3 Link between the patient/client and other formal structures**

The LHW serves as a link between the farm workers and the social services and other formal structures like the police and education departments. They assist the farm workers to apply for social grants, as well as to help with the placement of children. They know the community they serve and also know the different circumstances of families. They are trained, can read and write and assist other illiterate farm workers to

complete the necessary forms. In this way they assist to empower farm workers. In this category two sub-categories were identified and are discussed:

- **Help farm workers apply for social grants**

Farm workers are also affected by the social-economic struggle in this country. They are sometimes too sick or old to work. They have children to feed and clothe and sometimes are single parents. They are informed by the LHW of ways to improve their lives and are assisted to complete forms for social grants. They are also escorted to court by the LHW if necessary. Social workers normally involve the LHW for information on a family if necessary.

LHWs help people on the farm, i.e. single mothers, the elderly and disabled people to apply for social grants. They obtain the forms for them, help them to complete the forms and if necessary even administer that grant. They help the client to draw up a budget to survive on the little money that they get from the grant.

Many a time the people on farms are not able to read or write properly due to a lack of schooling or due to communication problems. The LHW plays a vital role in helping these people to apply for social grants.

- **Assist with the placement of children in need**

The LHW knows the families and their circumstances on the farm. When it is necessary, neglected or abused children will be placed with other families for care. The LHW also assists the social worker and police in their investigations regarding these affairs. They also give feedback to the social services regarding the adaptation of the children to these placements in different environments. Rennert and Koop (2009:9) concluded that CHWs in remote underserved communities can address problems in caring for children (Rennert & Koop 2009:9).

#### **4.4.2 Perception of the lay health worker as a carer**

The lay health worker is a holistic carer to people living in the community. This care ranges from birth to old age to both male and female farm workers. Andrews et al

(2004:358) argues that LHWs provide social support and cost-effective care which was confirmed with the exploration of the role of the farm lay health workers (Andrews et al 2004:358).

This care should be culturally sensitive and LHWs on farms are in the ideal position to render this care as they live in the same cultural group on the farm (Nemcek & Sabattier 2003:263). It is important to be aware of the profile of CHWs when considering the indigenous population in terms of culture, language and gender issues (Brown et al 2006:2).

**Table 4.3 Perception of the LHW as a carer**

<p><b>4.4.2.1</b> <i>Gathers information about illness</i></p> <ul style="list-style-type: none"> <li>• Provision of information to the farmer about sick employees</li> <li>• Act as a resource person for the patient on the farms</li> </ul> <p><b>4.4.2.2</b> <i>Provides first aid and treatment of minor ailments to farms workers</i></p> <ul style="list-style-type: none"> <li>• Treatment of minor cuts and bruises</li> <li>• Treatment of minor ailments</li> </ul> <p><b>4.4.2.3</b> <i>Provides care to the sick farm workers</i></p> <ul style="list-style-type: none"> <li>• Washing and feeding of deserted patients</li> <li>• Administration of medicines to the patient</li> </ul> <p><b>4.4.2.4</b> <i>Accompanies people to hospital</i></p> <ul style="list-style-type: none"> <li>• Resource information about the patient to formal health structures</li> </ul> <p><b>4.4.2.5</b> <i>Searches for particular patients</i></p> <ul style="list-style-type: none"> <li>• Assist with finding contacts</li> <li>• Assist with searching for the chronically ill patients on farms</li> </ul> <p><b>4.4.2.6</b> <i>Provides family support on farms</i></p> <p><b>4.4.2.7</b> <i>Cares for abused children on farms</i></p> <p><b>4.4.2.8</b> <i>Assists with the assessment of the mentally impaired on farms</i></p> <p><b>4.4.2.9</b> <i>Assists with the care for the aged on farms</i></p> <ul style="list-style-type: none"> <li>• Promotes excursions and support groups for the elderly</li> </ul> <p><b>4.4.2.10</b> <i>Assists with care for the dying on farms</i></p> <p><b>4.4.2.11</b> <i>Assists with record-keeping and administration</i></p>
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#### **4.4.2.1 Gathers information about illness**

LHWs gather information on the farms about illnesses, complaints, social problems, risks, pregnant women, health information needs by means of home visits.. They are also the informant to the employer about the health situation on the farm:

“...if people are sick...inform the farmer”.

Lewin et al (2005:13) found that as little as one home visit to a family can alter health behaviour and bring benefits to a client (Lewin et al 2005:13). Two sub-categories were identified under this category and are discussed:

- **Provision of information to the farmer about sick employees**

The LHW will inform the employer about how many ill people are on his farm. He/she will convey all the necessary information about the illnesses and how it will affect the labour situation on the farm. The employer will be informed about how many people the LHW is caring for and what the extent of this care will be. This will aid the employer to act regarding the necessary replacements or to seek formal assistance from the professional authorities.

By informing the employer of the amount of health related problems on his farm, the LHW can help him to act preventatively to avoid a crisis. If there are a number of cases of gastroenteritis on a farm the employer must be made aware of this. The source of the infection should be determined with help from the health inspector if needed. If there are many people with tuberculosis on the farm, the employer may need to have all his farm workers screened for this infection. If the farmer is not informed about the illnesses and health situation on his farm, he may not act in time to prevent a catastrophe.

- **Acts as a resource person for the patient on the farms**

Lay health workers are trained to have information available regarding the cause, spread and treatment of diseases. Farm workers can gain knowledge on different

diseases by communication with their lay health worker. This will empower the farm worker to improve his/her health and to seek preventative care if needed.

#### **4.4.2.2 Provides first aid and treatment of minor ailments to farm workers**

Whenever there is an incident or accident on the farm, the LHW is called in to assist. They are trained to level two in first aid and can apply their knowledge to prevent serious complications to injured persons. They treat minor cuts and bruises, as well as attend to complaints like stomach aches, headaches, diarrhoea, colds, and etcetera.

- **Treatment of minor cuts and bruises**

All minor cuts and bruises are treated on a first aid level. Lay health workers are not trained to suture wounds. They will call for ambulance assistance or the farmer will transport these cases to a trauma unit. The LHW can however stop the bleeding and thus prevent major complications, like shock.

LHWs have a wide range of activities in their scope of practice, including first aid and the treatment of common ailments (Lehmann & Sanders 2007:8).

- **Treatment of minor ailments**

The LHWs' perception of their role in the treatment of minor ailments evolves mainly around the precaution and treatment of stomach cramps and diarrhoea. They are very involved with the prevention campaigns to stop the death of children because of dehydration. They know the rehydration recipe by heart and will convey this information to each and every member on the farm.

Lay health workers know how to treat minor colds and flu. They also rely on traditional medicines like herbs to prevent a cold from advancing to a more serious illness, like pneumonia.

#### **4.4.2.3 Provides care to the sick farm workers**

LHWs must provide care for sick people on the farm and assist mothers with sick babies to guide them and help them to get well again. They also have to care for the deserted in the case of AIDS patients that are rejected by their families. They have to provide not only the care but also food, linen, blankets, etcetera as stated:

“...families throw sick person out”.

- **Washing and feeding of deserted patients**

Patients are given a full bed wash daily in some circumstances and at other times the LHW will assist the sick, dying or elderly in doing a half-wash. They assist these people to brush their teeth, empty the urine bags or colostomy bags. All these things are done in very primitive conditions and without any luxuries.

The LHW knows the ingredients of a well-balanced diet, as well as constrictions for instance with a diabetic diet. They will prepare food for the elderly and feed the sick people on the farm. Many of these ingredients will be obtained from self-prepared food gardens on these farms. The LHW also gives advice regarding healthy eating habits and will support the obese patient with a dietary problem.

Newly diagnosed type 2 persons with diabetes were also assigned to LHWs for case management in the community (Babamoto et al 2009:2).

- **Administration of medicines to the patient**

The LHW plays a major role in the buddy system for the treatment of tuberculosis. The clinic sister will give the medication to a LHW to administer these on a daily basis to the patient. The LHW also assists the people with hypertension and diabetes to take their medication regularly. The LHWs are crucial support when a patient has to complete a course of antibiotics, especially children, and they will inform the clinic sister if there is a problem.

#### **4.4.2.4 Accompanies people to hospital**

Sometimes it is necessary for the LHW to accompany the patient to hospital and act as a resource person to provide background and information regarding the patient's illness. Many of these farm workers do not understand their problems or might not have a relative to support them with hospital visits. The LHW must be available day and night for any emergencies:

“...must go to hospital at night”.

- **Resource information about the patient to formal health structures**

Every LHW has a resource “centre” about people on a particular farm. These records are kept in an office or in the house of the LHW. These records contain all particulars regarding a specific patient and household. When the professional services like a hospital need the information, then the LHW can provide this information quickly and efficiently.

Patients are generally scared and anxious when they have to go to hospital. The lay health worker who accompanies the person to hospital forms a vital support structure.

#### **4.4.2.5 Searches for particular patients**

In areas where transport and distance is a problem, the LHWs on the farms assist the professional services to search for patients. The LHWs know the farming community and also know the families and where they live. They also know when there are visitors on the farm, or when a family member is away from the farm.

- **Assists with finding contacts**

In the event of a patient not completing, for instance his/her treatment for tuberculosis, the lay health worker is contacted by the clinic to search for this person on the farm. The LHW must then refer that person to the clinic and do the follow-up work. LHWs also follow-up on contacts of persons with a disease like HIV or other sexually transmitted infections.

“...if the sister phones...looking for client...we know them and send them to the clinic...”.

Nemcek and Sabattier (2003:263) found that the LHW had a very important role to play in case finding . The lay health worker is in the ideal position to encourage patients and clients to start or resume treatment.

- **Assists with searching for the chronically ill patients on farms**

The LHWs perceived their role to be an important one, when it comes to detecting a chronically ill patient. They know the effect of diabetes and hypertension on the body and will do their utmost best to help prevent these complications. They assist the community health nurse to help patients adhere to treatment regimes and also support these patients. They will be on the lookout for defaulters and will contact the nearest clinic if a problem persists. “CHWs work with clients, to address health issues, for instance chronic disease prevention and healthcare access” (Ingram et al 2012:529).

#### ***4.4.2.6 Provides family support on farms***

LHWs work with families, and individuals as well. They get involved in family quarrels, act as mediator between spouses, help children with schoolwork and do aftercare for children who have lost their parents. They try very hard to keep families together, but if necessary they will support spouses and children in divorce cases. They advise pregnant women, help with breastfeeding, setting up of vegetable gardens and teach the family healthy habits.

In some instances it is necessary for the LHW to obtain food parcels, linen and blankets to hand to the poor on the farm. The LHW has a good link with social services and with other resources like the hospice, Salvation Army and other donors to get these items and to help these needy families. LHWs are comforters for all families on a farm. They are available to families in crisis and are willing to be on standby for 24 hours of the day.

#### **4.4.2.7 Cares for abused children on farms**

When children are abused, the lay health worker assists the social worker to take the children to a place of safety. They then have to counsel the family and arrange for visitation. If the perpetrator is a family member and goes to prison, the LHW must again arrange for a social grant for the family. They inform the employer and comfort the family. They visit abused children and assist with all the follow-up work that is necessary. All cases of abuse are brought under the attention of the LHW to take action.

Sometimes it is necessary for the LHW to take in abused children until the social worker can place them in a selected family. At times it may be necessary for these children to stay with the LHW for some time. They feed, clothe and comfort these children. Their homes are more often a place of safety for abused children. When a family has a case of abuse in their household, the LHW must do the follow-up work and assist the family to “heal”. Sometimes the abuser is the head of the household and may therefore go to jail and then there are a number of issues that the family has to deal with. The LHW assists these families in the line of all these crises.

#### **4.4.2.8 Assists with the assessment of the mentally impaired on farms**

The LHWs are faced with many challenges. They sometimes have to evaluate if a person is mentally stable. They help to administer medication to the psychiatric patients on the farm and refer them for follow-up visits at the clinic. If that person or any other person on the farm becomes unstable, then the LHW is the evaluator of the situation. It is expected of them to call the police, give an affidavit, accompany the patient to the mental institution and reassure the family:

“...and go with patient to police and mental institution”.

