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Evaluation of community home-based care programmes in the Capricorn District Municipality

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Thesis presented in partial fulfilment for the degree of Master of Management (in the field of Public Sector Monitoring and Evaluation) to the Faculty of Commerce, Law, and Management, University of the Witwatersrand

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Abstract

This implementation evaluation is focused on the service delivery process of community home-based care within Capricorn District Municipality, Limpopo Province. Previous research on community home-based care shows that the programme plays an important role in the provision of health care services. Interviews and documents analysis are used in this research to assess the process of delivering community home-based care in order to improve the quality of life for patients with chronic illnesses. Key themes in the conceptual framework which shapes this evaluative assessment are programme coverage, service delivery process, organizational support and outcomes of community home-based care programme. The study shows that community home-based care was designed to be an extended arm of the Department of Health in the provision of health care services especially in the rural areas. The research shows that the service provided by the programme has improved the lives of many patients with chronic illnesses, and it remains important to the wellbeing of the community. The study reveals many challenges which threatens the sustainability of the community home-based care. It is concluded that the Department of Health should realize the importance of community home-based care and provide full support before the programme collapses as this can lead to a national disaster in the health care system.

Keywords: Community home-based care, Caregivers, Chronic illnesses, Department of Health, Capricorn District Municipality.

Declaration

I declare that this dissertation titled 'evaluation of community home-based care programmes in the Capricorn District Municipality' is my own, unaided work. I have acknowledged and referenced all sources that I have used and quoted. I hereby submit it in partial fulfilment of the requirements of the degree of Master of Management (Public sector monitoring and evaluation) in the University of the Witwatersrand, Johannesburg. I have not submitted this report before for any other degree or examination to any other institution.

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I would like to thank the National Lotteries Commission for awarding me the bursary to complete my postgraduate studies.

Dedication

This research is affectionately dedicated to the following :

My late grandmother – Mrs. Mmamaropeng Hlapisi Moshi. May her soul rest in peace

My parents – Ms. Roslinha Moshi and Lesiba Masibe

My sister – Tshegofatso Moshi

My sons – Itumeleng and Tshepang Moshi

You have been my pillar of strength. I will always be grateful for your support. May the lord bless you.

Table of contents

Abstract i

Acknowledgements iii

Dedication iv

List of figures vii

List of tables viii

Chapter 1: Introduction to the research 1

1.1. Context of the study 1

1.2. Conceptualizing the research 1

1.3. Delimitations of the research 3

1.4. Justification of the research 3

1.5. Preface to the research report 3

Chapter 2: Literature Review 6

2.1. Emergence of community home-based care in Africa. 6

2.2. Community home-based care in South Africa. 7

2.3. Non-governmental organizations in primary health care. 8

2.4. Knowledge gap 9

2.5. Monitoring and Evaluation 9

2.6. Proposed conceptual framework 18

Chapter 3: Research Methodology 21

3.1. Research strategy 21

3.2. Research design 21

3.3. Research procedure and methods 22

3.4. Research reliability and validity measures 27

3.5. Research limitations 27

Chapter 4: Perspectives on the practice of community home-based care by stakeholders in the Capricorn District Municipality (CDM) 28

4.1. Stakeholders understanding of the logic behind the community home-based care programmes 28

4.2. Stakeholders' understanding of the purpose of community home-based care programmes 33

4.3. Stakeholders' understanding of the link of community home-based care activities to the goal of the programmes 41

4.4. Stakeholders' perceived gaps in the implementation of community home-based care programmes 49
4.5. Stakeholders' understanding about the future of community home-base care programme 52
Chapter 5: Analysis of stakeholders perspectives about the practice of community home-based care programme 56
5.1. Stakeholders' understanding of the logic behind the community home based care programmes 56
5.2. Stakeholders' understanding of the purpose of community home-based care programmes 59
5.3. Stakeholders' understanding of the link of community home-based care activities to the goal of the programmes 64
5.4. Stakeholders's perceived gaps in the implementation of community home-based care programmes 69
5.5. Stakeholders' perspective about the future of community home-based programme 71
Chapter 6: Conclusion and Way Forward 75
6.3. Perspective on the future 77
References 79
Annexure 1: Questionnaire 83
Annexure B: Schedule of interviews 91

List of figures

Figure 1: Stepwise model of programme evaluation ……..12
Figure 2: Overview of programme theory……..14
Figure 3: A simple logic model ……..17
Figure 4: Results chain ……..18
Figure 5: Programme theory of community home-based care……..19
Figure 6: Factors which led to the formation of home-based care programme……..29
Figure 7: Chronic and non chronic illnesses covered by home-based care programme……..30
Figure 8: Gender profile of home-based care beneficiaries ……..31
Figure 9: Age profile of community homre-based care beneficiaries ……..32
Figure 10: Stakeholders's perspective about the purpose of home-based care programme …..35
Figure 11: Stakeholders's perspective about the relevance of home-based care programme ……37
Figure 12: Stakeholders's perspective about termination of home-based care programme ……40
Figure 13: Activities of community home-based care programme ……42
Figure 14: Training required to improve of home-based care programme……44
Figure 15: Perspectives about the support received from programme stakeholders……46
Figure 16: Perspectives of the respondents about the challenges of home-based care programme ……50
Figure 17: Perspectives of the respondents about the future of home-based care programme…. ……53

List of tables

Table 1 : Survey administered …….. 28

Chapter 1: Introduction to the research

1.1. Context of the study

The high increase in the number of people infected with chronic illnesses in developing countries has severely affected the health care system in Sub-Saharan region (Mamba & Ntuli, 2014). South Africa has the highest number of HIV/AIDS cases in the world with at least five million people living with desease. To address this challenge, South African government has adopted a community home-based care strategy in the year 2000 to facilitate the provision of primary health care services (Hatlane, 2014). Mamba & Ntuli (2014) explained that the need for community home-based care services became evident when patients with chronic illnesses were either discharged or not admitted in hospitals due to lack of capacity within health care institutions. Community members were encouraged by government to establish and register non-governmental organizations which will assist the government to provide primary health care in South Africa. This led to an increase in the number of community home-based care in South Africa with at least 1422 registered 2004 (Naidu, et al., 2008). However, this non-governmental organizations have their own share of service delivery challenges which must be addressed in order to improve the quality of health care provided. Community home-based care is important to promoting, restoring and maintaining the patients comfort, function and health towards dignified death (Mamba & Ntuli, 2014).

1.2. Conceptualizing the research

This section outlines the problem to be addressed by this research and the reasons why it is important to conduct this study. In order to find answers to the problem, research questions and some delimitations set by the researcher are also outlined.

1.2.1. The research problem statement

Community home-based care play an important role in the provision of primary health care services in South Africa, and a lot of research into this area has been conducted in Africa, especially the sub-saharan region (Dippenaar, Chinula, & Selaledi, 2011). Previous studies have described the purpose and challenges of community home-based care which affect the quality of service provided to patients with chronic illnesses. However, what is not clear in this studies is how community home-based care programme is designed to improve the quality of life for people living with chronic illnesses (Phaladze, 2003). Weiss (2008) suggested that behind every programme there is a theory which explains how programmes are designed to work and achieve

the expected outcomes. It also explains the rationale why the proposed actions will lead to the intended programme outcomes. Previous studies on community home-based care have not documented the underlying programme theory and make it known to all programme stakeholders. Potter, van der Merwe, Kaufman, & Delacour (2008) mentioned that programme theory allows for effective evaluation of social programmes, and that an evaluation which is not informed by programme theory becomes a theoretical and method-driven activity.

Programme theory has been central to successful community initiatives in the United States for many years (Coalter, 2012). The review of 28 articles on programme theory evaluation revealed that a lot of research on this subject is done by European countries with the United Kingdom being the front runners. The review also shows that monitoring and evaluation of social programmes in Europe is guided by the use of programme theory. Programme theory research in South Africa is done mainly by the University of Cape Town and University of Stellenbosch. However, this form of evaluation has not been put to practice by many organizations within the country. From all the articles reviewed on programme theory, only two were related to monitoring and evaluation of social interventions at non-governmental organizations; and this sources were published in South Africa. This evaluative assessment focuses on the design of service delivery process of community home-based care in Capricorn District Municipality (CDM), Limpopo province and it is guided by key themes identified in the proposed programme theory derived from the literature.

1.2.2. Research purpose statement

The purpose of this study was to assess how community home-based care programmes, which the South African government introduced to support the provision of primary health care, are designed to improve the quality of lives for people with chronic illnesses within Capricorn District Municipality (CDM) in Limpopo province. A secondary aim of this study was to examine whether the programme has been implemented as intended. Community home-based care was adopted by the South African government in the year 2000 as a strategy to provide primary health care. This was necessitated by an increased number of HIV/AIDS infections in the country (Hatlane, 2014). The study has the potential to improve future implementation of community home-based care programmes and ultimately its impact on the lives of people living with chronic illnesses. It also has the potential to influence legislation and policy on Primary Health Care (PHC) in South Africa

1.2.3. Research question

- What is the logic, purpose and design of community home-based care programme within Capricorn District Municipality in Limpopo province?

1.2.4. The research sub-questions

- What is the stakeholders understanding of the logic behind the formation of community home-based care programme?
- What is the stakeholders understanding of the purpose of community home-based care programmes?
- What is the stakeholders understanding of how community home-based care activities are designed to achieve the goals of the programme?
- What do stakeholders identify as gaps in the implementation of community home-based care programme?

1.3. Delimitations of the research

This research attempt to assess how activities are designed to achieve the outcomes of community home-based care programme, and whether the programme is being implemented as intended. This is not an impact assessment study and it does not attempt to assess the plausibility of the proposed programme theory of community home-based care. The study will be conducted within Capricorn District Municipality (CDM) and will not be extended to other district municipalities in Limpopo province. This study will be conducted within a short time period with limited budget. The sample will be small and not representative of the population. As a result of this limitation, the findings will not be generalized to other parts of the province or country.

1.4. Justification of the research

Most evaluations on social programmes focus mainly on the impact of interventions without understanding the mechanisms which led to the change. Previous research on community home-based care provide detailed information about the purpose of the programme without explaining how it is achieved. This research attempts to close this knowledge gap by assessing the design of the service delivery process for community home-based care. Future evaluations of community home-based care programmes can therefore be focused on the key variables of the programme and ensure that evaluations are not a theoretical and method-driven activity. Programme managers will be able to know which aspects of the programme works and/ or do not work so that it can be improved in the future. This evaluation will provide information for decision making about the future of community home-based care in Capricorn District Municipality.

1.5. Preface to the research report

The purpose of this research report is to present the findings regarding the design, purpose and logic of community home-based care programmes.

Chapter 1 of this research report provides context under which this study on the practice of community home-based care is undertaken. The research focuses primarily on the rationale, design and puporse of community home-based care programme in Capricorn District Municipality. The gaps and challenges regarding the current practice of community home-based care are also outlined in this research report.

Chapter 2 explores the findings made by previous research on community home based care programme and in the broader field of Monitoring and Evaluation. The focuses on the discussion about the emergence of community home-based care in Africa, the role of non-governmental organizations in primary health care, and the description of community home-based care programme in South Africa. This chapter also highlight the purpose, key facts and debates in the field of Monitoring and Evaluation, and how various approaches are used to evaluate programmes. The key themes regarding community home-based care are identified in previous studies to help focus this research and are outlined in the conceptual framework.

Chapter 3 focuses on the research methodology followed when conducting this research on community home-based care programme. A qualitative research strategy was adopted for this study using descriptive research design to address the research problem. The research is conducted in the five local municipalities under Capricorn District Municipality and a purposive sampling method was used to select research participants. Interviews and document analysis are used as techniques for data collection. Ethical considerations and limitations about this research are also highlighted in this chapter.

Chapter 4 presents the research findings on the practice of community home-based care programme from the perspectives of the stakeholders in Capricorn District Municipality in Limpopo province. The focus of this chapter is on the history of community home-based care South Africa and the demographic profile of the patients served by the programme. Discussion about the findings on the activities, training and stakeholders of the programme is also undertaken by the researcher. The chapter also present the findings about the outcomes, successes and failures failures of the community home-based care programme. Furthermore, a presentation is made on the findings about the importance of the programme, the conquences of terminating the programme, the challenges facing the programme, and lastly the future of community home-based care programme.

Chapter 5 of this report focuses on the analysis of the research findings. The analysis is linked with the themes in the conceptual framework as outlined in Chapter 2. It focuses on the the demographic profile of the respondents, how community home-based care programme was formed, the beneficiaries, outcome and activities of the programme, and the organizational support given to the programme. Chapter 5 also looks at the relevance and importance of community home-based in the primary health care. Lastly, the researcher focuses on the potential consequences of shutting down the programme, challenges and the future of the programme.

Chapter 6 present conclusions and a way forward regarding community home-based care programme. The rational behind the formation and purpose of the programme are discussed. The focus then turn to how the programme is designed and implemented to improve the quality of lives for people living with both chronic and non chronic illnesses. Lastly, recommendations are made on the future of community home-based care and possible areas of conducting future research on the programme.

Chapter 2: Literature Review

This section explores the broader issues affecting primary health care sector, particularly the role of non-governmental organizations in the community. It provides insight into the practice of community home-based care by broadly discussing various issues affecting the health care system and the prevalence of the HIV/AIDS pandemic in Africa. The review is organized to provide understanding into the history of community home-based care in Africa, with particular attention to its purpose and challenges and the role of non-governmental organizations in South Africa in the fight against chronic illnesses. The review also looks at the broader field of monitoring and evaluation, and its contribution to the success of social programmes. The key attributes of monitoring and evaluation are discussed to provide an understanding of the various approaches used to conduct evalutions of many social interventions. The review also outline the conceptual framework to be used for this research on community home-based care programmes in the Capricorn District Municipality.

2.1. Emergence of community home-based care in Africa.

Mamba & Ntuli (2014) indicated that the number of people living with chronic illnesses in Africa is gradually increasing and this present a problem to the continent given its inadequately funded and weak health care systems. In Africa, community home-based care programmes started in Zambia and Uganda (Rosenberg, Mahude, Hartwig, Rooholamini, Oracca-Tetteh, & Merson, 2005). It is used as a strategy and solution to the capacity challenges facing the health care delivery system for Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) management in developing countries (Phaladze, 2003). Swaziland hospitals have also experienced their own share of overloading with HIV/AIDS, tuberculosis (TB), and Malaria patients necessitating that they be cared in their homes (McCreary, Mkhonta, Popovich, Dresden, & Mndebele, 2004).