#### **4.4.2.9 Assists with the care of the aged on farms**

The special care of the aged is another role where the LHWs act as carers. They assist the elderly with daily chores and sometimes have to feed and wash them if there is no

family on the farm. They oversee the medication that they are using and help them with the obtaining and administering of the pension:

“...must see that they are not robbed of their pension”.

- **Promotes excursions and support groups for the elderly**

The elderly are many times neglected, are frail and uncared for. LHWs arrange special day trips to nearby farms, to choir appearances and to town to help the elderly to enjoy their lives up to the last minute. LHWs arrange with the nearby clinic for special days for the elderly to help them with foot care, hypertension problems and eye sight. They will assist if necessary, the elderly to obtain spectacles and walking aids.

On some of the farms the LHWs started support groups for the elderly. They meet monthly and discuss themes like eyesight, staying strong and healthy and their testament. Here they learn from each other and share their special interests like bird watching.

#### ***4.4.2.10 Assists with care for the dying on farms***

When a person dies on a farm, the lay health worker is called in to do everything regarding that death. Female LHWs take on tasks like palliative care and treatment support (Daniels et al 2012:8).

It is sometimes necessary for the LHW to identify the body, give a statement to the police and arrange the burial. They support the family and do bereavement counselling. The LHW knows the people on a farm and will sometimes be asked by the police to identify the body of a deceased person. They will also assist the district surgeon to make a final diagnosis regarding the cause of death.

A death in a family can be disastrous, especially where no funds are available for burials to take place. The LHW will assist these families to obtain the necessary funding and will arrange the burial. They will contact the priest or minister and together with the other women on a farm will arrange the food and accommodation for burial goers. Long

after the neighbours, friends, other family members have left, the LHW will stay with the bereaved. Months after the burial, the LHW will still be available for comfort to a family:

“...you have to do everything...”; “...lay body out...”.

#### **4.4.2.11 Assists with record-keeping and administration**

LHWs must keep a record of everything they have done, as well as keep statistics for the farm that they are working for. They have to make phone calls, write referral letters, fill in forms and do weight plotting on the road to health charts:

“...we do weight plotting after weighing the babies...”; “...we have to write down all we have done and what we observe...”; “...we have to write a letter to refer a person for a sputum test...”.

The particular forms and lists that have to be kept by the LHW will depend on the firm that has done their training. Sometimes the primary health care service will provide the kind of records that must be kept. All records of patients must be legally complied with and kept for a minimum of 10 years.

All the children under five must be weighed monthly by the LHW. These weights are plotted on a road to health card provided by the primary health care clinic. LHWs are taught how to interpret these percentile lines and will refer the child to the clinic immediately should a problem arise.

All cases that are referred to the clinic must have a referral letter. These can be in a specified format, but sometimes the LHW just has to write a short note to the clinic sister regarding the ailment or circumstances of the individual.

#### **4.4.3 Perception of the LHW as a community developer**

It also became clear that LHWs are community developers on farms. The lay health worker promotes the use of available healthy foods, emphasises the benefits of improved sanitation and hygiene to prevent disease. Rural communities rely on each other for support and the LHW helps the community to work together. They have few

other support structures, live far apart and transport is not good. Community Health Workers make a valuable contribution to community development and their actions can lead to improved health outcomes (Lehmann & Sanders 2007:1).

**Table 4.4 Perception of the LHW as a community developer**

<b>4.4.3.1</b>	<b><i>Makes a difference in lives of people</i></b>
<b>4.4.3.2</b>	<b><i>Reacts to community needs</i></b>
<b>4.4.3.3</b>	<b><i>Initiates community activities</i></b>
<b>4.4.3.4</b>	<b><i>Promotes self-care on farms among workers</i></b> <ul style="list-style-type: none"><li>• Provides motivation for the youth on farms</li><li>• Empower farm workers</li></ul>
<b>4.4.3.5</b>	<b><i>Promotes spiritual care for women on farms</i></b>
<b>4.4.3.6</b>	<b><i>Promotes hygiene on farms</i></b>
<b>4.4.3.7</b>	<b><i>Arranges community meetings</i></b>
<b>4.4.3.9</b>	<b><i>Acts as research participant</i></b>

#### **4.4.3.1 *Makes a difference in lives of people***

The LHW makes a difference in the lives of people in the community as they motivate people to live a better life. They arrange events and functions and help families to bond and care for each other.

Circumstances are sometimes not too rosy for the poorer farming communities and LHWs endeavour to motivate people to lust for life by setting an example by living a healthy lifestyle. The LHW needs to be optimistic and always has to provide alternative outcomes for negative people by ensuring a balanced kind of lifestyle. As mentioned – the future might not look so good and prosperous especially for the youth on farms. The LHW helps the youth to develop a career by attending school regularly and helps them to set goals to follow a specific career path in life.

“...to take time off their hands...”.

“...bonding of parents and children”.

The above make the children more secure and they can focus on the future.

Van Zyl (2003:4) found that the process of having a LHW available led to an educational process that was disseminated by these LHWs to enhance a positive cycle of social development amongst the underprivileged communities (Van Zyl 2003:4).

The “sakhis” in the Mumbai study wanted to share knowledge and experiences and care seeking behaviour with their peers (Alcock et al 2009:957).

#### **4.4.3.2 *Reacts to community needs***

LHWs must react to the specific needs of a particular community. If necessary they will initiate religious services and song and dance evenings. Long distances and transport problems make it difficult for people to attend social functions in town, therefore the LHW will initiate song and dance evenings for all the people on a farm. This sometimes involves a lot of planning and LHWs group together to obtain a hall or shed where people from different farms can then attend the event. These events support the specific culture and can bind people together.

The LHW also teaches the people on the farm to crochet, to knit or do embroidery. They teach them to relax and start food gardens. They also get people involved in sport activities, like football and netball:

“we must give children hugs and show love...”.

“we sing and dance for relaxation...”.

These are just some of the events that LHWs initiate to develop the farming community.

#### **4.4.3.3 *Initiates community activities***

LHWs help the farm workers to start their own vegetable gardens to provide food or even a choir for abused children. As they said (to):

“...keep their minds off it...”.

This leads to educational opportunities to talk about abuse in general or drug abuse. LHWs teach farm workers about healthy living in a holistic way and by taking part in social activities to enhance their social capabilities.

Nemcek and Sabattier (2003:261) explained that LHWs were extenders of the health services and agents for developmental change.

Some of the LHWs mentioned that they thought it would be good to support abused children by letting them sing songs. These included physically, sexually and emotionally abused children. The LHWs taught the children to sing spiritual and folk songs. They also mentioned that a choir performed at various settings and that it is sustained by donations from all around the area.

A group of lay health workers started a forum for women. This platform serves to empower women to enhance their circumstances. Here they can voice their opinions, attend functions as a group and socialise. This is also a very special support group for women from different spheres of life.

#### **4.4.3.4 *Promotes self-care on farms among workers***

LHWs motivate the farm workers to self-care as mentioned, but also discuss their future plans to help them to improve their current situation as stated:

“we talk to them on what they want to be someday...we improve their self-worth”.

Sometimes the farm workers are in a circle of poverty and each generation stays on the farm for years. The LHWs will assist the individual to explore ways to improve his/her life by encouraging them to finish school and help them to apply for a bursary to further their studies. By motivating farm workers to self-care, the LHW assists them on being self-sufficient and not to rely only on the income of the farm.

- **Provides motivation for the youth on farms**

The LHWs perceived their role as being a very specific role regarding the youth. With all the crime, drop-outs from school, sexual activities and drug abuse all around the farms, they felt that they have to take care of this vulnerable group of people. They arrange debates, concerts and outings for the youth and through role-play will demonstrate to the youth how to succeed in life.

- **Empowers farm workers**

According to participants the whole idea of empowering people was to obtain a better life for all. They do their utmost best to make the vulnerable groups independent and self-sustaining by involving them in various activities in the farming community.

#### ***4.4.3.5 Promotes spiritual care for women on farms***

Although LHWs are mostly women – men also – use religion quite easily as a basis to get to know women on farms better. The LHWs have prayer groups for women and will use this special opportunity to talk about women's issues like pregnancy, abortion, breastfeeding, family spacing, pap smears, marriages etcetera. They empower women to make their own decisions and to stay healthy and strong.

Religion is a very serious aspect of the farming life according to the participants. They perceived religion as being the foundation of all their work. All events and meetings start and finish with prayer. Special religious services are held for baptism, funerals, Easter, etcetera. Women form small cell-groups pray for specific purposes like a very sick child.

#### **4.4.3.6 Promotes hygiene on farms**

Special clean up operations are organised where farms are cleaned up of all rubbish, and debris and then the farmer will assist in obtaining extra rubbish bins. Health talks will accompany these operations and sometimes outside sponsors will supply food and drink for the day.

The LHWs are very serious about hygiene on the farms. Major cleanup operations have been organised in the Boland area by the LHWs. These involved not only the farm workers, but the local authorities and professional services as well. The cleanup operations also involve the recycling of items such as plastic bags.

#### **4.4.3.7 Arranges community meetings**

LHWs arrange special community meetings where mutual items will be discussed like problems with the police service and social service. Social workers, health staff, police and teachers attend these meetings together with leaders of the different farms. These meetings enable the whole system to work better together.

At some of the above-mentioned meetings a specific need may arise to arrange a function for a bigger quorum to dissolve more information regarding farming life. The LHW plays a vital role in organising these functions and will then serve on an organised committee.

The LHWs perceived their role as being part of a committee that arranges meetings with the police, health staff and social workers. These meetings take place every quarter and involve all the leaders in the farming community. On this platform legal matters, health matters and social matters concerning the farm workers are discussed.

#### **4.4.3.8 Acts as research participant**

Researchers often come to LHWs to ask questions and to take photos on the farms.

The lay health workers said the following:

“...ask us questions and do certain things”.

“...filming on the farm”.

LHWs are not always clear of what the outcome of these questions were and often do not understand the purpose. Nutritional interventions from companies sometimes require of the LHWs to weigh children regularly and do the weight plotting. There seems to be a lack in the feedback that the LHWs get from these interventions.

Some of the LHWs mentioned that they need to become involved with the research teams who visit some of the farms, as they do not always get feedback on their inputs to such research. Two of the participants were involved in a dietary study that was done on their farms. They felt they needed to represent the farm workers.

The CHWs existing social network and their propensity to help their communities could lead to exploration of these CHWs (Terpstra et al 2011:86).

#### **4.4.4 Perception of the LHW as a counsellor/educator/advisor**

The LHW is used to increase knowledge and to promote behavioural change (Andrews et al 2004:358). Whatever the LHWs do or wherever they go, they are always ready to educate, motivate, counsel and advise.

**Table 4.5 Perception of the LHW as a counsellor or educator**

<b>4.4.4.1</b>	<b><i>Advisor to farm workers</i></b> <ul style="list-style-type: none"><li>• Advisor on health services</li><li>• Provides debriefing services to patients on farms</li><li>• Provides advice on tuberculosis and AIDS to farm workers</li><li>• Provides advice on feeding of babies on farms</li></ul>
<b>4.4.4.2</b>	<b><i>Motivator</i></b>
<b>4.4.4.3</b>	<b><i>Family counselling</i></b>
<b>4.4.4.4</b>	<b><i>Child counselling</i></b>
<b>4.4.4.5</b>	<b><i>HIV counselling</i></b> <ul style="list-style-type: none"><li>• Inform patient of test result</li><li>• Inform partners</li></ul>

#### **4.4.4.1 Advisor to farm workers**

LHWs give advice on nutritional aspects, hygiene, how to stay healthy, correct diet, prevention of illness, etcetera. In a study that was done in India, it was also the LHW who intervened with the nutritional status of pregnant and lactating women, and their nutritional status improved (Taylor & Jinabhai 2001:125).

Alcock et al (2009:957) mentioned that LHWs were required to give information and that they were seen as a source for accessing information and not a source of knowledge.

They give religious talks "...to live happy and do good..."and disseminate information about available health services. They give talks on tuberculosis, HIV and AIDS, obesity, hypertension, foot care and a variety of general health subjects:

"...we keep the patients calm at the clinic, because of the long waiting time..."

"...we tell them about TB and AIDS".

"...and anything else..."

- **Advisor on health services**

LHWs are an information resource about what kind of health services there are in a region, how to access these services and the variety of options that a patient has. They inform the people on the farm about the constraints of health services and how to best make use of these services.

LHWs are commonly employed as advisors to disseminate health related messages (Kennedy et al 2008:212).

- **Provides debriefing services to patients on farms**

According to the LHWs they will debrief a patient, especially after a devastating diagnosis like HIV has been made. Shortage of staff and time constraints sometimes make it impossible for professional health staff to spend long sessions with patients. The LHW will then further advise the patient regarding her/his illness.

- **Provides advice on tuberculosis and AIDS to farm workers**

As tuberculosis and AIDS are the diseases that most people suffer from in these regions, the LHW is very up to date with knowledge on these diseases. They advise patients about the cause, treatment and outcome of these diseases.

- **Provides advice on feeding of babies on farms**

Breastfeeding is always promoted at all the health care services and LHWs will support a mother to breastfeed as long as possible. They also advise on alternative feeding when it is impossible to breastfeed. LHWs advise farm workers on when to wean a baby and when to start solids. They are well-informed to advise women especially on nutritional habits.

#### **4.4.4.2 Motivator**

The LHW is an important tool for the success of any tuberculosis treatment programme. They encourage patients to complete their treatment and motivate them when they have side effects of a treatment. They act as directly observed treatment supporters (DOTS) and "...observe that they take their pills every day."

Van Zyl (2003:2) used LHWs to intervene when there were compliance problems on the farms in the Boland (Van Zyl 2003:2). LHWs motivate pregnant women to go for antenatal checkups, to breastfeed, to do family spacing and to care for other children in the family. They motivate the elderly to take their medication regularly, as well as motivate the employer to enhance the conditions of the people on farms.

When a person is ill, it sometimes causes a lot of strain on a family. The LHW motivates the patient to complete treatment and to be optimistic to get healthy soon. They support the patient and talk about his/her concerns regarding the illness. In this way a patient that is worried can have an informed LHW to talk to. It is important that a patient completes the prescribed treatment from professional health services. The LHW motivates the patient to comply with all prescriptions regarding his/her illness and is in an ideal position to monitor the patient for compliance.

With the high incidence of pulmonary tuberculosis in the Western Cape, it is very important that patients complete their treatment to prevent resistance to the treatment schedule. As a special effort the clinic sisters give the monthly treatment to the LHW, who in turn will give it to the patient on a daily basis. This serves as a buddy support system and makes it easier for the patient to finish the treatment which usually runs for six months.

#### **4.4.4.3 Family counselling**

LHWs do family counselling, as well as bereavement counselling. They assist families in the grieving process and intervene in quarrels in the household:

“...after the death...”.

“...between spouses to prevent divorce”.

Keeping families together is an important role of the LHW as this assists in the functionality of families on farms.

As mentioned previously, the death of a family member can be devastating for the relatives. LHWs said that they could do the bereavement counselling for months after the spouse has passed away. They will contact the rest of the family and will even stay with the immediate family for the week before the burial. The counselling will extend to all family members, children included.

LHWs have a role as comforter for the whole family and is a very trusted companion in times of family crises. The training of the LHW covers a specific course in counselling

skills and according to them they are involved wholeheartedly when they have to comfort a family.

#### **4.4.4.4 Child counselling**

Mothers with new babies are very vulnerable and sometimes uninformed. LHWs intervene and do child counselling, especially for those new mothers and give advice on feeding of the baby.

In the event of child abuse or neglect, then it is also the LHW that will intervene and do counselling with the child until referral to an appropriate resource. Rennert and Koop (2009:9) did a study on a specific intervention with CHWs to address problems in caring for children and found that PHC in remote underserved communities can be done when LHWs are used (Rennert & Koop 2009:9).

Cash (2004:1) discussed the CHIP programme in Virginia where LHWs enhanced the quality of care for children and did the referral as an ongoing process.

“We sometimes have to take the (the children) in...”,

which lead to situations where LHWs would care for these children in their own homes in cases where there are no sufficient godparents or immediate placements available for abused children.

“we take own initiative as mothers and know what to do...”.

When there is a case of sexual abuse on the farm, the LHW is the person to take action and to give talks and educate people about sexual abuse.

Services for abused children are centered in nearby towns or the city and outreach facilities are very scarce. The LHW is the first contact source for an abused child and has a trusted relationship with that child as the LHW stays on the same farm. Children will confide in the LHW as he/she is familiar to them. LHWs will also accompany abused children to court and arrange for child crisis services.

Sexual abuse of children is not uncommon in the Boland area. The perceived role of the LHW is to inform and educate children about the signs of sexual abuse. This they will do with role play, with videos and by means of informal talks.

#### **4.4.4.5 HIV counselling**

LHWs are specially trained to provide pre-and post- test counselling for people to go for HIV tests. They do the counselling to inform partners and also do counselling for the taking and compliance to anti-retroviral treatment. The LHW is available to encourage, motivate and counsel individuals in hard to reach areas (Kai & Drinkwater 2004:216).

Williams (2001:216) discussed the same initiative with the promotora de salud where follow-up visits were done, as well as referrals for HIV patients (Williams 2001:216).

Joseph et al (2012:141) confirmed the above statement and stated that “LHWs can play an important role in the provision of HIV services that ranged from translation, adherence counselling, VCT, medication distribution” (Joseph et al 2012:141).

- **Inform patient of test result**

It is sometimes necessary for the LHW to inform patients of their HIV test result, as they are the persons who sometimes did the pre-test counselling. When their results are given at the clinic, the LHW may also be present to support and comfort the patient.

- **Inform partners**

When a decision has been taken to inform a partner of an HIV positive person, it is the LHW who will be present with the patient to convey this message. LHWs may not inform sexual partners without the consent of the patient.

#### **4.4.5 Perception of the LHW as a role model in the community**

The Lay health worker is a role model in the community; a mentor who does crisis intervention and lobbying (Nemcek & Sabattier 2003:263).

**Table 4.6 Perception of the LHW as a role model in the community**

<b>4.4.5.1</b>	<b><i>Serves as an example to others</i></b>
<b>4.4.5.2</b>	<b><i>Practise what they preach</i></b>
<b>4.4.5.3</b>	<b><i>Mind, body soul involved in health work</i></b> <ul style="list-style-type: none"><li>• Holistic approach</li><li>• Physical strength</li></ul>
<b>4.4.5.4</b>	<b><i>Have high self-esteem</i></b>

**4.4.5.1 Serves as an example to others**

The LHW must be a mentor and serve as an example to others in the community. It is an important role and the LHW must be a good person and trustworthy. As they said in the interview:

*“...must be a good person and serve as an example...” “...people must trust the Lay health worker...”*

If there are any meetings to attend or public health talks, then the LHW must set the example to attend, otherwise the other farm workers will lose interest. Vananda (2001:19) found that LHWs who attended a talk on the HIV vaccine were in the right position to spread the correct information in their communities (Vananda 2001:19).

Dick et al (2007:383) commented on the LHW position as a “role model” in the community. Farm workers perceive the LHW to be a good person. That means that they look up to that person to set an example of a good life for them. LHW must not make assumptions, be fair in their treatment, religious and must show a lot of compassion and love to others.

People must be able to trust the LHW. They need to know that all information will be kept confidentially and need to be assured that their privacy will remain on the agenda of the LHW. LHWs in the group conveyed this message very clearly to the researcher. If

trust is broken, no-one, not even the formal health sector, can rely on the work of a LHW.

The ability to be honest at all times is of high priority to the LHWs. Even though it sometimes may hurt to tell the truth, they felt that they must be honest at all times regarding the health situation of particular people and in general.

#### **4.4.5.2 *Practise what they preach***

LHWs must be motivated to lead in an impeccable life. They sometimes:

“...want to stop, but think of the need of the people...”.

They are not allowed to abuse alcohol or any ill-health related action. They may not shout at people. They must be honest, have a holistic approach to health and must have a lot of courage and endurance.

“You cannot tell somebody to stop drinking wine and stand with a glass in your hand”.

This is not seen as an example to others.

The LHWs need to be motivated to do their jobs. In harsh circumstances they need to keep their cool and amongst the dark moments in their working life, need to stay focused. LHWs may not abuse alcohol as this is a very serious problem on the farms in the district. They must set an example as to when and how to use alcohol. They need to stress the serious effect of alcohol on an unborn child and they also conveyed the message that they are totally against the “dop”-system on farms. They will debate with authorities and farmers on this matter.

The whole concept of the reason why LHWs get involved, is to make a difference in the lives of people around them. By setting an example of a good, honest life and by caring for people and showing them neighbouring love, they can help other people to rise from their circumstances.

#### **4.4.5.3 *Mind, body and soul involved in health work***

The holistic approach enables the LHW to put mind, body and soul into practice:

“It is not just Magrieta, but the whole person...the real person... who does the job...”.

For the success of the lay health worker, the person must also have physical strength and emotional strength to help others to build their self-esteem:

“...to help others to help themselves...”; “to make a difference in their lives”;  
“...to motivate others...”.

The lay health worker’s own beliefs are important and it is necessary to act as a role model and not to spread the wrong information (Puoane & Bradley 2003:29).

- **Holistic approach**

The LHW applies his/her total being to do the work. They also care for themselves in a holistic way to be an example to others. They work, rest, socialise, play in a balanced way and see to it that they themselves stay healthy and fit.

- **Physical strength**

The group said that they need physical strength to bath patients and to work the long hours. They also need their physical strength to help patients with strokes or invalids. They need their strength to support their own bodies and to walk long distances to the houses of the farm workers.

Their whole being must be involved when they motivate others for a better life. Their verbal actions must be complemented by non-verbal behaviour to convey this message. They must look healthy and happy to set an example to others.

#### **4.4.5.4 Have high self-esteem**

These were the direct words of the lay health workers in the group:

“We are not just a farm person, but a somebody in our communities...”.

“...you must think high of yourself to make a difference in their lives and motivate them...”.

LHWs must empower themselves with knowledge, practical skills, interpersonal skills and have a lot of courage to do their job. They must love themselves to love others.

The LHWs felt that their role was an important one and that nothing can replace the kind of work that they are doing. Without them all will be lost to help the farm workers to attain a healthier life. With all the obstacles like resources, distance and poverty it is hard to do the work that the LHWs are doing. They need endurance to see all situations through.

The LHWs have to have a high self-esteem and they must be able to build on that. They have to show leadership skills and must be able to love and trust themselves. They need a lot of confidence to do the work on the farms as they may include specific risks like malpractice and lawsuits.

### **4.5 APPLICATION OF THEORY ON THE RESEARCH FINDINGS OF THIS STUDY**

It became necessary for the researcher to place the findings of this study within the existing theory in order to give the findings structure. In this section of the report, the researcher reflected the findings of this study within the Neuman's systems theory. This was done in order to give findings of this research structure.

#### **4.5.1 Theoretical**

Newman used the systems model to set forth a structure that shows the parts and subparts of the client (lay health worker) and their relationships to one another and the environment. These lay health workers are in an open system where they are in

dynamic interaction with their environments. The lay health worker system is composed of five interacting variables, namely physiological, psychological, sociocultural, developmental and spiritual, and have a basic core structure unique to each lay health worker, but with a range of responses to all human beings.

The lay health worker applies these variables when rendering lay health care and when reaching and interacting with the community they serve.