Mamba & Ntuli (2014) indicated that the necessity of community home-based care especially in developing countries became evident when patients with chronic illness were either discharged or not admitted in hospitals due to shortage of beds, overcrowding, inadequate number of medical and nursing professionals. They stated that HIV/AIDS pandemic has hit mostly sub-saharan as a region in Africa. For this reason, the past 20 years has seen sub-saharan region moving from in-patients hospital admission and care towards community home-based care (Mataure & Thupayagale-Tshweneagae, 2013). However, Tembo, Pengpid, & Peltzer (2012) noted that

community home-based care organizations also do not have the capacity to deliver service to many patients outside the hospital. Although Mouton (2009) said that South Africa has put measures in place to strengthen the health and educational systems, Hatlane (2014) argues that the country remains with the highest number of HIV/AIDS infections in the world with at least five million people living with the disease. Historically, home-based care was limited to the elderly, children and disabled persons but the growing number of people infected with HIV/AIDS has necessitated the expansion of the programme (Phaladze, 2003). According to Uys (2001), care provided by Caregivers often start with counselling the patients, and usually ending with bereavement counselling of family members. Mamba & Ntuli (2014) added that an important role of home-based care is to promote, restore and maintain patients comfort, function and health towards dignified death.

2.2. Community home-based care in South Africa.

According to Uys (2001) the system of care has three components i.e. hospital care, outpatient care, and community-based care. Furthermore the components of an integrated community home-based care model are community Caregiver team, hospitals, hospices, clinics, patients and their families, support groups, care for orphanage and vulnerable children, and the community at large. In 2000, an increased number of HIV/AIDS infections in South Africa led to government responding to the need for primary health care services by adopting a community home-based care strategy (Hatlane, 2014). Community home-based care is defined as the care given to patients in their homes by families and supported by skilled social workers to meet spiritual, material and psycho-social needs (Phaladze, 2003) (Mataure & Thupayagale-Tshweneagae, 2013).

The primary goal of community home-based care is to instill hope to patients with chronical illness to maintain their independence and high quality of life through quality and appropriate physical, psychological, spiritual and palliative care (de Saxe Zerden, Zerden, & Billinghurst, 2006) (Mamba & Ntuli, 2014). Hatlane (2014) pointed out that the scope of practice for Caregivers is to promote and help maintain the health of clients; education and awareness on health-related issues; risk assessment of community members; and the provision of palliative care to families and individuals. Murphy (2005) elaborated that community home-based care involves care for the bed/house bound patient, directly observed treatment short-course, counselling, care for orphans, distributing food parcels, blankets, coal, clothing, advocacy and practical assistance; income generation projects; and awareness campaigns.

Campell, Gibbs, Maimane, & Nair (2008) indicated that care giving requires a commitment of time and effort from community Caregivers that comes at a high price to them without material gain. A serious debate about the role of health volunteers and what can be achieved through home-based care programmes without the provision of sustainable stipends to volunteers needs to take place. This view is emphasized by Ingle (2012) who added that the cornerstones and drivers of community home-based care programmes are a powerful civil society movement and volunteers. There should be a comprehensive collaboration of stakeholders to support the social, financial, material, technical and psychological needs of Caregivers (Dippenaar, Chinula, & Selaledi, 2011). In their research on cost and quality performance indicators for home based care in South Africa, Naidu, et al (2008) found that community home-based care is largely dependent on volunteers as they are less expensive to maintain as compared to professional personnel, home-based care is more cost effective than hospital care and the delivery of community home-based care in urban areas is less costly than is rural areas.

2.3. Non-governmental organizations in primary health care.

Sub-Saharan Africa has seen an increase in the number of non-governmental organizations being established early in 2000. These non-governmental organizations have become an important part of a development engine as they are able to provide services to peripheral areas that government is not reaching (Chiranga, 2011). This increase in the number of non-governmental organizations has created an environment where they become highly dependent on financial support from donors who have injected large amount of resources in the not-for-profit sector to fight the HIV/AIDS pandemic (Holtzhausen, 2013). Between 2003 and 2004 there were at least 1422 non-profit organizations providing community home -based care to patients with chronic illness in South Africa (Naidu, et al., 2008).

According to Chiranga (2011), international organizations have made massive injection of funding for development programmes in Africa, especially where diplomatic relations with the west have been good. Gwandure & Mayekiso (2013) add that international donor organizations have supported and funded research, development of medicines and prevention technologies, and treatment programmes on HIV/AIDS in Sub-Saharan Africa. However, Chiranga indicates that financial support that is not supported by structural transformation of non-governmental organizations will lead to outcomes that are not sustainable. Non-governmental organizations in a developing country such as South Africa are better placed to link the community needs with the state resources (Allwood, 1992). Community-based organizations provide fundamental support to

government in the fight against HIV/AIDS pandemic. They assist with the implementation of programmes aimed at behavioural change in the context of HIV/AIDS and empower marginalized communities through training and peer educations programmes (Tembo, Pengpid, & Peltzer, 2012). South African government has realized the importance of community-based organizations and has given non-profit organizations mandate to deliver community home-based care (Mataure & Thupayagale-Tshweneagae, 2013).

2.4. Knowledge gap

Community home-based care practice has numerous challenges which need to be addressed urgently. Funding for home-based programmes seems to be the most significant constraint followed by lack of equipment and trained personnel, transport problems, medication and stigma (Swartz & Roux, 2004). Other challenges include the high turnover of professional nurses leaving the country to work abroad and a lack of social support for Caregivers (de Saxe Zerden, Zerden, & Billinghurst, 2006). The programme is also faced with the challenges of greater travelling time by Caregivers especially in rural areas resulting from longer distances and poorer transport facilities (Naidu, et al., 2008). Phaladze (2003) said that Caregivers are also exposed to the high risk of contracting the HIV/AIDS due to lack of knowledge and skills or the material resources necessary for HIV/AIDS prevention and management. Mamba & Ntuli (2014) added that carergivers are faced with challenges of poor economic status of patients, lack of remuneration, and children as primary Caregivers.

Other issues of concern with community home-based care is the reliance on volunteers, the difficulty of providing care in the context of poverty, lack of intergration of home-based programmes into government health provision threatens the survival of non-profit organizations offering these services to the community (Rosenberg, Mahude, Hartwig, Rooholamini, Oracca-Tetteh, & Merson, 2005). Mataure, Thupayagale-Tshweneagae, & Sibanda (2015) informs us that health infrastructure, human resources, coordinated services, community participation and capacity building are crucial to quality and efficient health care.

2.5. Monitoring and Evaluation

This section explores the broader field of monitoring and evaluation. The discussion is focused on established facts, key issues, debates and attributes in Monitoring and Evaluation.

2.5.1. Definition of Monitoring and Evaluation

Programme evaluation studies gained momentum during the 1930's in the field of education and public health. Mouton (2007) indicated that programme evaluation had to employ objective and

systematic research methods and procedures in the 1950s to become scientifically acceptable. In 1984 Evaluation Research Society and Evaluation Network merged to form the American Evaluation Association which resulted in evaluation studies spreading to other parts of the world. Mouton (2007) explained that this merger led to the formation of African Evaluation Association (AEA) in 2002. In 2003 a number of evaluation experts were brought to South Africa to attend a conference which resulted in the formation of South African Monitoring and Evaluation Association (SAMEA). The need for monitoring and evaluation system in South Africa became evident when Department of Monitoring and Evaluation (DPME) was established to monitor governments service delivery programmes (Louw, 2012). Furthermore, donor organizations engage in monitoring and evaluation activities to gather evidence and measure the success of programmes towards improving social conditions. Rossi, Lipsey & Freeman (2004) says that funding organizations that invest in social programmes should hold them accountable through monitoring and evaluation activities. Van Rensburg (2008) affirmed this view in saying that monitoring and evaluation is necessary for both internal and external systems of the organization to provide evidence-based information required for informed decision making.

Rossi, Lipsey, & Freeman (2004) described programme monitoring as a process of documenting aspects of programme performance to indicate whether the programme is being implemented as planned to achieve its intended outcomes. Mouton (2007) elaborated that monitoring is a continuous process of assessing service delivery process with the aim of intervening with corrective measures where there is a deviation from planned activities. On the other hand programme evaluation is defined as the systematic use of social research methods to investigate the effectiveness of interventions to inform programme of action in improving social conditions (Alkin, 2013). Mouton (2009) indicated that most organizations are still caught up in impact evaluations. According to Loots (2008), an evaluation that is focused on programme design, implementation, goals and effectiveness of programme delivery reflect not only a sound research methodology but a real desire for knowledge of what effect the programme has on its beneficiaries. The purpose and development of evaluation is grounded in three roots of the evaluation tree. Firstly, social accountability provides greater motivation and rationale for evaluation especially for development programmes funded by government entities; secondly, systematic social enquiry which refers to the need to employ research methods and procedures as evaluation models with an objective to determine social accountability of programmes and to contribute towards knowledge construction; and lastly, epistemology of evaluation which is concerned with gathering evidence to

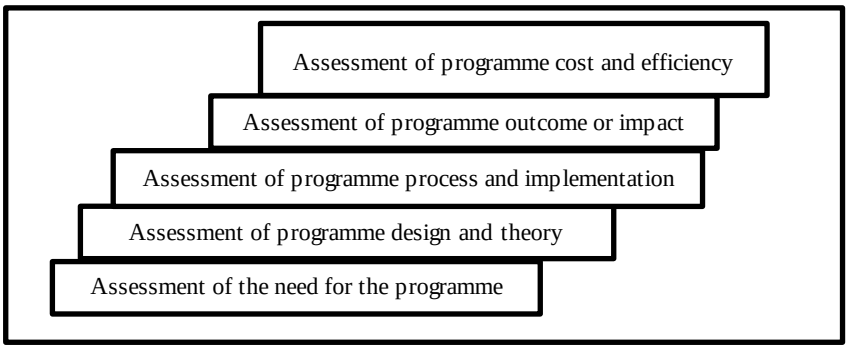
support the legitimacy of value claims made about the programme, and that the truth is in fact what people make it to be (Alkin, 2013, p. 13).

Programme evaluators use research methods to conduct an evaluation of a specific programme with an intention to provide information for decision making about these programmes in the future. Weiss (1998) said that it is not always the case that evaluations are conducted for decision making but there could be other factors that influence a decision to conduct an evaluation. For example, evaluations takes longer and those in authority may use it to delay decisions, or some administrators may use it to give legitimacy to a particular decision, and or use it for public relations purposes where it serves to only glorify a commissioning organization. Monitoring and evaluation of programmes enables the feedback loop required in project management for continuous improvement in programme design and implementation (van Rensburg, 2008). Hulton (2007) explained that evaluation information can be used to help improve the design, implementation and impact of the programme. Formative evaluation is a form of evaluation that can improve a programme by examining its delivery, the quality of its implementation and the assessment of the organizational context, personnel procedures and inputs (Salie & Schlechter, 2012). It can be used to identify the strengths and weaknesses of the programme by gathering data about its design and implementation in order to improve programme efficiency.

Weiss (1998) indicated that there are two pairs of terms which are often used in programme evaluation. The first pair include an outcome evaluation and process evaluation; and the second pair encompasses formative and summative evaluation. According to Weiss (1998), an outcome evaluation refers to an assessment of the effect of the programme on the lives of its beneficiaries, while process evaluation is not too different from the concept of monitoring which is concerned with what actually happens within a programme. Loots (2008) explained that process evaluation can either serve to improve the programme or be formative driven. It involves monitoring of programmes to identify deviations from planned activities and put corrective measures in place in order to achieve planned outcomes. Furthermore, Weiss (1998) explained that formative evaluation serves to provide information that can be used to improve the programme during planning and design, while summative evaluation provides information about the effectiveness of the programme on its beneficiaries. Summative evaluation help programme developers to decide on the future of the programme. Formative and summative evaluations refer to the intention of the evaluator for commissioning the study; whereas outcome and process evaluation refers to the phase of the programme that is being studied.

The core of evaluation research is to refine and discover the theory underlying a programme that is being evaluated (Befani, 2010). According to Loots (2008), evaluation of interventions will differ in terms of the purpose of the programme, the kind of data required, and the nature of the intervention. These differences can be seen in the evaluation model proposed by Rossi, Lipsey, & Freeman (2004) and seconded by Louw- Potgieter (2012) in **figure 1** below. The model shows that various types of evaluations can be conducted i.e. need assessment; evaluation of programme design and theory; evaluation of programme process and implementation; impact evaluation; and efficiency assessment.

Figure 1: Step-wise model of programme evaluation (Rossi, Lipsey, & Freeman, 2004)



Alkin (2004) explained that (1) the first step in the model is the analysis of whether or not the programme correctly conceptualize the social problem it addresses; (2) the second step is to assses the external and internal consistency of the proposed programme theory; (3) the third step in the model is to assess if the programme has been implemented exactly as planned and at the intensity level required; (4) the fourth step is an assessment of the programmes effectiveness in bringing about change in the lives of people who participated in the programme; (5) the last step in the model is to assess the efficiency of the programme by examining whether or not the benefits of the effects produced by the programme justify the costs of the programme to its stakeholders. Louw-Potgieter (2012) proposed that an evaluation model developed by Rossi, Lipsey, & Freeman in 2004 should be used to judge the merit of social programmes and that it is also possible for programme evaluators to focus their attention on one type of evaluation in the model. Salie & Schlechter (2012) have also came up with a model showing that programme evaluation consist of problem identification, need analysis, assessment of programme design, implementation assessment, outcomes assessment, and impact assessment.