- The *physiological* variable is the structure and function of the body of the lay health worker. According to the research they will apply their physical strength to lift bedridden patients, wash and treat the ill, care for neglected children and the elderly, accompany patients to hospital, etcetera. Lay health workers can be male or female and here physical strength and endurance will play a role in performing duties.
- *Psychological* variables comprise of cognitive and affective characteristics of lay health workers. According to them, they need to have a strong self-esteem to counsel others, to care for the dying, to act as mediator between employer and employee and to handle their own affairs at home. They need to be able to communicate with people and have the cognitive ability to pass the course in lay health work. They need life experience and a strong will to develop the community around them for "...a better life for all".
- The *sociocultural variable* entails the social, economic, demographic, political, recreational cultural, health characteristics and communication patterns of the lay health workers. According to their feedback and the main themes of the research findings it is necessary that the LHW understands the community they serve and be culturally sensitive. Their own social stand will determine how much they can feed into their farming community. They live in their community and are chosen by their peers to ensure stability on the farm. They are respected by their fellow farm workers and are role models. They have recreational capabilities to arrange events to develop their communities. They act as mediators, counsellors and as link between different spheres of people in the particular community. They rely on the support system of the formal health sector.
- The *spiritual variables* are the moral, religious and value system of the LHW. According to their feedback they rely strongly on their spiritual and religious beliefs to counsel people and to do bereavement sessions. They believe that

they must be reliable, honest, trustworthy people to act as role models and to lead people to live healthier lives.

- The *developmental variable* refers to the process related to the development of the LHW over a lifespan. The LHWs mentioned that they have follow-up courses and are registered by the training body. They have to apply their skills to an ageing community and are very involved with the elderly. They react to the needs of the community and if they serve a poorer area, they will link with social services for assistance. They link with the educational facilities regarding the schooling of children and will assist in the education of adults. They assist the local primary health care clinics when they follow-up on people with communicable diseases. With the assistance of LHWs the morbidity and mortality levels in a defined population will decline.

To serve as link in the community; to be a carer for all age groups; to be a community developer; to be a counsellor and role model, the lay health worker must have optimal system stability. This occurs when all system variables are in balance and functioning. Clarity on their role in the community can serve as a primary prevention strategy to reduce risk factors like malpractice. When an incident occurs which involves the practice of a lay health worker, then a secondary prevention strategy would be to rectify the incident after inspection and consultation to prevent similar incidents. Additional training may be needed to equip the LHW to react to specific needs in the community. Tertiary prevention can be initiated if an LHW experiences too much stress in a particular role and caution must then be applied when redirecting his/her course to another role, i.e. just doing DOTS (directly observed treatment support) work and not doing counselling.

#### **4.6 OMISSIONS**

According to the feedback from the LHWs none of them are use to staff mobile units as described in the literature (Nemcek & Sabattier 2003:263).

It is also unclear how involved their role as research participant is because they do not always know when they are taking part in research. They are instructed to plot the weight of babies on a record and these records are then utilised for research for instance.

Clarke et al (2005:674) described their role as intervention tool to combat tuberculosis and the outcome was successful because the tuberculosis treatment rates were a great success (Clarke et al 2005:674). According to the research participants they are still involved with the treatment of patients with tuberculosis. On the other hand, the example set by Bang et al (2005:72) where LHWs were used in peri-natal care in India, were not followed as the LHWs in this particular study were not involved in peri-natal care, per se (Bang et al 2005:72).

The role of the LHW was thoroughly explored and the feedback confirmed what was written in the literature.

#### **4.7 CONCLUSION**

The research findings about the role of the lay health worker were discussed in chapter 4. Literature was screened to confirm the findings and some omissions were discussed. The role of theory was also explained. The next chapter will be the description of guidelines for the role of lay health workers.

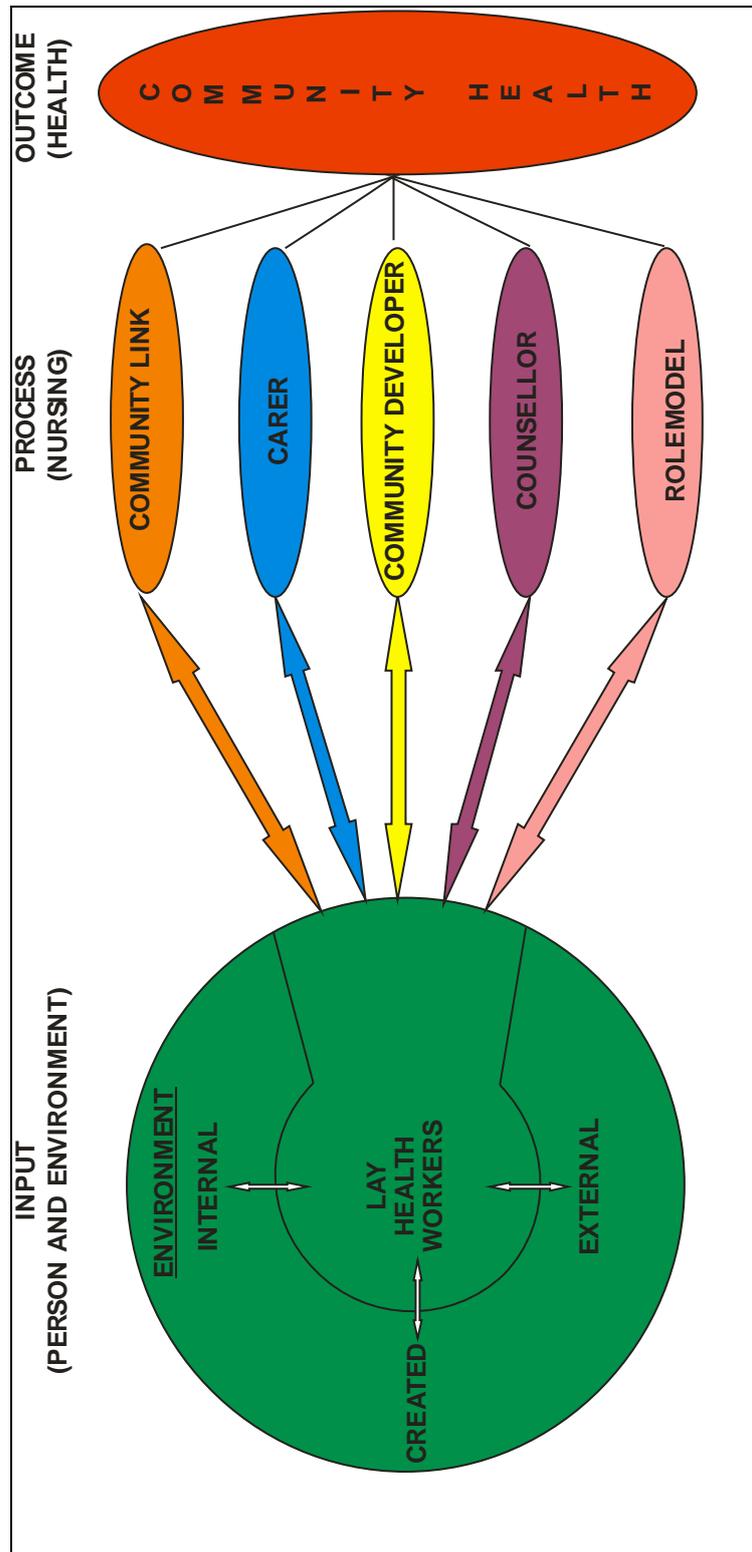


Figure 4.1 Lay health worker systems model

## **CHAPTER 5**

# **GUIDELINES FOR THE ROLE OF THE LHW IN THE PROMOTION OF HEALTH OF THE RURAL COMMUNITIES**

### **5.1 INTRODUCTION**

In the previous chapter research findings on the exploration of the role of the LHWs on farms in the Boland area of the Western Cape were discussed. This chapter serves as a platform for the researcher to address issues identified in the findings and literature used in this study. The researcher used literature and findings as the basis for developing guidelines for the role of the farm LHW in the promotion of health of people in the rural Western Cape Province. The main purpose for this chapter is to provide an answer to the second objective of phase three of the dissertation. The guidelines formulated by the researcher can also serve as the basis for health service managers, especially in nursing to recruit, select and train lay health workers in the rural areas particularly in the Boland area.

The survey list of Dickoff et al (1968:478), as cited in Meleis (2007:155) guided the process for the development of the guidelines described in this chapter. The guidelines are based on the research findings and literature used for the control of findings. The guidelines that were formulated were further evaluated by health experts for their applicability using an evaluation criteria proposed by the National Health and Medical Research Council (NHMRC) of the Australian Government (2012).

As indicated earlier in this introduction, the guidelines are an important resource for the support of health (nursing) services managers in the recruitment, training and appointment of LHWs in the rural areas of the Boland area.

### **5.2 BACKGROUND FOR THE DEVELOPMENT OF GUIDELINES**

The aim of clinical guidelines is to improve quality of care by translating new research findings into practice. Specific recommendations must be included which are supported

by evidence and a clear structure, as well as a clear layout. To promote their implementation, guidelines could be used as a template for local protocols, clinical pathways and inter-professional agreements (Wollersheim et al 2005:1).

There has been a widespread move towards developing clinical practice guidelines which are designed to improve the quality of health care to reduce the use of unnecessary, ineffective and harmful interventions and to facilitate the treatment of patients with maximum chance of benefit with minimum risk of harm and at acceptable cost (NHMRC 2012:1).

Guidelines for LHWs can be effective in bringing about change and improving health outcomes. The roles and activities of CHWs are enormously diverse throughout their history, within and across countries and across programmes. Sometimes CHWs perform a wide range of tasks that can be preventative, curative and/or developmental and in other cases CHWs are appointed for specific interventions. CHWs make a valuable contribution to community development and their actions can lead to improved health outcomes. For CHWs to be able to make an effective contribution, they must be carefully selected, trained and supported (Lehmann & Sanders 2007:1). Guidelines were developed to facilitate the role of these CHWs so that all the role-players can have a better understanding of what these roles entail.

### **5.3 THE APPLICATION OF THE SURVEY LIST IN THE DEVELOPMENT OF GUIDELINES**

In this study, in order for the researcher to develop the guidelines to support the LHWs in the promotion of health of rural communities in the Boland area, the researcher made use of the survey list proposed by Dickoff et al (1968:245), cited in Meleis (2007:155), as an infrastructure (see figure 5.1).

The survey list proposed by Dickoff et al (1968:245), cited in Meleis (2007:155), lists six aspects of activities. These are: the purpose or terminus, the agent, recipient, framework (context), dynamics and the procedures. These components of the survey list are discussed in detail (and in figure 5.1).

### **5.3.1 Purpose**

The purpose is defined as the reason for which something exists or is done. According to Dickoff et al (1968:245), cited in Meleis (2007:155), purpose refers to the categories of activity and goals in which someone engages. The purpose also refers to the end point of an activity or works that result in the final goal or outcome. In this study, the main purpose of the guideline is to address issues that the LHWs experience, with regard to challenges they have in serving as a link in the community.

### **5.3.2 Agent**

According to the survey list of Dickoff et al (1968:245), cited in Meleis (2007:155), the agent is a person who has adequate awareness and capacity to carry out certain activities. In this study, the agents are the nursing (health) services managers responsible for planning health services, recruitment and deployment of LHWs in the rural areas of the Western Cape Province.

### **5.3.3 Recipient**

According to the Farlex (2013:1) the term recipient refers to “a person who receives something”. Dickoff et al (1968:245), cited in Meleis (2007:155), indicate that the ‘recipient’ is the receiver of the activity designed by the agent. In this study the recipients are the LHWs responsible for the promotion of health of rural communities in the Western Cape Province farms.

### **5.3.4 Framework or context**

The ‘framework’ refers to the context or the setting in which the activities takes place. According to Merriam Webster Dictionary (2013:1), the context refers to “the interrelated conditions in which something exists or occurs”. According to Watson, Broemeling, Reid and Black (2004:1), contextual factors such as social, cultural, economic and physical environment influence health service delivery in the community. Context, together with the input from the environment, directly determines the output of health service activities. In health service delivery the context is vital and influences input, activities, outputs, and outcomes.

According to Watson et al (2004:3), for efficient service delivery and effective outcomes in the health care system, the interrelationship between environment or the context in which the health service delivery takes place, inputs (human, material, information), activities such as clinical care and outputs (immediate result of activities) and final outcomes, which benefit both the individual patient, as well as the community are necessary. The external environment (social, physical and economic contexts) influences availability of resources (inputs), activities, outputs and outcomes. The level of participation and characteristics of a community also influence the outcomes of health service activities.

The context or setting for this study refers to the rural areas of the Western Cape where the LHWs perform their activities of promoting health of rural farm workers.

### **5.3.5 Dynamics**

In this study, the dynamics are those factors which inhibit the promotion of health in rural areas by LHWs.

### **5.3.6 Procedures**

The procedures are those methods, techniques or sets of rules that direct activities and which a given responsible person is required to perform (Moleki 2008:30). In this study, the procedures entail the guidelines proposed in order to support the LHWs in the promotion of health of farm workers.

## **5.4 DESCRIPTION OF GUIDELINES TO FACILITATE THE ROLE OF LHWs IN A RURAL COMMUNITY**

The central role of guidelines is to help LHWs make better decisions regarding their role in the community they serve. The five themes namely: (1) Perception of the LHW as a link in the community; (2) the LHW as a carer; (3) the LHW as a community developer; (4) the LHW as a counsellor/educator/advisor and (5) the LHW as a role model, were used as basis to formulate guidelines and are discussed hereafter. The formulation of the guidelines was based on these findings and literature, followed by the rationale for

inclusion in the set of guidelines, as well as the actions. The discussion of the guidelines follows next.

#### **5.4.1 Guidelines to facilitate the role of the LWH as a link in the community**

One guideline was developed from this theme in line with the three categories that emerged from this theme, i.e. related to the LHW as link between the community and the formal health care services, the farm worker and the employer, and between the patient and other formal structures.

##### **5.4.1.1 Purpose for this guideline**

The main purpose of this guideline is to address issues that the LHWs' experience, with regard to challenges they have in serving as a link in the community.

##### **5.4.1.2 Summary of statements on which this guideline is based**

#### **Box 5.1 Summary of conclusion statements for the LHW to serve as a link between formal and informal structures in the community**

- Participants experienced that the professional health care services need a specific contact person on each farm for patient referrals. The formal health care services are not accessible 24 hours every day and LHWs are in the ideal position to render a service all hours, as they are the first level of contact in the community.
- LHWs need to be trained to recognise health related problems on farms. They can detect danger signs and refer patients timeously to the relevant community resources.
- Strong referral lines between LHWs, patients, farmers, public health sector and other community resources should be established. Patients will not be missed when the referral patterns are well known and utilised.
- Farmers do not know about all health related problems on their farms and all the role players need to be informed of the overall purpose of having an LHW available on the farm.
- Lay health workers help families in need by referring them, i.e. for social grants or placing children in special care. They therefore need to be empowered by knowledge of these available resources.

### **5.4.1.3 Outcome**

Effective use of the LHW as link in the community will enhance service delivery by this category of workers as he/she will bring the farm workers closer to connect with formal health services.

### **5.4.1.4 Rationale**

LHWs share a deep understanding of beliefs, perceptions and salient concerns of farm workers and are able to engage with their peers in a culturally appropriate manner. The LHW spends a significant amount of time with individuals on farms and this fosters deeper relationships and enhances consumer trust. They are balancing the power dynamic between the patient and providers of health care. The main role of the LHW network is to create connections between the farming community, health services and community based organisations by addressing informational, cultural, socioeconomic and linguistic gaps (Samuels, Adess, Harper, Peacock, Wyn & Stone-Francisco 2003:3).

### **5.4.1.5 Recommended activities and procedures for the implementation of the guideline**

- **Secure the LHW as the first level contact in PHC services in the rural farming community**
- Establish effective selection criteria to appoint appropriate persons to serve as LHWs, i.e. demographic parameters, physiological-, psychological-, sociocultural-, spiritual- and developmental variables.
- Inform all role players of the list of available LHWs in the area, i.e. farmers, formal primary health care services, farm workers, social services, police, hospitals, churches, schools, local organisations, etc.
- Display information with regard to location, name and contact details of all available LHWs to all the role players.

- Draw up a list of available resources and contact details for referral purposes, i.e. emergency numbers, nearest primary health care clinic and the farmer's contact details.
- Posters and information about availability of LHWs, to be published in the local newspaper, on bill boards, restrooms, on farms and in the local primary health care clinic.
- Notice to all role players that LHWs must be used as first level contact before farm people should access formal health services.
- Issue LHWs with means of communication, i.e. cell phone, fax, two-way radio.

➤ **Train LHWS to identify health related problems and use the available referral structures**

- Enhance leadership skills among LHWs with focused, original curricula, training sessions and various capacity building opportunities.
- Teach LHWs to advocate for healthcare quality for themselves and their families and to apply these skills to serve their broader community.
- Educate LHWs to understand health risks and self-help measures and navigate them through the difficulties of the health care system.
- Empower LHWs with knowledge to use communication tools and communication networks.
- Train LHWs with appropriate curricula regarding basic health care and first aid.
- Ensure that all programmes are evidence-based and LHWs will be included in decision making and policy planning regarding health services.

➤ **Establish a set of referral lines between all role players in the health field in the rural community**

- Draw up an organogram, which includes the LHW and inform all the formal health care workers.
- Arrange workshops with community members to keep them informed as to where they must report to in case of an ailment/need for care.
- Develop a referral form for use by the formal health sector, as well as by LHWs.

- Develop a monthly report form, for use by LHWs and to inform employers of referral data.
  - Develop a mechanism to detect wrong referrals.
- **Keep farmers informed about health related problems on their farms on a continuing basis**
- Give farmers a full description of LHWs on their farms and inform them about their scope of practice.
  - Lay health workers must hand in monthly reports to the farmers with detailed information of ailments they have treated, as well as home care and first aid that they rendered.
  - LHWs must inform farmers and the local clinic staff of any problems that arise out of their work, as well as obstacles in order to render safe health care to the farm workers.
- **Empower LHWs with knowledge of available resources and networking systems in their community**
- Supply LHWs with a list of contact persons and contact numbers for social welfare, Child line, church groups, rape crises, AIDS hotline, etc.
  - Circulate brochures and information leaflets about health related organisations to lay health workers.
  - Include information about the services available in a community in the training curriculum of LHWs.

#### **5.4.2 Guideline to facilitate the role of the LHW as a carer in the community**

This guideline was developed from this theme in line with the eleven categories that emerged from the theme. The eleven categories were grouped as follows:

- Provision of acute care to farm workers
- Provision of chronic/continuous care to farm workers
- Record-keeping and general administrative function of lay health workers

#### **5.4.2.1 Purpose of this guideline**

The purpose of this guideline is to enhance and clarify the role of the LHW within their caring responsibilities.

#### **5.4.2.2 Summary of statements on which this guideline is based**

##### **Box 5.2 Summary of conclusion statements to clarify the role of LHWs as carers**

- Lay health workers provide first aid care and treatment of minor ailments to farm workers.
- LHWs provide care to sick farm workers and care for abused children of farms.
- The LHW assists with the assessment of mentally impaired people.
- LHWs accompany people to hospital and assist with continuous care for the aged.
- The LHW takes care of dying people on farms and renders family support.
- LHWs do record-keeping and gather information about illnesses.
- LHWs search for particular patients on farms when necessary.

#### **5.4.2.3 Outcome**

Specific caring duties of the LHW will be identified.

#### **5.4.2.4 Rationale**

The LWH cares holistically for people in the farming community. This care ranges from birth to old age and includes all farm workers. Sometimes the specific intervention to a problem is of an acute nature. That means that the LHW must act immediately to save a life, or to relieve pain and suffering. In other instances the care is more of a chronic ongoing nature. In line with legal requirements are the administrative functions of LHWs.

#### **5.4.2.5 Recommended activities and procedures for the implementation of the guideline**

##### ➤ **Identify the activities related to acute care**

- Make a list of the acute care activities that LHWs have to do, i.e. treatment of minor cuts and bruises; treatment of shock and treatment of minor ailments, like stomach aches, headaches, colds and diarrhea.
- List the appropriate interventions for the care of sick farm workers like bed-baths, feeding methods and the administration of medicines to patients.
- Identify all forms of abuse to children and list actions that LHWs must do in these cases.
- Draw up a protocol on the consultation of mentally ill people.

##### ➤ **Identify the activities related to chronic care**

- Draw up a schedule of the types of patients that must be accompanied to the hospital, as well as the particular information that the LHW must relay to the professional health service.
- Tabulate the activities that LHWs can do with the aged to keep their health optimal.
- List the chronic care activities like foot care, continuous monitoring of vital signs, screening tests for eye sight, weight plotting, etc.
- Write a protocol on the immediate care of the dying patient at home.
- Make a list of the types of support to families in need.

##### ➤ **Identify the general administrative duties of LHWs**

- Develop the daily, monthly and annual record-keeping system.
- Develop specific patient records for every patient that the LHW consults.
- Make a list of all statistical interventions that is needed.
- Train LHWs to make sense out of the data that they gather to act upon when necessary.

- List the patients that LHWs must follow up, like TB contacts and people who missed appointments at the clinic.
- Supply the LHW with information about signs and symptoms of diseases.

### **5.4.3 Guideline to facilitate the role of the LHW as a community developer**

The guideline that was developed for this theme is in line with the nine categories that emerged from this theme. The categories were all grouped together during the development of this guideline.

#### **5.4.3.1 Purpose of this guideline**

The purpose of this guideline is to clarify the role of the LHW as a community developer.

#### **5.4.3.2 Summary of statements on which this guideline is based**

#### **Box 5.3 Summary of conclusion statements to clarify the role of LHWs as community developer**

- Lay health workers react to community needs and make a difference in the lives of people on farms.
- LHWs initiate community activities and promote self-care on farms among workers.
- In some instances LHWs promote spiritual care for women on farms.
- The LHWs promote hygiene on farms and arrange community meetings.
- LHWs act as research participants when rural research is undertaken.

#### **5.4.3.3 Outcome**

Aspects related to community development that LHWs do, will be identified.

#### **5.4.3.4 Rationale**

Rural communities rely on each other for support and the LHW helps the community members to work together on farms. Farm workers live far apart and transport is not always available. They rely on the LHW for support and to enhance their way of living.

#### **5.4.3.5 Recommended activities and procedures for the implementation of the guideline**

The following activities were recommended for the guideline:

##### ➤ **Identify community needs**

- Assist LHWs to do a survey on their farms to list the needs as indicated by the farm workers.
- Elect farm workers to serve on a committee to discuss community needs and problems.
- Assist lay health workers to convey information about developmental needs to the farmer and official structures.

##### ➤ **Investigate possible activities that farm workers can do to enhance social well-being**

- Arrange an informal gathering for a few farms in a cluster and allow the farm workers to partake in sporting activities. LHWs must make a list of the outcome of these activities for further competitions.
- Arrange a choir practice with all the women on the farms and develop a peer group session to discuss issues related to problems women have.

##### ➤ **List the activities of LHWs related to health promotion**

- Arrange discussions between LHWs and environmental officers and steps to be taken in the event of, i.e. and outbreak of gastroenteritis.
- Display hand washing and cleaning techniques in rest rooms on farms.
- Issue health promotion material like flipcharts to LHWs.
- Assist LHWs with monthly inspections to households on farms.
- Draw up a checklist for inspection regarding hygienic factors.

➤ **Empower LHWs to partake in research activities**

- Link the LHW to interested parties who would like to do research in the specific area.

**5.4.4 Guideline to facilitate the role of the LHW as a counsellor/educator/advisor**

The guideline that was developed for this theme is in line with the five categories that emerged from this theme. The categories were grouped together.