2.5.2. Established facts and debates in evaluation

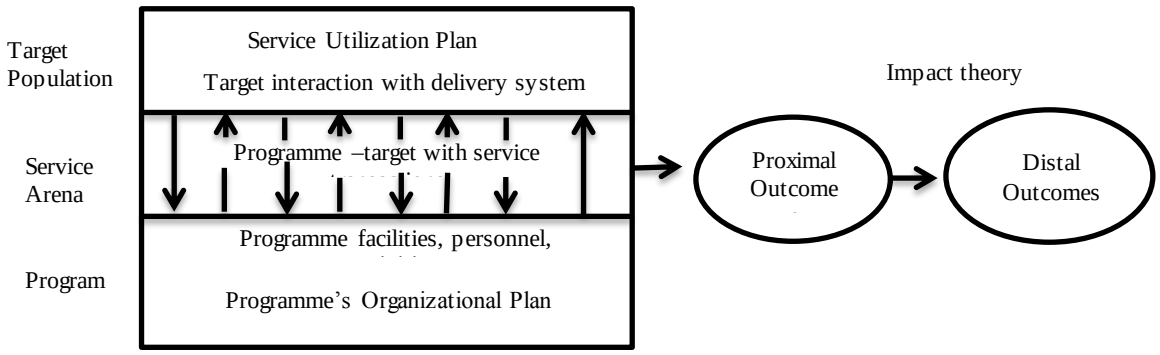
Programme theory has become an important aspect of monitoring and evaluation of social programmes in recent years. Donaldson (2007) said that an interactive symposium revealed that programme theory is central to many of the visions and modern theories of evaluation practice into the new millennium. Weiss (1998) also informed us that behind every programme there is a theory. It is this theory that has attracted academic interest in the field of policy and programme evaluation because it explains the causal link between programme activities and outcomes of the programme (Nakrosis, 2014). This causal link between programme activities and the outcomes of the programme was termed programme theory by Bickman in 1987 (Louw-Potgieter, 2012). Programme theory has been approached in many ways by researchers throughout its development and all approaches have a common element i.e. causal link between programme activities and the outcomes of the programme. Terms such as outcomes hierarchies, theory of change, theory in action, theory-based evaluation, theory driven evaluation, and programme logic have all been used to describe programme theory (Harden, 2006).

Theory of change has been central to community initiatives in the United States for many years; where programme evaluators have been working with programme implementers from the start of the project to design and evaluate the programme. During the 1980's, many countries were faced with economic challenges and issues of accountability which led to the reform of the public sector; and they used programme theory and logic models to address their challenges (Funnel & Rogers, 2011). However, in South Africa, programme evaluators are not involved in the design of the programme but are only called in to assess the programme while is underway (Mason & Barnes, 2007) (Coalter, 2012). It is important for evaluators in South Africa to get involved in planning and designing of programme activities so as to understand the underlying theory necessary for conducting impact evaluation. Programme evaluation becomes a theoretical and method-driven activity when is not based on programme theory (Potter, van der Merwe, Kaufman, & Delacour, 2008). Programme theory model should be used to direct many evaluation processes of development interventions (Rogers, 2008). The value of programme theory is underpinned by the fact that programme stakeholders takes ownership and responsibility of the interventions aimed at addressing their needs. They make it clear what outcomes they hope to achieve in the long, medium and short-term, how they expect the programme to achieve this, and they also provide a rationale as to why they believe the proposed programme actions will achieve the expected outcomes (Mason & Barnes, 2007). Furthermore Mason & Barnes (2007) said that programme

theory also put more emphasis on the context under which the programme operates as it can affect the achievement of expected outcomes.

Rossi, Lipsey, & Freeman (2004) presents an overview of a programme theory framework which can be used to guide evaluation of programmes in **figure 2** below. Programme theory is underpinned by the use of logical framework that looks at the programme process theory and programme impact theory consisting of service utilization, service delivery, organizational support, outcomes, and impact (Rossi, Lipsey, & Freeman, 2004)(Donaldson, 2007)(Rundare & Goodman, 2012). Louw-Potgieter (2012) indicated that the assumptions about how an organization its reaching its programme beneficiaries and how these beneficiaries interact with the programme are reflected in the service utilization plan. The support required for effective implementation of the programme such as facilities, personnel, administration are described in the programmes organizational plan (Donaldson, 2007). Programme impact theory is based on the assumption that the programme process theory has been implemented as intended to achieve proximal and distal outcomes of the programme. Buys & Louw (2012) says that the changes expected in the participants of the programme as a results of its activities is known as programme impact theory.

Figure 2: Overview of programme theory (Rossi, Lipsey, Freeman, 2004)



The conceptualization and design of social programmes should reflect assumptions of all stakeholders about the nature of their problems and demonstrate how these will be solved (Rossi, Lipsey, & Freeman, 2004). The underlying programme theory should be designed to be plausible by giving details of the evidence based on similar programmes, the levels and exposure of participants, the resources and skills necessary to deliver the programme; and it should also be evaluable (Blamey, MacMillan, Fitzsimons, Shaw, & Mutrie, 2012). The nature of interventions differ in many ways as they are implemented at project, organizational and policy level. Hansen & Vedung (2010) suggested that a more suitable term for programme theory is intervention theory. A

well-developed intervention theory has three dimensions that inform how programmes are designed. Firstly, the context in which the programme will be implemented (situational theory); secondly, the chain of reasoning of the cause-effect relationships among aspects of the programmes in order to achieve the intended outcomes (causal theory); and thirdly, the need for the envisioned programme outcomes (normative theory).

An articulated programme theory should be spelled out in programme document and well understood by all stakeholders. When the underlying assumptions about programme services and practices presumed to accomplish programme outcomes have not been fully articulated and recorded, the programme theory is said to be implicit (Rossi, Lipsey, & Freeman, 2004, pp. 167-168). Donaldson (2007) and Chandler & Williamson (2013) refer to an implicit programme theory as a black box approach. An explicit programme theory provide details on the internal and external conditions under which programmes are being performed, and also tells us how, for whom, and why programmes are failing or succeeding to improve social conditions by providing an evidence-based narrative (Nakrosis, 2014). It helps build consensus among diverse stakeholders on how the programme is supposed to work to improve their social conditions. It provides information that highlights gaps and opportunities for collaboration with implementing partners. It also supports the development of meaningful indicators to track progress and report achievements (Funnel & Rogers, 2011).

Rogers (2008) explained that programme stakeholders are only concerned with the outcomes of the intervention and it is possible measure the impact of our interventions without assessing the programme theory. This view is supported by Field & Louw (2012) who says that the success of a programme can be measured without assessing its underlying theory. Field & Louw indicate that if the outcomes of an intervention satisfy the need of all stakeholders then it is pointless to undertake process evaluation. However, Weiss (1998, as cited in Field & Louw, 2012) informs us that it is helpful to understand how programmes are designed so that they can be improved in the future. A well-documented programme theory allows the evaluator to design and operationalize an effective evaluation system to measure the outcomes of the programme.

Donaldson (2007) support this arguments by pointing out that in cases where the programme is not successful, a theory evaluation is able to identify reasons or gaps for programme failure. Programme theory evaluation of a successful programme will allow programme managers to strengthen the design and increase the attribution claim of the activity. If the programme is not

being implemented as it was supposed to, an outcome evaluation may be misleading. Chen (1990, as cited in Alkins, 2013) also argued that an outcome evaluation has limited usefulness to programme stakeholders as it does not provide information on the strength and weaknesses of the programme design and how programmes can be improved in future. According to Befani (2010) an intervention should be evaluated in its entirety within the context of its operation as this is a dynamic and uncertain environment which threatens the existence of social programmes. Chen (2005, as cited in Hansen & Vedung, 2010) noted that some aspects of the programme will spark disagreements among stakeholders, and this is where a theory stakeholder evaluation should be conducted to incorporate diverse views about how programmes are supposed to be organized and implemented to achieve particular outcomes.

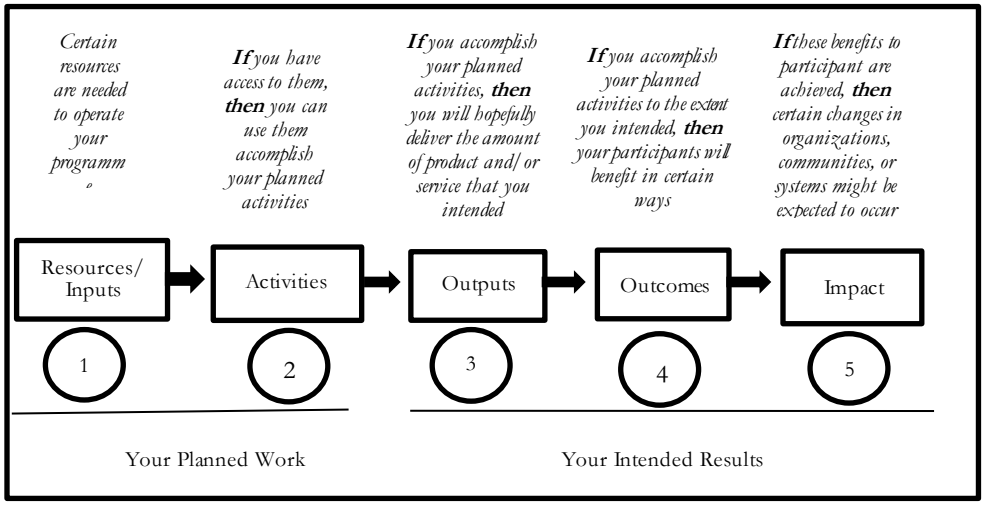
2.5.3. Key attributes of an evaluation exercise

Mason & Barnes (2007) stated that the recent literature concerning the use of theory behind the programme for data collection and analysis use logic models or other forms to outline the components of the programme and the links between them. This is necessary to unpack the "black box" that is between the activity and its outcomes. Burnett, Curran, Loveday, Kiernan, & Tannahill (2014) says that an outcome logic model is sometimes used to provide a framework for evaluation. It is a tool that can be effectively used to plot the programme from its inception through implementation to outcomes. This model consists of the resources used by a programme, the activities which were implemented and participants reached, and the results of the programme. Hulton (2007) explained that although a single and linear causal path is often used to show a programme theory of an intervention, the form of the logical framework should reflect the complex and complicated nature of interventions. The causal-link between activities and outcomes is not unidirectional and thus not following a single or linear programme theory (Watkins, Lyso, & deMarrais, 2011). Mason & Barnes (2007) said that it is impossible to get full details of what is intended to happen within projects and what happens in practice to understand why outcomes are or are not achieved until the project is in operation and data collection has begun. In this way programme theory is continuously refined as it is being developed.

Hulton (2007) indicated that the input component of the logical framework include financial, human, physical and other types of resources necessary for activity implementation. Outputs refer to immediate tangible and non-tangible results of an activity. Short-term outcomes should be achieved within 1-3 years while longer outcomes should be achievable within a 4-6 year framework. Final outcomes of the programme are the long-term changes occurring within 7-10 Years. Furthermore, Watkins, Lyso, & deMarrais (2011) added that short term outcomes are

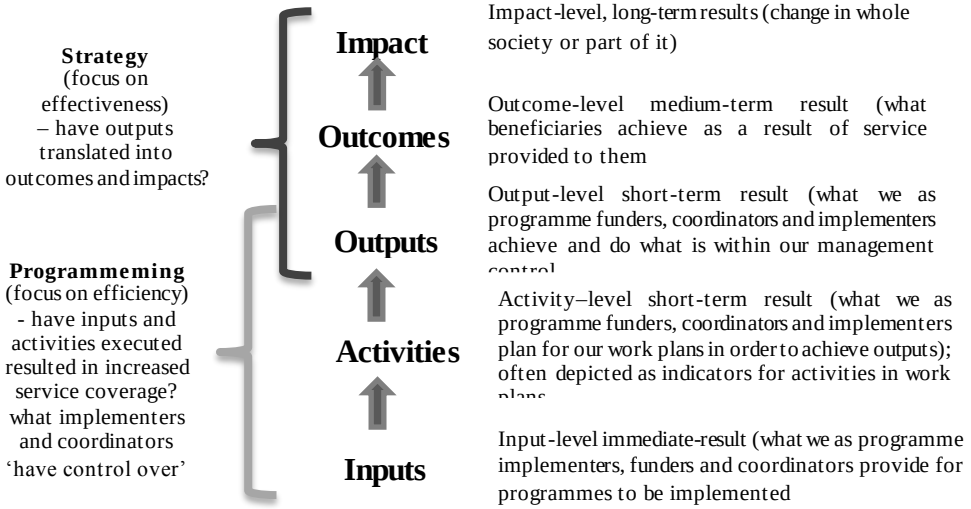
focused on the results of the programme affecting an individual within a team; the intermediate-term outcomes affect the team as a whole, and the long-term affect the overall organization. The inputs, activities, and outputs described in a logical model are part of the programme process theory; while the short, intermediate, and long-term outcomes are part of the programme impact theory in the programme theory representation (Rossi, Lipsey, & Freeman, 2004) & (Donaldson, 2007). Funnel & Rogers (2011) provided a similar explanation of programme-theory, although using different terminology, as a two parts process of a theory of change and theory of action. The central processes designed to bring about change for programme beneficiaries is the theory of change; while theory of action explains how programmes are designed to activate these theories of change (p.16).

Figure 3: A Simple Logic Model (Rogers, 2008)



Rogers (2008) provide an example of a simple logic model published by the W.K. Kellogg Foundation in **Figure 3** above. Funnell and Rogers (2011) said that to develop a outcomes chain, programme managers should firstly prepare a list of possible outcomes; secondly, cluster the outcomes into a manageable number and name each cluster of outcomes; thirdly, arrange clustered outcomes in a chain of *if-then* statements or multiple *parallel if-then* chains; fourthly, identify any feedback loops among the outcomes, and lastly validate the outcomes chain with a range of different stakeholders and by seeing whether the outcomes chain tells a coherent story. The results chain documents the sequence of results that should be achieved in order for the programme to be successful (Gorgens & Kusek, 2009). **Figure 4** below shows an example of a results chain model adapted from Rodriguez-Garcia and Zall Kusek (2007) by Gorgens & Kusek in 2009.

Figure 4: Results chain by Gorgens & Kusek



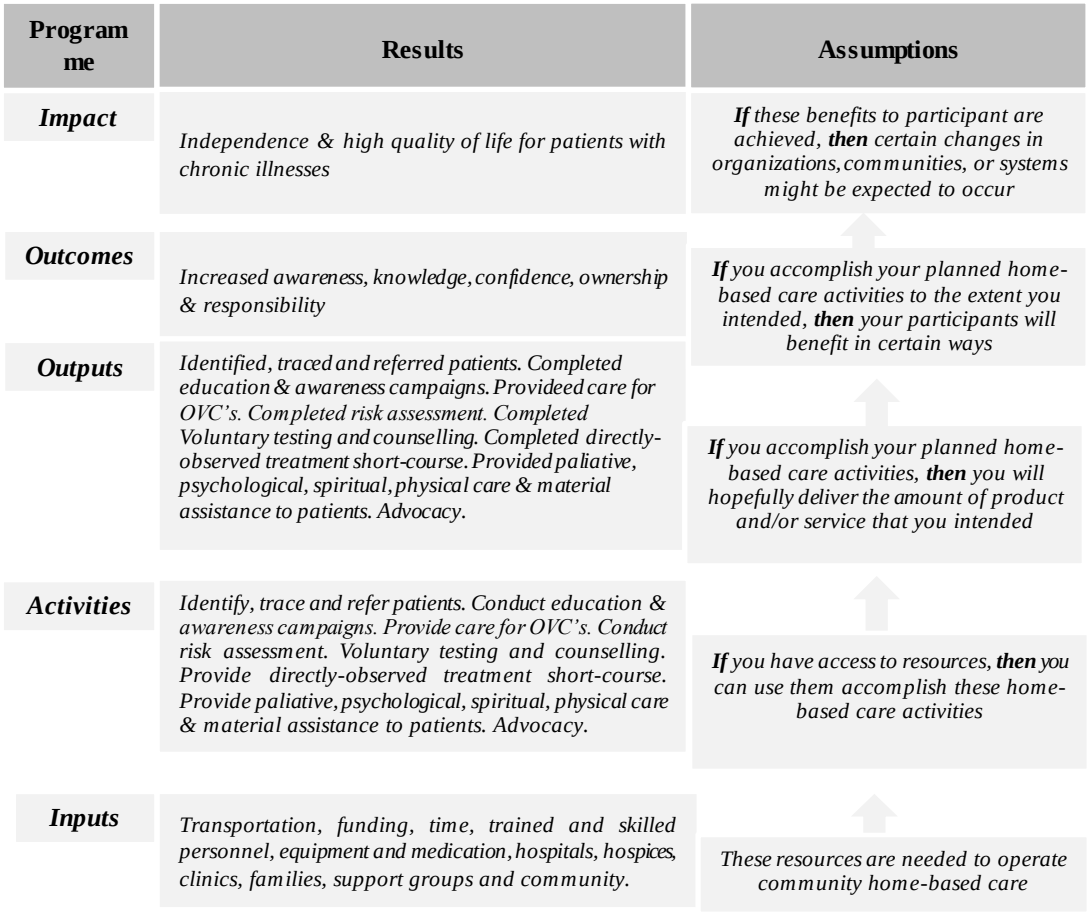
Results framework is sometimes refered to as the logic framework or monitoring and evaluation framework, and it is linked with the expected results of a programme (Gorgens & Kusek, 2009). Authors generally agree that there are some actions which cannot be omitted when building a results-based framework. Kusek & Rist (2004) indicated that it is important when developing a results-based framework to select outcomes and goals of the programme, performance indicators for the outcomes, gather baseline information on the current problem the intervention is attempting to address, set specific targets for the goal attainment, regularly collect data to assess whether the outcomes are being met, analyse and report the results for decision making about the future of the programme.

2.6. Proposed conceptual framework

Research has shown that the primary goal of community home-based care is to improve the quality of lives for patients with chronic illnesses. It has also revealed many challenges faced by programme managers and care givers in a drive to achieve the goals of the programme. However, current research has not outlined the service delivery process of community community home-based care programmes i.e. how the programme is conceptualized and designed to improve the quality of lives for people living with chronic illnesses. There is a lack of research information which describes the causal linkages between the key design features of home-based care activities and the intended outcomes of community home-based care programme. Previous studies have not documented the programme theory of community home-based care programmes. It is also not evident how stakeholders of home-based care planned to address the many challenges facing the

programme. This is not an impact evaluation research; but an evaluative assessment focuses on the design of service delivery process of community home-based care in Capricorn District Municipality (CDM), Limpopo province and it is guided by key themes identified in the proposed programme theory derived from the literature as depicted in **Figure 5** below.

Figure 5: Programme theory of community home-based care programme



Weiss (1998) made a point that a well-documented programme theory allows the evaluator to design and operationalize an effective evaluation system to measure the outcomes of the programme. Programme theory of community home-based care programme has not been documented and thus not making it easy to design and operationalize an effective evaluation. However, the author has gathered sufficient information from the literature to reasonably propose a programme theory of community home-care programmes. **Figure 5** above shows that programme theory of community home-based care has features of programme process theory and programme impact theory as described by Rossi, Lipsey, Freeman (2004**)**. Mason & Barnes (2007) have indicated that the value of programme theory is that stakeholders make it clear what outcomes they hope to achieve, how they expect the programme to achieve them, and they also provide a

rationale as to why they believe the proposed programme actions will achieve the expected outcomes.

The entry point to this interrogation was to understand the factors which led to the formation of community home-based care programmes. This history will help us to understand what the programme of community home-based care was planned to achieve when it was introduced. It will also indicate to us whether or not the outcomes in the proposed programme theory represent what the programme was established to achieve. The respondents had to explain the meaning of the intended outcomes of community home-based care programme as proposed in the programme theory. They explained the meaning of the long-term outcome of an independent and improved quality of life. Programme stakeholders described how community home-based care programme is designed and implemented to achieve its goals. Furthermore they described the gaps and challenges in the current practice; and also gave a perspective about the future of community home-based care programmes.

Chapter 3: Research Methodology

This chapter presents the research methodology followed when conducting this research on community home-based care programme. A qualitative research strategy was adopted for this study using descriptive research design to address the research problem. The research is conducted in the five local municipalities under Capricorn District Municipality and a purposive sampling method was used to select research participants. Interviews and document analysis are used as techniques for data collection. Ethical considerations and limitations about this research are also highlighted in this chapter.

3.1. Research strategy

The primary objective of this study was to assess how community home-based care programmes, which the South African government introduced to support the provision of primary health care, are designed to improve the quality of lives for people with chronic illnesses within Capricorn district municipality in Limpopo province. A secondary aim of this study was to examine whether the Department of Health implemented the programme as it intended to. In his earlier work, Mouton (2001) mentioned that qualitative research methods describe and evaluate the performance of programmes in their natural settings. Mouton (2007) further indicated that qualitative evaluation is best used to gather contextual information and detailed knowledge about what is being evaluated. The advantage of qualitative research is that the focus is on an insider-perspective rather than on an out-sider perspective. It is against the above background that the study was conducted within the qualitative paradigm. This qualitative approach will help the researcher understand the underlying assumptions of stakeholders about the purpose, design and logic of community home-based care programmes.

3.2. Research design

Weiss (1998) explained that formative evaluation refer to the intention of the evaluator for commissioning the study; whereas process evaluation refers to the phase of the programme that is being studied. This was a formative evaluation study assessing both the programme process and programme impact of an intervention with the intention to improve future programmeming. According to Salie & Schlechter (2012), the intention of formative evaluation is to improve a programme by examining its delivery process, the quality of its implementation and organizational support. Mouton (2001) alluded to the strength of process evaluation in that it assess whether interventions have been well conceptualized and properly designed; whether the target group has

been adequately covered; and whether the intervention was implemented as designed. Process evaluation usually asks descriptive research questions. Babbie & Mouton (1998, as cited in Salie & Schlechter, 2012), stated that descriptive research is 'the precise measurement and reporting of the characteristics of some population or phenomenon under study'. It is against this background that this study was conducted within a qualitative paradigm using descriptive research design.

3.3. Research procedure and methods

3.3.1. Data collection instrument

Thomas, Nelson, & Silverman (2011:p 286) indicated that an interview techniques as method of data collection is more valid because the responses are more reliable; and the percentage of returns is much greater. They generally use smaller samples, especially when a graduate is doing the survey. According to Ahuja (2001) the two major functions of the interview technique is to explore and describe issue related to the problem. Thomas, Nelson, & Silverman pointed out that the advantages of conducting semi-structured personal interviews is that the researcher has control over who can respond; and can clarify any questions during the interview. It is againt the above background that data was collected by means of in-depth interview using semi-structured interviews to interogate the design, implementation, purpose and logic of community home-based care programmes in the Capricon District Municipality.

The questionnaire consisted of both open and closed ended questions which were be pretested with respondents from the first two home-based care organizations selected in the study. Feedback from these organizations was incorporated in the revised version of the instrument. The interview questionnaire covered the demographic profile of the respondents; questions related to the outcomes of community home-based programmes; questions related to the implementation of the programmes; questions regarding the organizational support towards the programmes; and questions related to the shortcoming/gaps identified in the programme theory. The interview guide was designed in English and translated in sepedi, a local language in the Capricorn District Municipality.

3.3.2. Target population and sampling

Capricorn District Municipality is one of the five districts in Limpopo province. It is comprised of five local municipalities: Polokwane municipality, Aganang municipality, Blouberg municipality, Lepelle Nkupi municipality and Molemole municipality. According to Census 2011, the district has over 342 838 households with the population of 1 261 463. The sampling frame for this study

consisted of registered home-based care organizations in the Capricorn District Municipality who have been previously funded by the National Lotteries Commission.

Wagner, Kawulich, & Garner (2012) said that qualitative research is not prescriptive in nature and the methods chosen are often unique to a particular study. Due to the intense and in-depth nature of qualitative research the sample size is usually small and thus allowing for a deeper and rich data collected from the respondents. Sample is defined by Thomas, Nelson, & Silverman (2011) as a "group of participants, treatments, or situtations selected from a larger population". Qualitative research usually adopts a purposive sampling strategy to select participants that are relevant to the research questions (Bryman, 2012). It does not attempt to select a representative sample and its findings cannot be gereralized to broader population as it is a non-probability sampling approach. Bryman points out that purposive sampling is not a convenient sampling. Organizations, people, and other units of analysis relevant to the research questions are selected with the goals of the research in mind; and their selection is such that they differ from each other in their characteristics.

It against the above background that the study used a purposive sampling method to select key members of community home-based care organizations to participate in this study. The research data was collected from the stakeholders of community home based care within the Capricorn District Municipality. The targeted stakeholder composition included 10 Programme Managers and 10 Caregivers of community home-based care; 10 Ward Councillors; and 2 Officials from the Department of Health. The questionnaire was administered to 30 research respondents, which is 2 less than what has been proposed in the approved research proposal. Due to the local government elections, it was always going to be a challenge securing interviews with the Ward Councillors. This is the reason why the two Ward Councillors under polokwane municipality could not honor the appointments despite several attempts by the researcher.

The Officials from the Department of Health interviewed in this research are females and are aged between 36 – 55 years. They are married and their highest qualification is national diploma. All the Programme Managers interviewed in this research are females and majority of them are aged between 36 – 55 years.. More than a quarter of the Programme Managers do not have matric qualification, while the other quarter has matric as their highest qualification, and only 20% have national diploma, and the other 10% has bachelors degree. Half of the of the Programme Managers are married while 40% are not married. Research data shows that all Caregivers interviewed in this research are females with 80% of them aged between 36 – 55 years, and the

other 20% aged over 55 years. Majoriry of the Caregivers do not have matric qualification, and less than half of the caregivers are married Majority of the Ward Councillors interviewed in this research are males and are aged between 36 – 55 years Half of the 50% of the Ward Councillors interviewed do not have a matric qualification and all of them are are married.

3.3.3. Ethical considerations when collecting data

Bryman (2012) said that there are some ethical principles that must be taken care of before conducting any research. These ethical principles requires that there is no harm to research participants, informed consent is sought from participants, there is no invasion of privacy, and that there is no deception of research participants. Wagner, Kawulich, & Garner (2012) added that ethical research minimizes some of the issues that may be unsatisfactory to those who are involved, and or have interest in the research. Research participants have the right to privacy or non participation, the right to remain anonymous, the right to confediality, and the right to expect experimenter responsibility (Thomas, Nelson, & Silverman, 2011).

It is against this background that approval to conduct the research on home-based care organizations funded by the National Lotteries Commission was obtained from the Chief Executive Officer. Permission to conduct the study will also be requested from the management of participating home-based care organizations. However ethical clearance was not required as there was no potential harm to the research participants. Informed consent was sought verbally from the respondents to ensure that they don't feel coerced to participate in the study, and they were also informed about the purpose, duration, methods and potential uses of this research. Privacy and confidentiality is increased by hiding the identity of the interviewee, and also not disclosing any information they have shared during the interview which may harm or embarrass the respondents. They were also informed of their right to withdraw at any stage of the interview. The information gathered during the interviews is reported factually without any fabrication of data.

One source of invalidity is that the interviewer tends to improve with experience, and thus the results of earlier interviews may differ from interviews conducted later in the study. Thomas, Nelson, & Silverman (2011) indicated that the interviewer must ensure that the vocabulary level is appropriate and that the questions are equally meaningful given the ages and educational backgrounds of the participants. A pilot study was conducted with two community home-based care organizations within Polokwane local municipality. A voice recorder was used to serve as a backup to the answers captured by the researcher during the interviews. This use of voice recorder

was meant to increase the validity of the research as original data can be traced in the near future. However, the recorder was stolen during a housebreaking at the researchers place of residence.