**5.4.4.1 Purpose of this guideline**

The purpose of this guideline is to clarify and enhance the role of the LHW as counsellor/educator/advisor.

**5.4.4.2 Summary of statements on which this guideline is based**

**Box 5.4 Summary of conclusion statements to clarify the role of LHWs as counsellors/educators/advisors**

- The LHW serves as a source of information about available health services.
- LHWs give advice to farm workers about illnesses like tuberculosis and AIDS.
- LHWs advise caregivers on the feeding of babies.
- LHWs serve as motivators to support farm workers in difficult times.
- LHWs serve as counsellors for families, children, HIV positive people, etc.

**5.4.4.3 Outcome**

Enhancement of the role of LHWs as peer group teachers and counsellors.

**5.4.4.4 Rationale**

LHWs can be used to educate farm people on a variety of health related matters. They are well-trained and informed about different diseases and how to prevent these illnesses. With the AIDS pandemic rampant in our country, it is very important that LHWs be empowered to relay the correct message about this disease to their peers.

With the dual infection rate of HIV and TB, it is of vital importance that all available resources reach out to inform all community members about prevention and treatment options. Lay health workers are well positioned to advise farm workers on a variety of topics.

#### **5.4.4.5 Recommended activities and procedures for the implementation of the guideline**

The following activities were recommended for this guideline:

##### ➤ **Enhance the knowledge pool of lay health workers**

- Train all lay health workers about HIV/AIDS and Tuberculosis.
- Give LHWs a checklist of signs and symptoms of common diseases like HIV/AIDS and tuberculosis.
- Give LHWs a booklet and reference guide to well-known endemic diseases.
- Supply LHWs with a list of all available health services.

##### ➤ **Empower the LHW with counselling skills**

- Train all LHWs in counselling skills by using clinical nurse practitioners as a resource and creating a learning context with the LHWs.
- Use strategies of reflection and feedback for LHWs to “open up” and use themselves more therapeutically.
- Assist the LHW in the use of narratives, dialogue, language and discourse for understanding patients’ problems.
- Assist the LHW to learn the skill by doing a simulation where the CNP acts as the facilitator and the LHW as the participant.
- Give feedback to the LHWs to build confidence and to improve their interaction with other people (Mavundla, Poggenpoel & Gmeiner 2001:15).
- Do debriefing sessions with LHWs to detect emotional strain by having them talk to the psychologists on the PHC team to verbalise their worries and fears.
- Do group discussions with LHWs to identify problems or strong points and to share ideas about counselling practices.

➤ **Support the LWH to give information to farm workers**

- Arrange a lecture for LHWs on teaching skills to enhance their knowledge on how to convey information to other people.
- Involve dieticians on the PHC team to lecture LHWs on feeding options for babies to build on their knowledge and remove wrong feeding practices.
- Give a demonstration to LHWs about best practices in breastfeeding and bottle feeding/cup feeding.
- Arrange a visit to the library for LHWs to obtain literature on various topics related to their work on farms.

**5.4.5 Guideline to facilitate role modelling by the LHW in the community**

The guideline that was developed is in line with four categories that emerged from this theme. These categories were about the perception of the LHW as an example to others, their involvement with their work and their high self-esteem.

**5.4.5.1 Purpose of this guideline**

The purpose of this guideline is to identify the LHW as role model in the community.

**5.4.5.2 Summary of statements on which this guideline is based**

**Box 5.5 Summary of conclusion statements to clarify the role of LHWs as role models in the community**

- LHWs serve as an example to others and they practise what they preach.
- The mind, body and soul of the LHW is involved in the work that they do.
- LHWs have a high self-esteem.

**5.4.5.3 Outcome**

LHWs will get the necessary respect as role models in the farming community.

#### **5.4.5.4 Rationale**

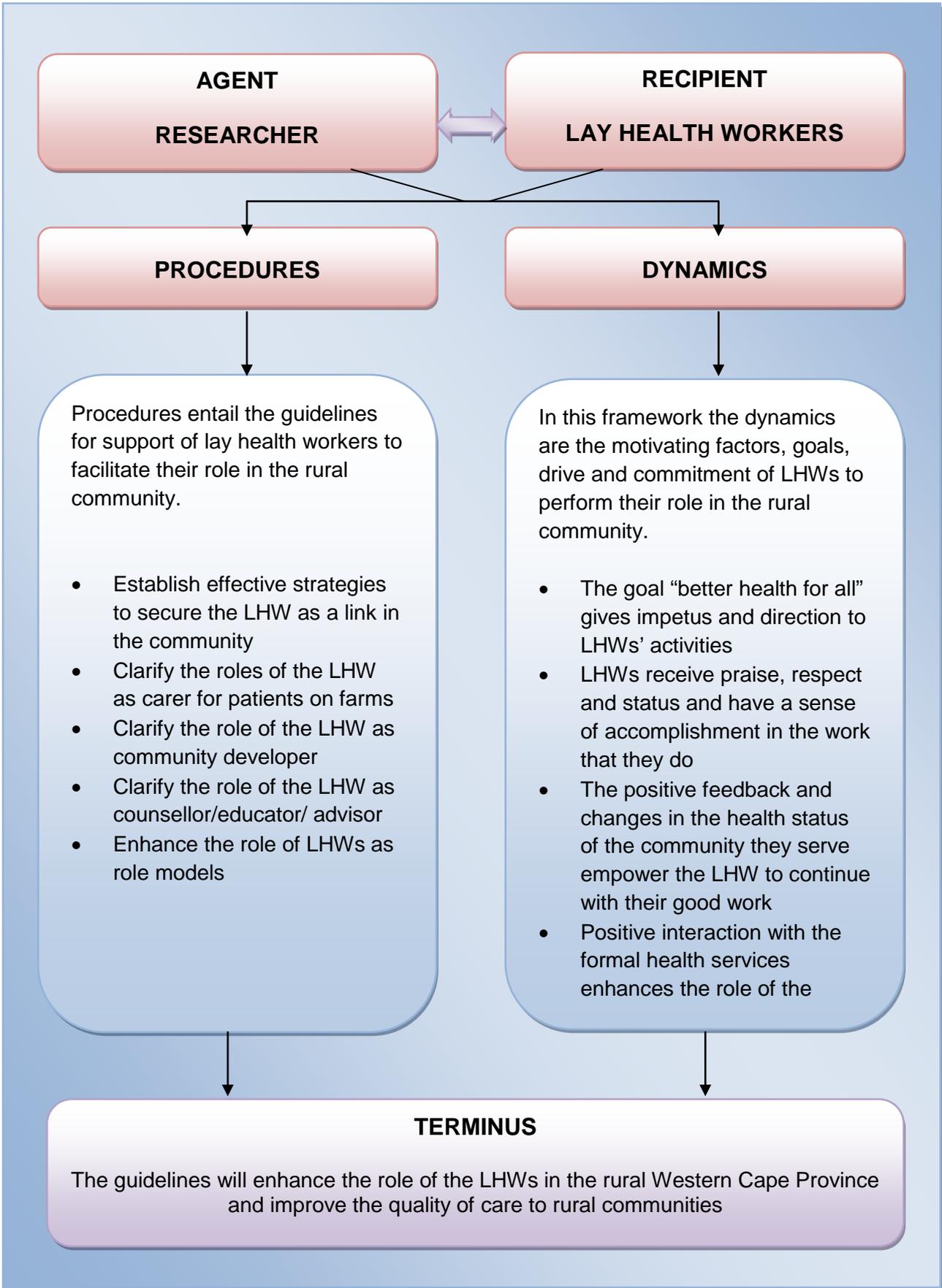
Lay health workers have a high self-esteem and apply their physical, emotional and spiritual skills to enhance the lives of farm workers. Their crucial role in the community must not be overlooked and all people must support them and acknowledge them as role models.

#### **5.4.5.5 Recommended activities and procedures for the implementation of the guideline**

The following activities were recommended:

- **Sustain the LHWs as role models in the community**
  - Support LHWs in all the work that they do on the farm.
  - Allow LHWs to debrief and have team building exercises.
  - Acknowledge work well done with special remuneration or prizes.
  - Give praise openly to LHWs when necessary.
  - Motivate LHWs by publishing their achievements in the local newspaper and other media.
  - Train all other health care workers and farmers on the content of the work that LHWs do to better their perspective.
  - Approach problems with LHWs objectively and immediately and guard to not demotivate LHWs.

In concluding these guidelines a framework for support of lay health workers to facilitate their role in the rural community is displayed in figure 5.1.



**Figure 5.1 Framework for support for LHWs to facilitate their role in the rural community**

## **5.5 EVALUATION OF THE GUIDELINES**

These guidelines were presented to lay health workers with the request to verify them. They were satisfied that the guidelines were clear, simple and applicable to their current and future roles. They were confident that it would enhance their function within the community and that the overall health status of the rural communities would be improved.

The guidelines were externally peer reviewed by two experts who train and employ LHWs. This ensured depth and quality of the guidelines. Guidelines will be disseminated and evaluated to determine if the general trend in lay health practice is moving towards improvement. The guidelines should be evaluated to see if they contributed to any specific changes in LHW practice and if health outcomes improved (NHMRC 2012:5).

## **5.6 CONCLUSION**

This chapter dealt with the development of guidelines to facilitate the role of LHWs on farms in the rural Western Cape. The guidelines were described under each of the five themes identified from findings as described in chapter 4. The next chapter will deal with conclusions, limitations and recommendations.

## **CHAPTER 6**

### **CONCLUSION AND RECOMMENDATIONS**

#### **6.1 INTRODUCTION**

Chapter 5 dealt with the development of guidelines for the role of lay health workers in the rural Western Cape Province, as well as the discussion and implementation of the research. In this chapter the researcher will draw conclusions regarding the role of lay health workers. The researcher also makes recommendations with regard to further research, practice and the education of nurses and lay health workers.

#### **6.2 CONCLUSIONS**

There are vast differences in the roles of LHWs in particular settings. They are applied as counsellors, health promoters, research participants, home carers and in many other different roles. The researcher was curious to know what exactly the role of the farm lay health worker was. The main purpose of this research was to describe the role of the lay health worker practising on farms in the rural area of the Western Cape Province.

A qualitative research design which is explorative, descriptive and contextual was used, because the researcher could develop a comprehensive understanding of the content of the role of the LHW on farms by exploring their perception of their role. The collaborative and participatory nature of this design, minimised suspicion and distrust of the research and therefore established its credibility.

The qualitative research design that was chosen for this study is a systematic, subjective approach that was used to describe life experiences of LHWs on farms. Insights were obtained by the researcher on the role of LHWs on farms, because this design explored in-depth, the richness and complexity of the phenomena. The researcher experienced the situation by being open and receptive to the phenomena and therefore she could describe what she has observed during fieldwork. This

research design is recommended for studies to develop an understanding of phenomena as it exists in the real world.

The phenomenology qualitative research method was used to investigate the perception of the LHWs with regard to their roles on the farms. This process entailed the construction on the meaning of human experience through intensive dialogue with LHWs who are living the experience.

The research was done in three phases. Firstly, the literature was searched for information on the roles of LHWs. A rich body of knowledge was found on the latter. Secondly, the roles of the LHW on farms were explored. This was done by conducting intense focus group discussions and in-depth interviews with farm lay health workers. A convenience non-random sample was used and five LHWs were engaged in the group discussions and interviews.

A combination of data collection methods, namely focus group discussions and in-depth interviews were used and the researcher was totally involved in perceiving, reacting, interacting, reflecting, recording so that meaning could be attached to the content of verbal and non-verbal behaviour of participants. The small focus group assisted the interaction between the individuals of the group and the researcher. The researcher was closely involved in the experiences of the subjects. Some participants were uncomfortable to express their views in front of the group, but with coaching from the researcher, this problem was dealt with immediately. This method is advocated to obtain information as it is reflected by individuals who are living the experience.