3.3.4. Data collection and storage

Mouton (2001) said that it is impossible to anticipate all the potential stumbling blocks when conducting a qualitative research. The researcher scheduled appointments with the respondents with the view of making time allowances for the unexpected that might intervene. The data collection was done during municipal elections and the researcher scheduled a special appointments with the Ward Councillors who were involved in the 2016 municipal elections. Mouton has also suggested that, given this challenges in data collection, the time allocated for the different stages in the research process should be presented in broad terms. Therefore the author proposed that the time frames for various stages in this study be as follows:

1. Data collection through interviews - 1 month (June 2016)
2. Data analysis and interpretation - 2 months (July – August 2016)
3. Integrating results and writing the report – 2 months (September - October 2016)

However, due to delays by the researcher in the data collection, the actual timeframes of the gathering data was as follows:

1. Data collection through interviews - 1 month (September 2016)
2. Data analysis and interpretation - 2 months (November – December 2016)
3. Integrating results and writing the report – 2 months (January – February 2017)

Prior to visiting the sampled organizations, the researcher made telephone calls to this organizations requesting an appointment to conduct the interviews. The interviews were held with each respondent separately from the other respondents to increase the independency of the responses. The principle regarding the administration of the research tool was that the manager would be interviewed first; then Caregiver; and lastly, the Ward Councillor. This principle was necessary as it was presumed that Programme Managers would have more information about community home-based care and lay a good foundation for the next respondents i.e. Caregivers and Ward Councillors. Majority of Programme Managers were presumed to be the founding members of community home-based care programme. The questionnaire was piloted with two home-based care organizations within Polokwane Local Municipality and Aganang Local Municipality to assess whether its questions would address the problem statement. After the initial interviews the questionnaire was amended in a way that the questions became more open ended so that respondents are not limited on how they should respond (see attached Annexure A for an amended questionnaire). There was also a deviation from the approved proposal regarding the

municipal order of interviews due to the estimated distances between the local municipalities. The revised order was as per table 1 below:

Table 1: Survey Administered

ORDER#	MUNICIPALITY	INTERVIEW TARGET	INTERVIEW ACTUAL	TYPE OF ACTUAL RESPONDENTS
1	Polokwane	6	4	2 Programme Managers 2 Caregivers
2	Aganang	8	8	2 Officials from the Department of Health 2 Programme Managers 2 Caregivers 2 Ward Councillors
3	Lepelle	6	6	2 Programme Managers 2 Caregivers 2 Ward Councillors
4	Molemole	6	6	2 Programme Managers 2 Caregivers 2 Ward Councillors
5	Blouberg	6	6	2 Programme Managers 2 Caregivers 2 Ward Councillors

During the interviews, the researcher took notes and also recorded the responses to the questions with the help of a voice recorder for comparison during data analysis.

3.3.5. Data processing and analysis

After the interviews, the researcher input both quantitative and qualitative research data into an excel sheet for cleaning any possible errors. The researcher followed Mouton's (2001) explanation that to begin the final data analysis, material from all your interviews that speaks to one theme or concept must be put in one category. The material within categories must then be compared to look for variations or similaries in meanings. The researcher should then compare across categories to discover connections between themes. When consensus between themes emerge, a coding list was designed to develop final themes with the goal of integrating the themes and concepts into a theory that offers an detailed and accurate interpretation of the research area. Mouton says that the

analysis is complete ‘when you feel that you can share with others what your interpretation means for policymaking, for theory, and for understanding the social and political world’. This data analysis therefore provide answers to the research question about the logic, purpose and design of community home-based care programme in the Capricorn District of Limpopo Province.

3.4. Research reliability and validity measures

Reliability of the interview guide was tested during a pilot study to determine the consistency with which respondents understood and responded to all questions. The validity of the instrument was determined by the extent to which it responds to the research questions and objectives.

3.5. Research limitations

The limited time available to the study necessitated that a small sample be selected and as a results the sample is not representative of how other community home-based care programmes work in the Capricorn District Municipality. This assertion implies that there is a possibility that a study might attain different results if conducted in other areas with many respondents. However, this study gives a qualitative description of the programme under study, and how it can be improved in future. Plausibility assessment of the extracted programme theory was not conducted given the short-time frame for conducting the study. The anonymity of the researcher was maintained during and after the study to ensure objectivity of the responses from Programme Managers and Caregivers of home-based care organizations funded by the National Lotteries Commission.

Chapter 4: Perspectives on the practice of community home-based care by stakeholders in the Capricorn District Municipality (CDM)

This chapter presents the results of this research and compare them to what other studies have found about the the logic behind the community home-based programmes; purpose of community home-based care programmes; the link of community home-based care activities to the goal of the programmes; and lastly the gaps in the implementation of community home-based care programmes. The research data was sourced from the interview documents and reports related to community home-based care from the stakeholders of the programme within Capricorn District Municipality. The data is presented according to the core themes outlined in the conceptual framework. Each theme presents a summary of the data, and linkages between questions is established for brevity purposes. Themes will be intergrated to form an overall analysis in an attempt to answer the research question.

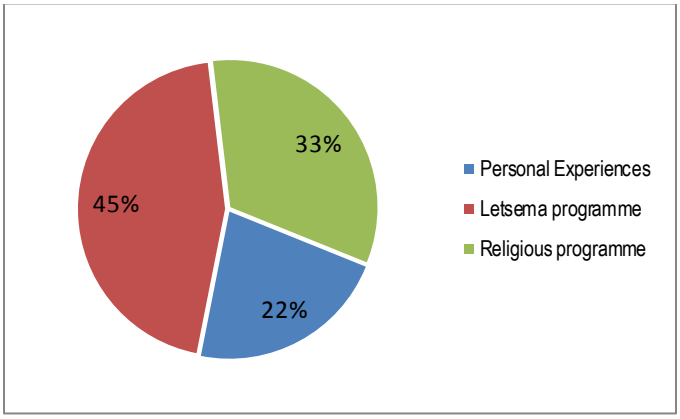
4.1. Stakeholders understanding of the logic behind the community home-based care programmes

This section presents the rationale behind the formation of community home-based care programme. It will help us understand how the programme of community home-based care started, what is was planned to achieve, and who benefits from the programme.

4.1.1. History of community home-based care in South Africa

All respondents indicated that their community home-based care organizations started between the years 2000 and 2007. At least 55% of the organizations were established between 2001 and 2002. They have explained various factors which led to the formation of their organizations with majority of them (45%) indicating that their programme was started through Letsema programme in 2002 under the presidency of Thabo Mbeki. One Caregiver said: “there were long ques at the clinics and home-based care was needed to help nurses in the homes by doing field work” (Interview no. 22, 7 September 2016). Another one said: “there were a lot of people not adhering to medication after being discharged from hospitals and there was a need for volunteers to help those in their homes” (Interview no. 15, 6 September 2016). 33 % of the respondents indicated that their programme was an initiative by religious leaders in church who wanted to help the community with the HIV pandemic. The other 22% of the respondents shared their personal experiences such as death in the family which led to the formation of their home-based care organizations. **Figure 6** below shows factors which led to the formation of home-based care programme.

Figure 6: Factors which led to the formation of home-based care programme



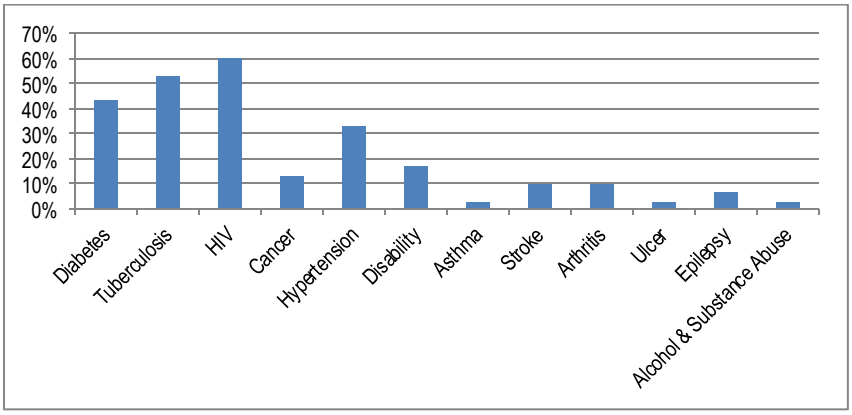
A community programme known as Letsema was introduced in the community where people volunteered their services in projects such as gardening, sewing, cleaning, singing and filling forms for patients at the clinics. One Programme Manager indicated: "the clinics were not able to reach out to patients in the rural communities and during president Mbeki's term, we started letsema programme to clean clinics. We ultimately received certificates and then allowed to do door to door visits to care for patients back in 2002. We referred patients to clinics for help and then started registering non-profit organizations" (Interview no. 23, 8 September 2016). Furthermore, the Programme Managers said that many people in the rural areas believed in traditional medication and did not adhere to medical treatment from the clinics. Those who were infected with diseases were dying due to lack of knowledge, care and support from the community. Most elderly people have chronic medical conditions which require that they be cared in their homes. The capacity of hospitals and clinics was also too small to admit all the patients and chronic patients needed close monitoring to ensure medical adherence.

Majority of Programme Managers indicated that during letsema programme, community members were trained on how to administer blood pressure tests, weight, wound dressing and health promotion. They said that during door to door visits, volunteers were able to identify people who needed medical care and refer them to the clinic for medical care. The volunteers were ultimately awarded with certificates of appreciation for their involvement in the programme by the Limpopo Department of Health. The department continued to provide health training and workshops to this volunteers and decided to absorb them into the health care system. Members of the community who volunteered their services became known as Caregivers. Furthermore, Programme Managers pointed out that Caregivers continued to visit patients in their homes and set their own targets until

they registered non-profit organizations known as community home-based care organizations. Due to the impact of Human Immunodeficiency Virus (HIV) and Tuberculosis (TB) on the community and the shortage of nurses at the clinics, the Department of Health realized the need to use home-based care organizations as the extended arm of government. Caregivers were used to provide home care services to patients who were discharged from hospitals especially the bed ridden, and also to look after the Orphaned and Vulnerable Children (OVC). One Programme Manager pointed out: "the orphans and vulnerable children were provided with food parcels by social workers" (Interview no. 21, 7 September 2016).

Community home-based care provide services to patients suffering from different types of illnesses. **Figure 7** below shows that the rate of response for coverage of HIV and TB is high at 60% and 53% respectively, when compared to other chronic and non chronic illnesses. The rate of responses for asthma, ulcer, alcohol and substance abuse represents only 3% of the respondents. Diabetes and hypertension are also covered by the programme with a representative number of respondents at 43% and 33% respectively. Although HIV and TB are dominant health problems, other diseases covered by community home-based care programme includes diabetes, cancer, hypertension, mental health, asthma, arthritis, stroke, ulcer, epilepsy and disabilities. As one Caregiver said " all kinds of sicknesses must be covered" (Interview no. 18, 7 September 2016). Those who have indicated that community home-based care should cover all chronic and non chronic illnesses affecting members of the community cited lack of access to health facilities in rural areas.

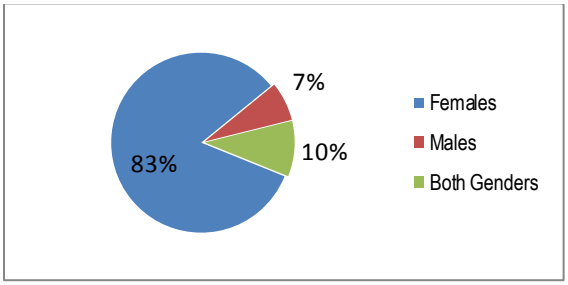
Figure 7 : Chronic and non chronic illnesses covered under home-based care programme



4.1.2. Gender profile of patients

Majority of respondents indicated that there is a high number of female patients served through home-based care programme. **Figure 8** below shows that at least 83% of the respondents indicated that females represents the most beneficiaries of community home-based care programme and only 7% said the male group dominate programme. 10% of the respondents indicated that community home-based care equally serves both males and females. There is not one gender that is served by the programme more than the other. There are a variety of factors highlighted by respondents which contributes to the high number of females in the programme. 17% of the respondents indicated that the population that receives home based care is dominated by women and most of them are not married.

Figure 8: Gennder profile of community home-based care beneficiaries



13% of the respondents indicated that the influence of alcohol, substance abuse and unemployment, especially young women, lead to sexually transmitted infections (STI's). One of the Councillors said " women are mostly under the influence of alcohol and substance abuse; and they also get a lifts from truck drivers, especially the youth" (Interview no. 17, 7 September 2016). The respondents indicated that one man is able to be involved in a relationship with more than one woman at the same time and they sleep together without protection and are infected with HIV/AIDS. One Caregiver said "women do not undergo HIV/AIDS testing before sleeping with the men, hence they are infected" (Interview no. 26, 8 September 2016).

10% of the respondents said that the immune system for females is weak and their health deteriorates quickly when compared to their male counterparts. They further indicated that some women do not exercise and these lead to chronic illnesses such as diabetes, stroke and high blood pressure. 40% of the respondents indicated that women are open and able to disclose their health status and get tested while men are secretive, denial and don't get tested until their health deteriorate before consulting the doctors. Men's pride does not allow them to visit and make

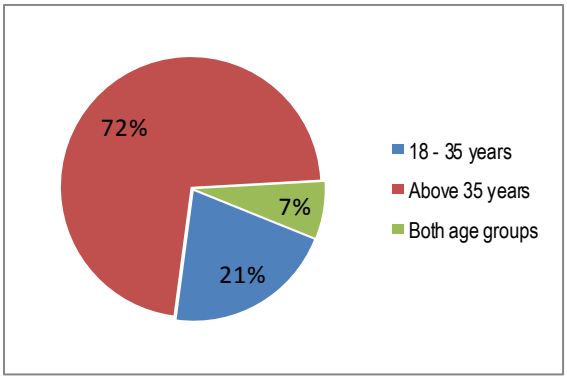
consultation with the doctors and clinics to get help. Even those who get tested do it because they are forced at work. Most men are not comfortable being looked after by women Caregivers who dominate the home-based care service. One Programme Manager pointed out that "women are willing to look after the sick even without first aid kit" (Interview no. 19, 7 September 2016).

13% of the respondents have indicated that although most women use the clinics and are referred to community home-based care by the nurses, the assumption is that if females are highly infected with diseases males are equally infected because they are sleeping together. They say that most men are not served by home-based care programme but they are taking medication from the mobile clinics. One Official from the Department of Health said "men wait until its difficult and then decide to consult" (Interview no. 29, 15 September 2016). Only 7 % of the respondents indicated that men represents high number of patients being served through home-based care programme. They said that men are usually treated for tuberculosis due to the usage of tobacco and alcohol which causes the disease.

4.1.3. Age profile of patients

Majority of respondents indicated that the people above the age of 35 years have the highest number of patients being served through home-based care programme. **Figure 9** below shows that at least 72% of the respondents indicated that people above the age of 35 years represents the most beneficiaries of community home-based care programme and only 21 % said the youth dominate programme. The other 7% of the respondents reported that the youth and elders are equally served by community home-based care. There is not one age group that is served by the programme more than the other. The respondents cited lack of understanding and knowledge of sexually transmitted diseases at 18 – 35 years, while protection is a taboo for the elderly persons.