Data was collected in the words of the participants and verbal and non-verbal behaviour could be observed. Data were analysed, categorised and sorted and according to major themes that emerged in the data the guidelines could be developed. The objectives of this study, i.e. to explore available literature on the role of LHW, to explore and describe LHWs' perception of their roles in the rural setting and the formulation of guidelines for the role of LHW in the rural Western Cape Province, were met.

Transcribing the data is a time-consuming exercise but necessary to organise data into specific categories and themes. This assisted the researcher to gain insight and to build

a logical chain of evidence and making conceptual coherence to analyse the content of the data collected.

The system model was applied by the researcher in this research to see how it would affect the findings of this study. As the case may be with qualitative research, the study framework was not forced but used to reflect findings within the categories of the system model. The Neuman system model can be applied to various settings where LHWs are used whether it be formal or informal (see figure 4.1).

The four aspects of this model, namely person; environment; health and nursing can be applied. The “person” is the LHW, who is in constant interaction with his/her environment. The “environment” is all the internal and external factors that surround the farm LHW. In this research “health” depicted the total physical, mental and psychological health of the LHW as he/she applies him/herself to the role in the community. The application of their knowledge and skills to enhance the health of their clientele is the “nursing” action of the LHW.

The Neuman theory was thus useful because the LHWs apply themselves totally in mind and body to do their work and they do it in an environment which impacts on the health of the farming community.

Guidelines were formulated by the researcher to serve as a basis for health service managers, especially in nursing to recruit, select and train LHWs in the rural areas. The guidelines described the LHW as a link in the community, as carer, community developer, counsellor and role model. These guidelines will enhance the role of the LHWs in the rural Western Cape Province and improve the quality of care to rural communities.

Lay health workers may be applied to different spheres in a society and LHWs on farms are only a certain aspect of work that LHWs are doing. LHWs can be only home-based carers, lay counsellors or DOTS workers, but their knowledge can be applied to holistically treat people on farms. LHWs on farms are specifically trained to address all the various needs of people living on farms in the Boland area of the Western Cape Province. They are role models in a farming society and have a specific place in the hierarchy of health work in the community. They are used to extend the work of

professionals in areas which are difficult to reach and where there are huge health related problems.

This research was done over some years and the researcher studied the role of the LHW in-depth. This will add to the body of knowledge on the role of LHWs in rural areas.

### **6.3 LIMITATIONS**

Previous studies concentrated on other issues of LHW practice, like their contribution to the outcome of health prevention interventions. Studies on the role of LHWs on farms were limited and in comparison to this study could not easily be done.

Fieldwork was initially hampered because of the long distances that the group participants had to travel to attend group discussions, but these were overcome with alternative transport arrangements.

The focus groups were small and information that were shared were limited to experiences by five LHWs. Bigger groups might have different views on their role and may add to the knowledge of the perception of the roles of LHWs on farms.

This study was done with participants from farms in the Western Cape Province and the perception of the role of the LHW in other provinces may differ, as those communities may have other needs.

### **6.4 RECOMMENDATIONS**

Recommendations can be made regarding practice, education and further research.

#### **6.4.1 Recommendations for practice**

Lay health workers on farms in the Boland area of the Western Cape Province have an extended role in their communities and are contributing to the health status of the people on farms. To improve the health status of the farming community all role players should form a team and farm LHWs should be included in these teams. A good working

relationship should exist between the LHW and the nearest primary health care facility. All information regarding patients should be shared amongst health workers to achieve a holistic approach to the patient's problems.

LHWs need a steady source of supplies and they need to be able to access transport, blankets, food parcels, gloves, bedpans and other equipment to care for their patients.

LHW programmes should be rolled out to include all farms and farmers should be briefed about the advantages of having a LHW available.

LHWS should be remunerated for their services and their achievements should be acknowledged.

#### **6.4.2 Recommendations for education**

The contribution of LHW to health in general should not be underestimated.

The training of LHWs is being done by different organisations and this influences the scope of their practice. This training should serve as a basis for further education and should be recognised as such.

The guidelines that were developed can assist the trainers whether it be nurse managers or staff from NGOs to ensure that LHWs are well prepared for their work.

Knowledge and skills are passed on from mother to daughter in generations on the farms and experience should be recognised and applauded.

Basic training of LHWs should be supplemented by in-service training and refresher courses. Gaps in learning skills must be addressed with further education and training.

Training of LHWS need not be expensive and local formal health professionals can be co-opted to help with training. All books and training material should be sponsored by service organisations in the area.

### **6.4.3 Recommendations for research**

Further research is necessary to explore the role of lay health workers. A comparison must be done to evaluate the contribution of LHWs to change disease patterns in rural and urban areas.

Research regarding the psychological stress experienced by LHWS can also be undertaken to explore the effect that this has on family lives on farms.

Specific programmes, i.e. tuberculosis support regimes that are organised by farm LHWs must be evaluated for effectiveness.

## **6.5 CONCLUDING REMARKS**

In a rapidly changing society with its demands on the physical, psychological, socioeconomic and mental well-being of its inhabitants all formal health services, especially primary health care services need all the help that they can get to provide health care for all. The formidable farm lay health workers in the Boland area of the Western Cape have laid an important cornerstone in providing first level health contact with people on farms.

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**APPENDIX A: ETHICAL COMMITTEE APPROVAL**

**UNIVERSITY OF SOUTH AFRICA  
Health Studies Research & Ethics Committee  
(HSREC)  
Faculty of Human Sciences  
CLEARANCE CERTIFICATE**

Date of meeting: 5 July 2006

Project No:05990165

Project Title: The role of the farm lay health worker in the rural Western Cape Province

Researcher: BJ van der Merwe

Supervisor/Promoter: Prof TR Mavundla

Joint Supervisor/Joint Promoter: -

Department: Health Studies

Degree: Master of Arts

**DECISION OF COMMITTEE**

**Approved**

**Conditionally Approved**

Date: 5 July 2006



**Prof TR Mavundla  
RESEARCH COORDINATOR**

**PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES**

## APPENDIX B: APPLICATION FOR RESEARCH

Message

Page 1 of 1

**B J vd Merwe**

**From:** B J vd Merwe [bemicvdm@bolanddm.co.za]  
**Sent:** 08 May 2005 01:30 PM  
**To:** 'Luce'  
**Subject:** permission  
**Importance:** High

Dr. Lannon

I am doing research on the practice of lay health workers and the effect of their work on the health services and the community.

I hereby request permission to hand out 50 questionnaires at the primary health clinics in the Paarl and Stellenbosch areas later during this year. Some of the staff and community members will have to complete the questionnaires and this will be very easy and will not take a lot of time or effort. The participants will stay anonymous.

I will explain everything to them.

I need your permission now, as I must send this to my study -supervisor soon.

Thank you for your help.

Bj Vd Merwe.

05890185( student number)

MA (CUR) course

UNISA

2005/05/06

## APPENDIX C: CONSENT FROM DISTRICT MUNICIPALITY



**CAPE WINELANDS DISTRICT**  
MUNICIPALITY • MUNISIPALITEIT • UMASIPALA

MEMORANDUM TO/AAN : Sr PJ van der Merwe  
Nursing Services Manager

Official / Beantwoort : Dr LS Lunnon

Ref No / Verw No : S.P. V/23 (W)

Date Datum : 09-06-2005

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### RESEARCH LAY HEALTH WORKERS

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Dear Sr van der Merwe

Your email dated 6 May 2005 regarding permission to do research on the practice of lay health workers and their effect on the health services and the community, refers.

Permission is hereby given to hand out and receive the questionnaires. Kindly serve us with the outcomes of your research.

In the light of the severe staff shortages consideration will be appreciated not to burden staff unnecessarily with extra work.

We wish you success with your studies.

Regards

**DR LS LUNNON**  
**DIRECTOR: HEALTH SERVICES**

LSL/cbvd

**APPENDIX D: INFORMED CONSENT FORM**

I ..... understand that the

Researcher will be conducting a focus group interview to explore the role of the lay health worker on farms in the Boland. It might also be necessary for the researcher to conduct a personal interview with me.

I have the right to withdraw from the study.

I have the right to privacy and dignity and the right to stay anonymous. Confidentiality will be adhered to. I have the right to fair treatment and to be protected from discomfort and harm.

I have been selected by my supervisor, because I have been doing lay health work for more than three years and I am willing to share that experience.

My participation is voluntary.

My identity will not be revealed.

I will attend the focus group on .....  
at .....

I will give my full co-operation to this study.

Date: .....

Participant: .....

Witness: .....

Researcher: .....

## APPENDIX E: TRANSCRIPTION OF THE INTERVIEW WITH THE FOCUS GROUP

### TRANSCRIPTION OF THE INTERVIEW WITH THE FOCUS GROUP - PAARL

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- R "We are here at the Du Toitskloof Resort to do a focus group interview with five lay health workers.  
Mrs Calltz from the Eben Dönges Hospital at Worcester is the observer and she will also take some notes.  
I am BJ van der Merwe and we have Sarie and Jolene, Magrieta, Klaas and Klara. Welcome to all ... please be comfortable and feel free to say anything that lies on your heart ... uhm ... I want to speak to you today about your role as health workers ... What does the role as health worker entail ... how do you experience your role as lay health worker ... Sometimes it feels just like a list of tasks that we do, but we have a certain role to play in the community and with the people that we work. We have a certain "hat" that we put on our head ... a certain way of how we do things ...  
So the question is - how will you explain your role as health worker?  
Anyone can speak first."
- P1 "I think it is an important role where we serve as **link in the community.**"
- R "So you say that you serve as a link between the community and the professional health services? ... uhm"
- P1 "Participant nodded - yes."
- R "Good! How will you describe this role as **link**? This is one of your roles as lay health worker? What other roles do you have? You do certain things and tasks ... How can we group it together as different roles?"
- P2 "We are also the **referral source** for people in the community."
- R "So you say that you are the **first level contact** with the community and therefore you must know how to refer the people to other sources? Good ... what else?"
- P3 "Yes ... another role of the health worker is also that **he serves as a link between the employee and the employer** ... you are the peoples contact on the farm ... sometimes the farmer does not know what is going on on his farm - you are the eyes and the ears on the ground and you have to tell the farmer what his employees are saying ... Sometimes the people are **shy and do not want to talk** to the farmer ... and ... and then you have to **listen to them** ... and then tell the farmer ... If the people are **sick you have to get the information and go inform the farmer** - so that he can understand if someone is ill and cannot work."
- R "So you are the mediator between the patient and the farmer? Is that right... if I say so?"
- P3 "Yes ... yes - exactly."

- R "Good ... good ... what do you two say?' ...
- P4 "A health worker must be a **good person and serve as an example** to the others ... it does not help to tell people what they must do ... and then you don't set an example."
- R "Like a rolemodel?"
- P4 "Yes, you can't tell somebody to stop drinking and then you stand with a glass wine in your hand ... he must stop shouting ... but you shout all the time ... and the **people must trust the health worker** ... as Sr van Zyl told us ... mind, soul and body ... if you tell somebody it will go better in their house, but he looks up to you and you do exactly the opposite ..."
- R "So you must be a rolemodel?"
- P4 "Yes and by being ... I don't know about the others ... but by being a health worker ... it built my **self esteem** ... I don't feel like just being a farm person, but they see me as **somebody in the community.**"
- R "Yes, yes."
- P4 "I am not just Magrieta ... but they look at me as a whole person - the **real person.**"
- R "So, this has built on your self esteem?"
- P4 "This was the **first thing they taught us** on the course ... to **built your self image** - if you do not have a good self image, how can you then help others!" ...
- R "Ja - ja yes so you have to have a good self esteem to work with other people? Let us now focus again on the roles that we have as health workers on our farms. What do we do for our clients, our **patients** on the farms? What is our work with them?"
- P5 "You must make the difference in their lives and motivate them."
- R "A motivater?"
- P5 "They wake the health worker at night ... we have more colds now, we have to have a husband that understands ... you must go with the people to hospital in the middle of the night ... you must be a **strong person** ... sometimes you want to stop working, but then you think of the need of the people ... it's nice after all to do the work; because you meet a lot of people ... you are very involved ... sometimes it's difficult, but sometimes you learn a lot ... you get to love the people ... must distantiate yourself other than get too involved. Sometimes the families chuck the patient out and you have to care and give linen and food and blankets and help with the social grant."
- R "So we identify ~~have~~ a carer's role?"