Figure 9: Age profile of patients served through the programme



30% of the respondents said that the elderly persons have experienced many challenges in their lives and chronic illnesses such as hypertension and diabetes usually find home in them because their immune system has weakened over the years. One Programme Manager mentioned that "mostly are suffering from chronic illnesses such as high blood pressure and diabetes and it is due ageing" (Interview no. 23, 8 September 2016). They indicated that lack of employment, alcohol and tobacco have contributed to the high rate of infections in the elderly persons. One Caregiver said "as people get older, they drink and misbehave and this lead to sicknesses" (Interview no. 15, 6 September 2016). 10% of the respondents indicated that the rural areas are dominated by elder persons who are not able to help themselves. This is because the youth has moved to the cities for better opportunities and home-based care service is generally to the elderly. One Councillor said "elders are too exposed to sexual activities" (Interview no. 28, 8 September 2016). They also said that the youth can afford to pay private doctors and help themselves than the elderly persons. 3% of the respondents said that older people are responsible and able to disclose information for assistance while the youth does not disclose due to fear of humiliation.

21% of the Ward Councillors and officials of the Department of Health indicated that the youth (18-35 years) has the highest number of patients being served through this programme especially in TB and HIV. This was generally based on what they have observed because they are not working in the programme of home-based care. 17 % of them have attributed this infections to poverty, unemployment, peer pressure, alcohol abuse and drop-outs from schools. One Councillor said " the youth don't stay in their homes, they walk at night, get raped and are exposed to many risks. Some don't even disclose that they were raped at some point" (Interview no. 17, 7 September 2016). The Ward Councillors said that young people do not spent quality time with their family, instead they choose to drink alcohol and abuse drugs. They do not get tested nor listen to their parents for guidance. They further indicated that young women fall pregnant and support many children while they are unemployed.

4.2. Stakeholders' understanding of the purpose of community home-based care programmes

This section present the outcomes of community home-based care programme. It will help us understand the what the programme was planned to achieve, its successes and failures; challenges and how it can be improved to achieve what it was intended.

4.2.1. Outcomes of community home-based care

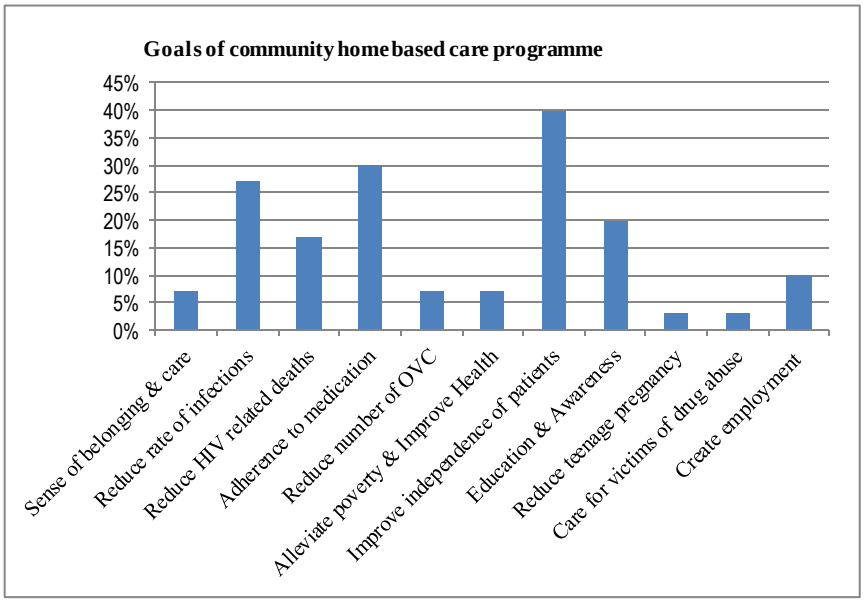
The officials from Department of Health indicated that the goal of community home-based care programme is to reduce pain and stress through the provision of care and support to patients and their families. They said that home-based care organizations provide a helping hand to the Department of Health. 30% of the Programme Managers indicated that community home-based care programme provide care and support to patients for cure and a healthy lifestyle. They indicated that the programme intends to bring hope to patients and make them feel that they are also important. One Programme Manager pointed out that "patients must feel at home and feel cared by the community, and have sense of belonging to the community because they are alone at home" (Interview no. 1, 4 September 2016). 38% of the Councillors said that the programme of home-based care aims to alleviate poverty and improve health of community members. They also indicated that the programme improves the wellbeing of the sick including those who were not hopefull of recovery. One Councillor said "although people will die but they will live longer. The programme is very critical. They are helping to pro-long life of the patients and this is very important as some people are able to recover and be normal again" (Interview no. 5, 5 September 2016). Another Councillor said "it improves health of patients and become independent enough to work" (Interview no. 16, 6 September 2016).

30% of the Caregivers said that the programme provide education and awareness on health issues which makes the community to be well informed and thus reducing the stigma. One Caregiver said "we need to educate people on HIV/AIDS to get rid of discrimination associated with the disease" (Interview no. 2, 4 September 2016). 20% of the Programme Managers emphasized that through education and awareness the number of HIV related deaths, rate of chronic and non chronic infections, stima, teenage pregnancy, orphans and vulnerable children may be reduced. One Official from the Department of Health pointed out that "they are helping hand of the Department of Health many things would not be accomplished without them. Many home visits in the households and health education in schools can be done through them" (Interview no. 30, 23 September 2016). **Figure 10** below provide a graphic presentation on the perspetives of the respondents about the purpose of community home-based care programme

Few Ward Councillors indicated that the programme help rural people understand primary health care and social problems affecting their communities. One Caregiver indicated that "5 years to come, rate of HIV/AIDS infection should be decreased. People should adhere to medication. No children should born HIV positive" (Interview no. 7, 5 September 2016). Furthermore, the

Programme Managers indicated that the programme aims to make treatment accessible to patients at all times and encourage them to adhere to their medication. One manager pointed out that "people are encouraged to adhere to treatment so that they heal and then discharged, and are in better living condition" (Interview no. 9, 5 September 2016). 60% of the Caregivers added the programme brings hope about the future to many patients in the community and improves the wellbeing of the community members.

Figure 10: Stakeholders perspective on the purpose of CHBC programme



30% of the Programme Managers indicated that the goal home-based care programme is that employees become nurses and work for government. This view was supported by few Caregivers and Councillors who said that the goal of the programme is to help its practitioners to be registered as an employee of the department. One Caregiver said "to be registered as an employee of the department is better than being nowhere" (Interview no. 10, 5 September 2016). 20% of the managers indicated that the programme also care for the victims of drugs, substance and alcohol. One Programme Manager added that the programme "care for the victims to a point where they quit abusing the substance" (Interview no. 12, 6 September 2016).

4.2.2. Successes and failures of community home-based care

All Officials from the Department of Health , Programme Managers and Ward Councillors indicated that the programme of home-based care has been successful especially in households where Caregivers are welcomed. They said that in cases where they are denied access to the patients, Caregivers inform nurses who can then do home visits. One Official from the Department of Health pointed out that "because children are not around, carers visit households to cook and

talk with the patients" (Interview no. 30, 23 September 2016). The programme managers stated that home-based care is successful because Caregivers receive cooperation from families and the community. One Programme Manager said "the programme managed to bring hope in the community and parents are now able to take their children for prevention of sicknesses at the clinics, and teenage pregnancy has also gone down" (Interview no. 6, 5 September 2016). They also indicated that the monthly meetings with the Caregivers suggest that progress is made and some patients are discharged from the programme. One Councillor said "the programme is doing very well and have covered a big ground, otherwise many people would have died. They collaborate with community development workers who cleans outside while Caregivers clean in the house" (Interview no. 5, 5 September 2016). The Ward Councillors indicated that the few deaths have been reported and these are for those people who have defaulted on treatment. A Ward Councillor said that "those who were not able to walk are now able to stand up and do for themselves" (Interview no. 27, 8 September 2016).

Few Programme Managers indicated that the majority of people passing away are elders and those who leave for Gauteng province when they are sick and come back home dead. They also indicated that patients have become friends with home-based carers. People who are infected with chronic illnesses are able to disclose their health status and TB patients are cured. 90% of the Caregivers indicated that the number of patients defaulting on treatment and cases of child abuse have declined. One Caregiver said "we are making slow progress as people were afraid to test and now they are taking medication. Pregnant woman are also booking antenatal clinic" (Interview no. 7, 5 September 2016). Another Caregiver said "when they started it was not easy to be allowed by patients in their homes. But now if Caregivers are on leave, patients get worried about not being visited".

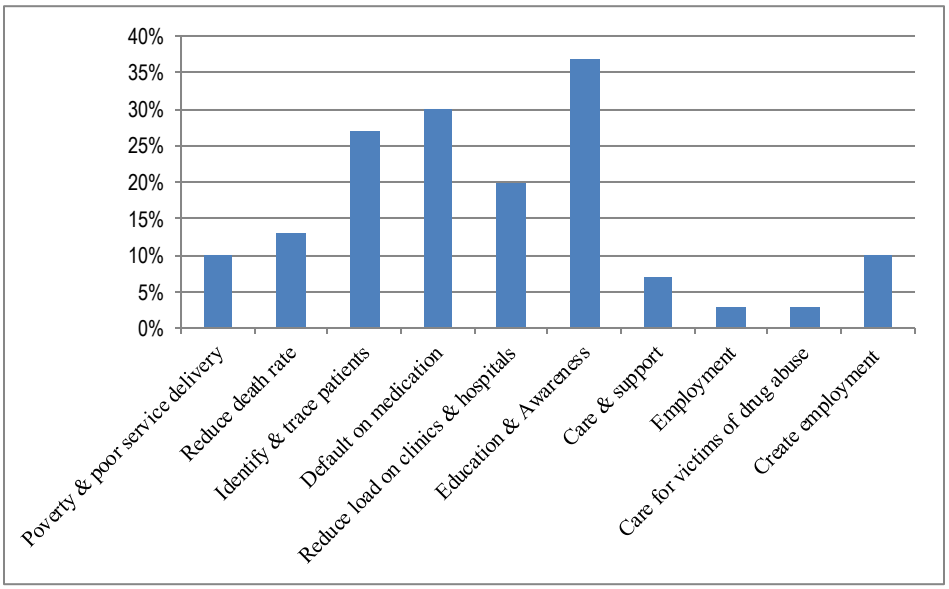
30% of Programme Managers pointed out that while success has been achieved, there are areas of the programme that still needs improvement. They said that the death rate related to HIV/AIDS remains high and Infant mortality was also reported to be on the rise. One manager pointed out that "parents don't visit the clinics for consultation, and thus default on treatment" (Interview no. 4, 4 September 2016). Furthermore, they indicated that role players are still needed, especially the municipality, to provide assistance to the programme by providing land for building offices. Programme Managers also mentioned that the Ward Councillors are not helpful when it comes to issues of land. 20% Caregivers pointed out that the Department of Health and Social Development

should increase their stipends. One Caregiver said "our plead is not falling on deaf ears. One day will get monthly salaries and not stipends" (Interview no. 26,8 September 2016).

4.2.3. Relavance of community home-based care in primary health care

All clinic and Programme Managers said that community home-based care programme is the extended arm of the Department of Health. They pointed out that all what is needed is to provide more training and salaries to Caregivers in order to streghthen the home-based care programme. Majority of the managers and Caregivers said that home-based care organizations help reduce the influx of patients into the already overloaded clinics because they are referred to home-based care and are taken care of in their homes. One manager pointed out that "nurses are not coping in the clinics. Home-based care programme is the extended arm of the Department of Health as nurses cannot leave admitted patients and do home visits" (Interview no. 21, 7 September 2016). One Caregiver said "the programme is very important. Home-based carers are the hand and eyes of the Department of Health on the ground. They are able to call nurses for urgent assistance although the department is not doing much for them" (Interview no. 10, 5 September 2016). **Figure 11** below provide a graphic presentation on the perspetives of the respondents about the relevance of community home-based care programme.

Figure 11: Stakeholders perspetives about the relevance of CHBC.



Majority of the Ward Councillors indicated that the programme helps a lot especially in the rural areas where there is poverty and poor service delivery. One Councillor said "people are staying in hygienic places and can speak to somebody who cares". Officials from the Department of Health indicated that many programmes of the Department of Health would fail without home-based care.

50% of the Officials from the Department of Health and Ward Councillors indicated that education and awareness about health issues is done through community home-based care programme. 70% of the Caregivers also indicated that education and awareness programmes helps people to know their health status as well as instilling good behaviour. One Caregiver said "many people did not have knowledge on health issues, but now people are able to get tested, follow treatment and get cured" (Interview no. 26, 8 September 2016). When asked about the importance of the programme, another Caregiver said "kudu kudu (very important), there are many people who still need guidance and home-based care is way to go" (Interview no. 18, 7 September 2016).

63% of the Councillors said that the patients are dotted and cared for in their homes and their health improves. Officials from the Department of Health have also indicated that patients with tuberculosis and bedridden cannot go to clinics everyday to collect their medication and TB law requires that patients must be dotted everyday. This view was supported by majority of Programme Managers and caregives who said that Caregivers are able to care, support and monitor patients in their homes to ensure that they adhere to treatment. One manager said (Interview no. 14, 6 September 2016). "very important. Patients get better while in their homes. Families come and thank Caregivers for job well done. Some patients only take medication when Caregiver is present". The other pointed out that "home-based carers are able to treat a very ill patient whom family members refuse to care for" (Interview no. 12, 6 September 2016). One Caregiver remarked "nurses would not know who is sick in the village but due to door to door visits by Caregivers, patients are identified and referred to clinics" (Interview no. 4, 4 September 2016).

Ward Councillors indicated that Caregivers are able to provide for their families through the monthly stipends received from the programme. One Councillor remarked "Caregivers are very patient and at peace with themselves to show that they love what they do" (Interview no. 8, 8 September 2016). Another Councillor said "the programme should continue. They are able to reach out to the orphans and vulnerable children who cannot be reached" (Interview no. 27, 8 September 2016). All Officials from the Department of Health indicated that the Department of Health regard community home-based care as a priority in the provision of Primary Health Care. They indicated that home-based care practitioners are being trained in a reengineering programme in Primary Health Care by the Department of Health. One Official from the Department of Health explained: "Caregivers are currently being trained in primary health care so that they learn more on what to do when they visit households, to be able to measure blood pressure, describe symptoms and also refer to clinics" (Interview no. 29, 15 September 2016). 80% of the Programme Managers

indicated that home-based care is regarded as an extended arm of the Department of Health because is not able to reach out to people in the rural areas. One Caregiver said that "they visit home based care and capacitate Caregivers through training. The new engeneering programme on primary health which will grow the service of community home-based care" (Interview no. 7, 5 September 2016).

50% of the Ward Councillors indicated that the Department of Health allow home-based care in the clinics and hospitals to educate people about their programme and medication is available most of the time. 80% of Programme Managers stated that the department continues to provide funding and training to home-based carers. One Programme Manager said "the little support in terms funding says they care" (Interview no. 25, 8 September 2016). 40% of the Caregivers agreed with is view but pointed out that the department is not providing enough support to the programme. They indicated that the department is not providing satisfactory salaries, sufficient equipment and there is no transport for patients and Caregivers. One Caregiver said "they see the importance of home-based care in the community. But they are not providing sufficient funding. I mean Caregivers are able to trace patients that the Department of Health cannot find " (Interview no. 18, 7 September 2016). One Official from the Department of Health said "Department of Health need to show it. But the biggest worry is that Caregivers do not grow, the department should absorb them into jobs, positions should be filled by Caregivers and this would encourage other to get involved. Because others have progressed, until then nothing would improve, e fofa ka moshwang (you cant work on empty stomach)" (Interview no. 30, 23 September 2016). One Programme Manager added that "home-based care is regarded as an extended arm of the Department of Health which is not able to reach out to people in the rural areas but are just not able to satisfy home-based carers by absorbing them as employees of government" (Interview no. 3, 4 September 2016).

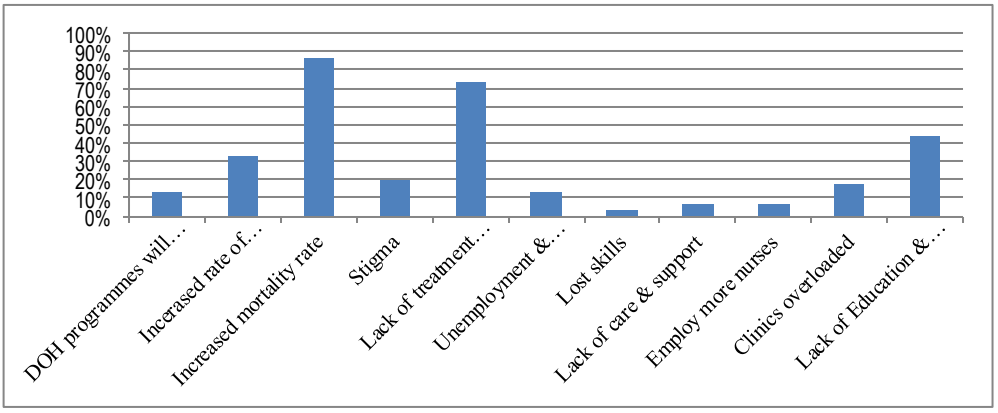
50% of the Ward Councillors indicated that the Department of Health do not regard home-based care programme as a priority in the provision of primary health care. They said that the Department of Health must take full responsibility as the programme is not the mandate of the Department of Social Development. One Councillor said: "Department of Health must take the fall. Out of 100%, we give them 25%"(Interview no. 5, 5 September 2016). The Councillors pointed out that if the Department of Health was taking the programme seriously, they would budget more money for training and salaries. Another Councillor said: "the amount of work being done by Caregivers is a lot but the Department of Health does not take them serious. They do not

have transport, working equipment, and even the stipend is not forthcoming" (Interview no. 16, 6 September 2016). 30% of the Caregivers added that the Department of Health do not realize the importance of home-based care programme. One Caregiver said: "if they took it serious, they would give sufficient stipend and register Caregivers with the department" (Interview no. 10, 5 September 2016).

4.2.4. Perspectives about the termination of community home-based care

The officials from Department of Health pointed out that if the programme is shut down, cure rate for tuberculosis will decline, mortality rate would increase and more people would be sick in their homes without care and support. 60% of the Caregivers added that the rate of infection and death would increase because nurses will not do door to door visits. One Caregiver warned: "people will die. No one will care for them, and illnesses will multiply" (Interview no. 24, 8 September 2016). This view was also shared by 52% of the Ward Councillors who indicated that the Department of Social Development will have to look after more orphans as a result of high death rate. One Councillor pointed out: "more people are sick in their homes but at least they are looked after. If the programme is shutdown, hospitals will be flooded with patients" (Interview no. 5, 5 September 2016). 40% of the Programme Managers indicated that home-based care programme reduces pressure on the clinics brought by the high number of people requiring medical assistance. One Programme Manager said: "there will be a disaster in the community" (Interview no. 14, 6 September 2016). Almost half of the Ward Councillors agrees that there will a disaster in the community because of an influx of people to the clinics which are already under staffed. They indicated that the community is already struggling to get access to doctors and proper health facility. One Councillor warned: "we would demonstrate until the president intervenes because Caregivers are doing a good job" (Interview no. 16, 6 September 2016). **Figure 12** below provide a graphic presentation on the perspetives of the respondents about the termination of community home-based care programme.

Figure 12: Stakeholders perspetives about the termination of CHBC



40% of the Caregivers indicated that the programme help with DOT (Directly-Observed Treatment) support by collecting medication for patients. One Caregiver said: "if the programme is shutdown, there will be disaster in many families. Granny's stay alone and carers help with collection of medication and bedridden are taken care of: pampers, bed sores and etc. " (Interview no. 2, 4 September 2016). Caregivers indicated that without home-based care, many patients are going to default on their treatment. Another Caregiver indicated that: "patients are not able to go to the clinics everyday for 6 months, so Caregivers collect medication on their behalf" (Interview no. 10, 5 September 2016). This view was supported by 30% of the Programme Managers with one pointing out that "this will be pain to the community. Caregivers remind patients about treatment especially the elders who cant read and they also take children to the clinics" (Interview no. 19, 7 September 2016).

Officials from the Department of Health indicated that many programmes of the Department of Health will fail if the programme is closed; especially when it comes to issues of education and awareness which are largely carried out by the Caregivers. 30% of the Programme Managers added that the community will continue to be stigmatized due to lack of knowledge as there will be no more education and awareness campaings on health issues. They pointed out that home-based care is the extended arm of the Department of Health. Almost half of the Ward Councillors indicated that they have put their trust in the programme and warned that if home based care is closed, the rate of chronic infections will increase. Few Caregivers also supported this view that there will be no more education and awareness campaings especially in schools. 20% of Caregivers indicated that the rate of unemployment will increase. One Caregiver said: "programme create employment for Caregivers and thus able to buy food for their families. Although we are not able to educate our children. It will lead to poverty and hunger" (Interview no. 24, 8 September 2016). 10% of the Programme Managers agreed that the government will have to employ more nurses to conduct regular home visits in the households if the programme is closed. Few Ward Councillors have also added their voive to the debate by indicating that the knowledge, skills and experience of Caregivers will be lost.

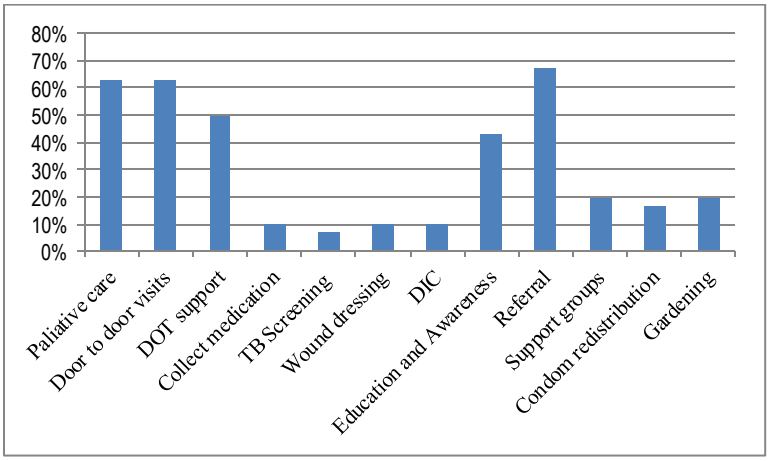
4.3. Stakeholders' understanding of the link of community home-based care activities to the goal of the programmes

This section presents the process of delivering community home-based care services to the beneficiaries of the programme. It will help us understand the activities and challenges of community home-based care programme.

4.3.1. The process of delivering community home-based care

Community home-based care programme is regarded by the stakeholders as an extended arm of the Department of Health and Social Development in the Capricorn District Municipality. 63% of the respondents indicated that Caregivers provide palliative care to patients by cleaning, bathing, wound dressing, cooking and feeding them on daily basis except on weekends. They assess the environmental hygiene of patients to ensure that it is conducive to their healing process. Every three weeks, patients are taken to clinics for check-up and the dead are reported to clinic management. Fresh wounds are taken care of by the clinics until patients get better and then be referred for wound dressing at the home-based care. **Figure 13** below provide a graphic presentation of the perspetives of various stakeholders about the activities of community home-based care programme.

Figure 13: Activities of community home-based care programme



67% of the respondents indicated that Caregivers walk long distances in difficult whether conditions conducting door to door visits in the villages. The aim is to identify critical patients requiring medical care and support; and refer them to the clinics and social workers for assistance. Caregivers also collect medication from clinics for the patients, including the elderly persons who are not able to walk. The Officials from the Department of Health also refer patients to home-based care after they have been given consent to do so by the affected people. 50% of the respondents indicated that the programme is designed to ensure effective support for patients to adhere to their medical treatment. During door to door visits, Caregivers provide health talks and Directly Observed-Treatment (DOT) support to their patients. They collect sputum from members of the community to screen tuberculosis and those infected are referred to clinics to get medication.

37% of the respondents said that through education and awareness campaings on health issues, community members are encouraged to eat healthy and have vegetable gardening projects. The gardening projects helps with the provision of vegetables for patients to fight high blood pressure. Education and awareness campaings on the HIV/AIDS pandemic involves the distribution of condoms communities through spaza shops, tarvens and schools. 10% of the respondents indicated that the programme also helps orphans and vulnerable children with food and school work; and refer their problems to social workers. The social workers help the orphans and vulnerable children to get access to social grants. They also investigate cases of abuse on their clients and where necessary they refer their client to places of safety. One Programme Manager indicated that "we have suggestion boxes for their patients especially those very sick to share their wants and not wants" (Interview no. 1, 4 September 2016). Those who are very sick can share their wishes before they pass away. Support groups are also available for parents and affected children.

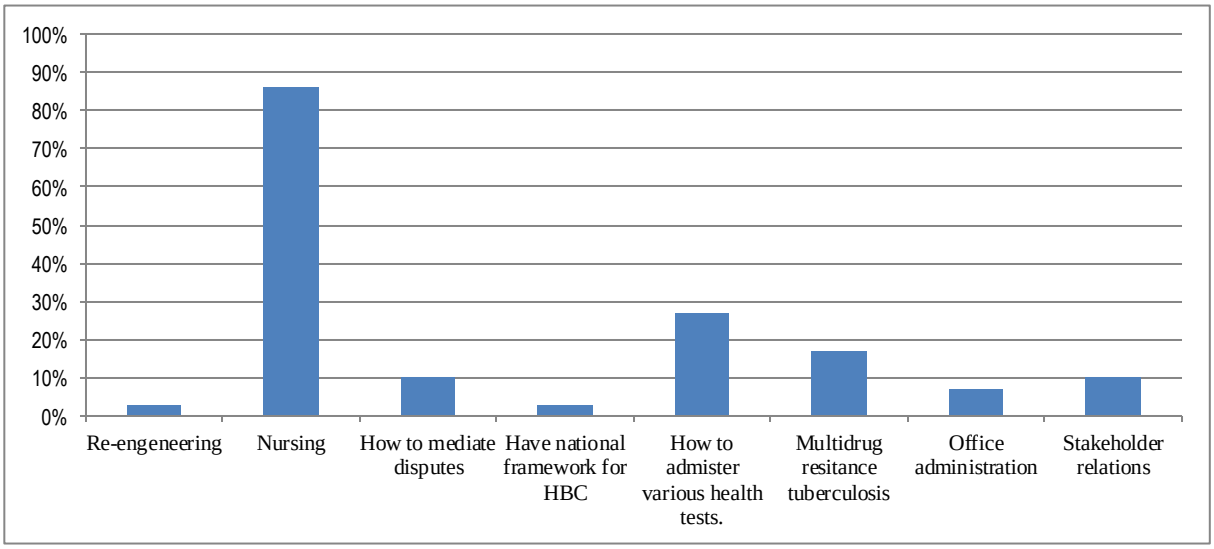
Majority of the respondents said that the frequency of home visits for patients by Caregivers depends on the category in which the patients have been classified. There is an assessment tool prescribed by the Department of Health that is used by Caregivers to categorise their patients. The patients are classified according to the nature of their illness into three categories i.e. those able to help themselves (category 1), very ill patients but not bedridden (category 2), and bedridden patients (category 3). The bedridden patients are visited three times a day, and the other categories are visited at least once in a day. Patients who are infected with tuberculosis should be visited everyday. 23% of the respondents indicated that Caregivers do not have a daily target of how many patients should be seen but their visits are determined by the health condition of their patients. The length of visit depends on the condition of the patients but Caregivers should spent quality time with the patients. The visit to the victims of alcohol and substance abuse are not done everyday. Patients must always report to the home-based care if they are planning to go on holiday.

4.3.2. Training and development for community home-based care

Few respondents reported that Caregivers are well trained and all they need is sufficient funding to better do their important work. One Ward Councillor said: "they have attended a lot of trainings. They need a lot of funding to better do their work, for the Department of Health to provide enough stipend given the importance of their work" (Interview no. 16, 6 September 2016). However, majority of the respondents have indicated aspects of training and development which requires improvement. 86% of the respondents mentioned that experience in nursing is necessary given that there are boundaries in the health sector such as disclosure of confidential information and non

description of medication. Caregivers should receive an advanced training on health care that will give them capacity to become assistant nurses. One Programme Manager indicated: "advanced programme on new developments on how to handle youth and children on issues of substance abuse" (Interview no. 12, 6 September 2016). One Official from the Department of Health pointed out: "they need advanced training to become assistant nurses. Officials from the Department of Health also accompany carers when they do home visits and schools for health talks" (Interview no. 30, 23 September 2016). **Figure 14** below provide a graphic presentation of the perspetives of various stakeholders about the training required for community home-based care programme.