- P5 "Yes ..."
- R "You also said that you have to act in a social workers role by helping people with the grants? We are looking for the different roles remember."
- P4 "Yes. Yes"
- R "So it is the carer's role where you sometimes have to physically care for the people and also have to refer to social services?"
- P4 "Yes. Yes"
- R "Good - what else do you do for the patients."
- P3 "Sometimes you have to go out and do a service in the patients house."
- R "Religious services?"
- P3 "Yes - so we also do religious work."
- R "So we identify a religious role as health worker in reaction to what the community needs?"
- P3 "You have to look after the patient during the illness and if he/she dies, you have to help with the arrangements for burial - everything ... they leave everything to do for you as health worker ... it's your baby ... you have to identify the body, lay it out and do everything."
- R "Uhm. Uhm."
- P2 "You also have to do all the counselling ... after the death ... with the family."
- R "Oh, so you do counselling also?"
- P2 "You must take them through the grieving process ... they rely on you as health worker."
- R "Uhm - if we come back to the counselling role - what does this entail. What kind of counselling do you do?"
- P1 "I had a case where I had to get the patient ready for death - we have to pray and everything ... the last moment he still was afraid - I had to comfort him and pacify him before his death ... was difficult to accept that he was dying ... I had to help him to go over to acceptance of his death."
- P2 "Like the other women who died, who was worried about her two children - I had to promise that I will see to it that they are taken care of."
- R "So you had to take on a social worker role to see that the specific placements of the children went well?"
- P2 "The clinic sisters are there again to take your hand and help you as health worker."

- R "Lets get back to the advisors role ... what can we identify there? About what do we give advice?"
- P1 "We give advice at the clinic when we work there and at our churches."
- R "About what?"
- P1 "At the church you tell them to live a happy life and just do good."
- R "And at the clinics? What kind of advice do you give to patients? What do you talk about in the waiting rooms?"
- P1 "Cough - cough.  
They must be calm and wait their turn and not loose their temper about the long waiting hours."
- R "Do you sometimes talk about health subjects?"
- P2 "Yes, we also give advice on TB, Aids and when they do not take their pills we have to give information and advice as how important it is."
- R "You also have to motivate patients?"
- P2 "Yes we have to DOTS them."
- R "DOTS?"
- P2 "Yes, we have to observe that they take their tablets everyday."
- R "And what about it when a patient dies?"
- P4 "We have to see to the children of the Aids patients. These children know you ... you come to their house everyday to care for the Aids patient ... so when he dies ... you have to arrange for placement of the children."
- R "So you do aftercare also?"
- P4 "Yes - we see to the rest of the family."
- R "Good - now do you keep records of your work - do you have forms to fill in?"
- P5 "Oh a lot ... !"
- P1 "We weigh the babies and have to plot this on the road to health card. If the weight gain is not good we have to advise the mother about feeding, TB etcetera."
- P2 "We have to write this down on the patient record and write referral letters if necessary ... or make phonecalls ..."

- P5 "I have a list that I must fill in ... date, time, problem and monitor the patient ... what was wrong and what I did for him ... all written down ..."
- P3 "If you suspect Tuberculosis according to the signs and symptoms you have to refer the person to the clinic for a sputum test ... this is very nice, because the sister of the clinic will write back to you on the letter if you were right and what else to do with the patient."
- R "So you would know what happened to your patient."
- P3 "Yes ... and sometimes ... our contact with the sister is so good, that she can phone me to tell me if the patient did not attend the clinic or that the patient must be at Niewedrift Clinic at a certain date and time and I will see to it that the patient get there."
- R "So you have to go look for the patient and tell him?"
- P3 "Yes, that's right."
- P2 "We may also refer the patients to the day hospital with a letter. That makes it easier for us and for the patient."
- R "Uhm, uhm. Ok"
- "And if we think of more roles ... you have now mentioned the carers role, social worker role, administrative role, curative role where you treat for minor cuts and bruises etc. and a counsellors role i.e. for the berieved ... you have also a referral role where you refer those that you cannot treat?"
- P5 "Sometimes you sit with patients that are ... how shall I say ... uhm ... they are mentally impaired ... you have to refer that person ... last week I had one like that!"
- R "So you must be able to determine what is wrong with that person? How can we call that ...? How severe is the case and when to refer?"
- P5 "Yes you have to know that."
- R "You have a crisis on hand and you must then decide? ... This is different than having a patient with a stomach pain ... this is a mentally disturbed person and you must know the criteria to refer? This is a major responsibility!"
- P5 "Yes, you also have to give an affidavit at the police station and go with the patient ... all the forms to be filled in and the Judge ... and then you have to go with to the mental institution where they admit the patient."
- R "Yes this is a lot of legal aspects."
- P5 "And while the patient is there, I have to arrange for the family to visit."
- R "Uhm ..."

- P4 "And while the patient is there, you have to arrange for the grant to be paid to the family."
- R "That also!"
- P4 "And you have to inform the employer and comfort the family."
- R "Sjoe, that's a lot of responsibilities!"
- P2 "Yes it is sometimes difficult and where there is crime involved ... it's terrible ... you can't choose sides, you have to listen to both parties ... you have to be the person in between to solve the problem."
- R "This is new, I have studied a lot of literature and this is not mentioned anywhere ... the role as interviewer between spouses quarrels. Other roles? You are quiet?"
- P1 "Sometimes people want to get divorced, then you as health worker must counsel them both to prevent this tragedy ... and if one of them tested HIV positive there is blame on the one partner and this causes a fight."
- P3 "And children also are abused, and you have to take these children under our wing and you have our own children also ..."
- R "Must you take the children in your home?"
- P3 "Yes - you must care for that child - especially if there was sexual abuse."
- R "If you work with children like these, you have to have some psychological background to attend to this child?"
- P3 "Yes - but there is no time to study all those things ... you must take your own initiative and as mother must know what to do ... they worry not about their children ..."
- P2 "I started a choir for the abused children - to get their minds off the problems and to keep them happy and to help them to have self-worth ... I ask them what they would like to be someday ... motivate them."
- R "So you motivate the youth?"
- P2 "Then they must go sing in other places ... and they don't have money ... they parents do not care and we have to raise funds ... And then we have a prayer group for the women in the mornings ... that helps."
- R "Alright - I will give you one minute to think ... what do you still do? Is there anything else that you can think of?"
- P1 "We also have to look after older people and see that they are not robbed from their pension."
- P2 "We are for them and take them out and sometimes wash them."

- P4 "We also help children and teach them."
- R "Do you teach them life-skills or what?"
- P4 "Yes, we teach them and give them hugs."
- R "Do you have to teach people about TB symptoms etcetera? You are a source of information I presume?"
- P1 "Yes, we have an educators role also we have to teach the people about hygiene and other illnesses."
- P2 "We also advise on the correct diet and how to stay healthy."
- P5 "We have to develop our people."
- R "What do you do to develop your community?"
- P5 "I have functions in my area ... just to get the parents and children together ... to take time off their hands "
- P3 "We have evenings of song and dance over a weekend to keep them busy ... and to help them relax ... otherwise they sit at home and think of all the wrong things to do. The kids are involved with booze and drugs ... there are no order or respect in the households ... so we talk on topics like that. We talk about love ... if the parents drink the children will do the same ... we must help them develop to a higher level. The parents must set an example to the kids and will then understand them better. It's not just the house - the children learn these things outside also, but parents must give the children an education and see that they go to school. To keep them busy and away from the wrong things - we have evenings of song."
- R "So you arrange activities to develop your farm and the community?"
- P3 "Yes, definitely."
- P1 "And then there is the old woman I took into my home - her children neglect her. I took her and arranged for a grant and visit to hospital and to clean her."
- R "Anything else you want to mention?"
- P2 "I just want to say that health work is bigger than just health ... and pills and spectacles ... It is broader ... it is from a baby to the old person and until a person dies ... it works with the whole person ... if an accident happens now, we must know what to do."
- R "Do you also do first-aid?"
- P2 "Yes we are trained at level two in first-aid some of us have worked in hospitals ... we would like to go there again ... to get a practical experience ... we made the workload less for the nurses ... we took blood pressure and

helped ... we took people to x-ray department ... they do their work and we do the little things - we are not paid - we do it voluntarily.\*

P5 "People are recognizing us for what we can do. We help to keep the farm clean and tell the people not to mess and the farmer is glad. He sees that we can change things in the environment. Also at the welfare office when we go there and tell them that we are a health worker, they listen to us."

R "Have we now covered all the different roles as lay health workers?"

P2 "We also give talks at the schools about health matters."

R "Yes, that is the education role."

P1 "We also arrange community meetings with the police, social services, other health staff and then they know what we can do and how to refer back to us on the farms. It's like a networking role."

R "Oh, networking role?"

P1 "Yes."

R "Are there sometimes other people that are questioning you about your roles and responsibilities? Like research teams and visitors?"

P5 "Yes, tourists ask a lot of questions and people do research and ask us to participate and do specific things."

P4 "They sometimes make a film about what we do. In the past the farmer had to do everything, but now we are there to help with the diseases and illnesses and the people do not bother the farmer with that."

P2 "We have to weigh the children and do it in a certain way for the researchers and then they write about that."

R "Anything else? Nothing? Then I want to thank you all for participating. I promise to handle this information with discretion and give you feedback. As I promised earlier - I will not use your names or anything that will identify you as a person. Have a nice day."

**INTERPRETATION:**

R= researcher

P1 to P5 = Participants one to five-responses

Main themes are in bold

Sub-themes are underlined

**MAIN THEMES OBSERVED DURING THIS INTERVIEW WITH FOCUS GROUP**

Link in the community

Referral source for people in the community

First level contact

Listen to shy people

Attend to sick people

Good person-serve as example-role model

Trustworthy person

Good self-esteem-somebody important-real person

Carer

Counsellor

Advisor

Recording/administration

Helper for mentally impaired

Educator

Development of the community

First Aid

Research participant

**SUB THEMES(WORDS)**

Link between the community and professional health services

Link-employee and employer

Framer uninformed-tell him what employees are saying

Eyesfeers on the ground  
Mediator  
Health worker set an example  
Mind, body, soul invo ved in work  
LHW is whole person  
Make difference in lives of people  
Go to hospital at night with the people  
Involved  
Love people  
Care and give linen, food and blankets  
Help with social grant  
Refer to social services  
Religious work  
Look after dying-arrangement for burial  
Assist in grieving process  
Comfort and pacify clients  
Teach them on happy life  
Calm patients- advise on waiting times  
Advice on health topics  
Observe to take medication  
Arrange for placement of children  
Plot the weight, record keeping ,phone calls  
Referral system  
Support for mentally ill-affidavit accompany patient  
Arrange for payment of grants  
Comfort the family and abused children  
Inform the employer  
Care for children

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Choir for children

Raise funds

Prayer groups

Care for the elderly

Wash patient

Teach people-hygiene

Arrange function in the community

Treat minor cuts and bruises

Measure blood pressure

Change things in the environment

Networking role

## APPENDIX F: LANGUAGE EDITING



**S**ERVICES

*English/Afrikaans*  
*\* Translations*  
*\* Editing*  
*\* Proof-Reading*  
*\* Academic Manuscript Preparation*  
*\* Archival Research*  
*\* Transcriptions from Archived Documents*



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### ***TO WHOM IT MAY CONCERN***

This letter serves to confirm that the undersigned

**ILLONA ALTHAEA MEYER**

has proof-read and edited the document contained herein for language correctness.

(Ms IA Meyer)

SIGNED