Figure 14: Stakeholders perspective about training required to improve community home-based care programme



27% of the respondents said that home-based care should be educated to administer certain tests such as blood pressure and HIV tests which do not necessarily have to be done only at the clinics. Caregivers need upskilling and workshops on both chronic and non-chronic illnesses such as HIV, tuberculosis, mental health, counselling, gender violence and nutrition. Multidrug Resistance (MDR) requires urgent training on all Caregivers and sufficient supply of medical kit. One Programme Manager said: "we need training on all chronic illnesses since patients are assisted in their homes. Current training are not enough and the Department of Health says those trained will do in-service training on other employees. Most training are not accredited, its just workshops" (Interview no. 3, 4 September 2016). 17% of the respondents indicated that training on all aspects of office administration is important. This training areas of concern include an accredited financial management, project management, report writing and computer. The other area of concern highlighted by the respondents involves mediation of disputes within families. Some respondents

reported that Caregivers should be capacitated in the areas of funding and teamwork, and that community home-based organizations should work together and learn from each other.

4.3.3. Stakeholders support for community home-based care

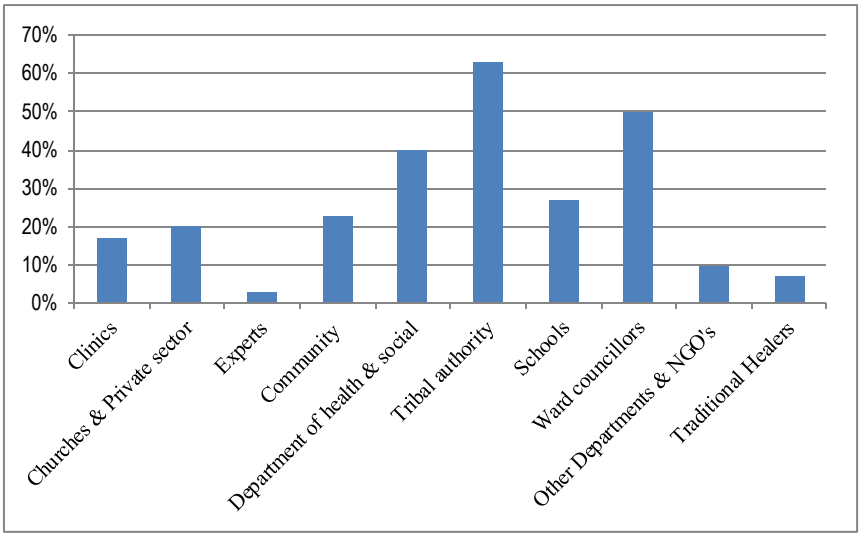
The Officials from the Department of Health indicated that the municipality need to interact with home-based care organizations to assist with employment. They said that this will ensure that people don't just become Caregivers for the rest of their lives, and in doing so they will make room for others to join home-based care service. Headmen are necessary to encourage members of the community to welcome Caregivers in their homes. This point was shared 60% of programme managers who indicated that good relationship with the tribal authority and government at all levels is important for successful implementation of the home-based care programme. They said that headmen are able to intervene and resolve disputes in households. They also indicated that the chief must at all times be informed about functions and events organized by home-based care organizations so that they can get support and approval.

80% of the Caregivers supported the role of the tribal authority in the implementation of the home-based care programme. They indicated that the chief and headmen are able to organize community meetings to give Caregivers a platform to give health talks to the community. One Caregiver said "traditional leaders must inform how the programme of home-based care works in their community" (Interview no. 7, 5 September 2016). Furthermore, Caregivers indicated that the halls and offices used for workshops and administration belong to the tribal authority. 78% of the Ward Councillors said that headmen are able to give Caregivers access to, and inform the community members about home-based care programme and related matters. They also indicated the community need to understand that the services provided by home-based care programme are important for the health of its members. One Councillor said "home-based care should be given a slot in community meetings to talk about home based care issues" (Interview no. 5, 5 September 2016).

40% of the Programme Managers and Caregivers pointed out that the support from the ward coucillors is the same as the one received from the traditional authority. They indicated that Ward Councillors are able to organize community meetings to address issues related to service delivery. One Caregiver said "Councillors assist the community with services such as electricity, toilets, water, and issues of housing" (Interview no. 24, 8 September 2016). 52% of the Ward Councillors indicated that ward committees are able to come up with solutions to the problems. One Councillor said " we can intervene where people are not able to accept their health status, especially in the

rural areas where Caregivers travel a lot" (Interview no. 20, 7 September 2016). **Figure 15** below provide an overall view of the level of support received from various stakeholders.

Figure 15: Perspective about the support received from stakeholders of CHBC



Government was also mentioned as an important role player in the provision home-based care service by 70% of the Programme Managers. One Programme Manager said "there is a need to categorically mobilise with all departments especially the Department of Health, Social Development, and Education" (Interview no. 12, 6 September 2016). They have indicated that government provides food parcels, stipends, training and working tools to home-based care practitioners. They also mentioned that government agencies such as South African Social Security Agency (SASSA) is able to assist patients and children with social grants, while social workers from the Department of Social Development assist patients with their personal and family issues. 13% of the Ward Councillors indicated that the Department of Agriculture is necessary to provide support to the greenery programme, and local government assist with the coordination of service delivery. All the officials from the Department of Health mentioned that the school governing bodies are necessary for health education in schools. 40% of the Programme Managers agree that schools give access to the Caregivers to give health talks to the leaners. 26% of the Ward Councillors indicated that the schools are able to refer learners to the programme for care and support. 30% of the Caregivers indicated that the schools and creches are able to give Caregivers access to the leaners for health talks and tuberculosis testing.

40% of the Programme Managers indicated that a good relationship with the clinics is important for successful implementation of the home-based care programme. They have mentioned that the clinics are able to refer patients to the programme for care and support in their homes. Furthermore, Programme Managers said that clinic staff are able to provide training to home-based care practitioners on how to care for the patients. They have also emphasized that in areas where there is no local clinic, mobile clinics are used to assist the patients. 65% of the Ward Councillors indicated that every clinic has a social worker who deals with domestic violence. 30% of the managers indicated that patients go to various churches and pastors are a position to convince patients about the programme. 26% of the Ward Councillors indicated that the pastors in churches are also important to the programme because they provide counselling to patients and their families.

30% of the managers and Caregivers indicated that good relationship with donors and the private sector is important for successful implementation of the home-based care programme. They have indicated that organizations such as the National Lotteries Commission, Dimension Data and local shops are able to assist with donations, salaries, food and furniture. This was supported by 26% of the Ward Councillors who indicated that donor funding can assist with things such as transport. Other important stakeholders of community home-based care programme as indicated by the stakeholders are traditional doctors, non-governmental organizations, South African Police Service (SAPS). 10% of the managers said that experts and retired professionals can provide expert advice to the practitioners. Furthermore, Programme Managers indicated that board members are necessary to give control and direction to the home-based care organizations.

There were some concerns about the level of support provided by various stakeholders to the programme of home-based care. All officials from Department of Health said that home-based care organizations get support from stakeholders but the municipality and schools are not providing satisfactory support to the programme. One Official from the Department of Health said " not all of them, especially at schools, the programmes are not adhered to; and also the traditional health leaders refuse access by home-based care practioners" (Interview no. 29, 15 September 2016). 60% of the Programme Managers indicated that they are not satisfied with the support from the Department of Health. They raised a concern that the social workers have recommended that the Department of Health and Social Development should stop funding organizations which are funded by the National Lotteries Commission. The other challenge which was raised is that

funding by the Department of Health is stopped when non-governmental organizations are starting to improve their working environment and money is only given to the impoverished organizations.

Furthermore, Programme Managers said that Councillors do not coordinate services such as the provision of water in the community. They also said that the Ward Councillors refuse to sign documents for home-based care because they said Caregivers and management do not support their political parties. One Programme Manager mentioned that in one meeting a Ward Councillor said "home-based care management must attend African National Congress meetings before she can sign" (Interview no. 3, 4 September 2016). There is also a concern that traditional healers do not understand how home-based care programme work. Programme Managers indicated that traditional health practitioners have not accepted Caregivers in the community and health talks with them would assist in this process. They mentioned that clinic staff members are not cooperative because they sometimes refuse to sign referral documents for patients to home-based care. They also indicated that social workers take time to monitor the orphans and vulnerable children; and also don't bring solutions to their problems. One manager remarked "the orphans and vulnerable children are left to fend for themselves" (Interview no. 21, 7 September 2016)..

90% of the Caregivers indicated that traditional leaders always attend the meetings of home-based care organizations and can request households to give Caregivers access to their health information. They have also indicated that the tribal authority is able to organize community meetings and gatherings for health talks. Furthermore, Caregivers mentioned that the tribal authority and Ward Councillors honour invitations for meetings hosted by home-based care organizations; and they also provide venues for the meetings. Majority of the Caregivers said that the schools give home-based care organizations access to the learners to conduct health talks. Furthermore, Caregivers said that the Officials from the Department of Health and nurses are able to conduct household and school visits with the Caregivers to show them how to administer tests such as tuberculosis and blood pressure. 10% of the Caregivers cited a lack of support from Programme Managers but pointed out that it is also difficult for their management because they are also not supported. One Caregiver mentioned that "when they apply for funding they do not get it; and or if they get it, the money is used for office and stationery" (Interview no. 2, 4 September 2016).

75% of the Councillors indicated they share information with the home-based care organizations on how to access opportunities, including funding. They said that they always make it a point to be

available for meetings and serve the community, including home-based care organizations. One Councillor said "Councillors always make it a point to be available for meetings and serve his community. If need be, he prioritises the meetings of home-based care" (Interview no. 5, 5 September 2016). The Ward Councillors also indicated that the tribal authority and clinics are consulted at all times by home-based care organizations about their work, and they are able to give messages of support to the programme. The tribal authority was also commended by the Councillors for giving home-based care organizations land to build offices in appreciation of the good work they do in the community. They said that the support may not be satisfactory but the more they engage with home-based care, they can expand the service to the community. However, 25% of the Ward Councillors indicated that home-based care organizations do not get satisfactory support from stakeholders. They have indicated that the Department of Health and Social Development should have a budget specifically for Caregivers, and they should also have an internal employee responsible for resolving problems regarding the programme. They have also raised a concern that home-based care practitioners have been volunteering their services for many years and will retire without medical aids, meanwhile they render an important service to the community

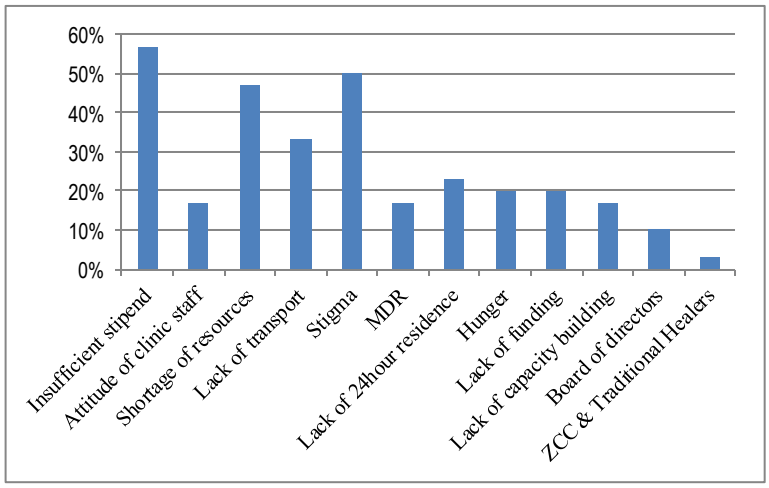
4.4. Stakeholders' perceived gaps in the implementation of community home-based care programmes

30% of the Programme Managers indicated that stipend for Caregivers should be increased. One Programme Manager said "home-based care programme will end-up being closed down if they do not get assistance because we cannot keep employees without paying them. There is no reward for this job and just getting tired of it" (Interview no. 1, 4 September 2016). Another Programme Manager said "carers are the core of home-based care programme and earn too little. If they can get infected, they wont be able to afford medical costs. They can go six months without pay but they still come to work" (Interview no. 9, 5 September 2016). 60% of the Caregivers supported this view with one saying: "we need to be fed before we can advise others, and the Department of Health must come to the party". Meanwhile 52% of the Ward Councillors pointed out that there is not sufficient funding for the programme. One Councillor said: "funding is a challenge. Even though this work is voluntary, they need stipends as a motivation because they are doing a good job" (Interview no. 11, 6 September 2016).

The challenge of insufficent funding was also raised by 60% of the Programme Managers who indicated that it makes home-based care organizations not to offer full service to their clients. One

Programme Manager pointed out that "orphaned houses are used for illegal activities such as drugs because they had to stop the Drop-in Centre Caregivers due to funding but will be recalled if the National Lotteries Commission provides funding" (Interview no. 1, 4 September 2016). The Programme Managers indicated that the Department of Social Development does no longer provide food parcels for the orphans and vulnerable children, and also to the patients. They said that poverty in families they assist give Caregivers stress. This view was seconded by 20% of the Caregivers who indicated that there is hunger in many families and this makes patients not to take medication. One Caregiver said "patients are breadwinners in their families and do not qualify for social grant. This means that they cannot afford food which is required for medication" (Interview no. 7, 5 September 2016). **Figure 16** below provide a graphic presentation on the perspetives of the respondents about the termination of community home-based care programme.

Figure 16: Stakeholders perspetives about the challenges of CHBC.



Officials from the Department of Health indicated that Caregivers are usually undermined by clinic staff because they are presumed to lack nursing knowledge as they are not qualified. There is also a concern from 20% of the Programme Managers who indicated that the clinics are not cooperating well with the home-based care organizations. One Programme Manager pointed out that "clinics don't refer HIV patients immediately but wait until they stop taking medication before requesting home-based care to monitor them" (Interview no. 23, 8 September 2016). One Caregiver added that "mobile clinics refuse to sign off referals for door to door visits by Caregivers" (Interview no. 7, 5 September 2016). Majority of the respondents indicated that there is shortage of supply of working tools such as first aid kits, stationery, umbrellas and uniforms by the Department of Health. One Programme Manager remarked "clinics do not take Caregivers seriously especially when it comes to first aid kit because they always claim shortage" (Interview no. 21, 7 September

2016). Few Councillors are also aware that not enough equipment is available for Caregivers to do their work effectively. One Councillor even warned that: "Caregivers are vulnerable to multi drug resistance tuberculosis because they assist people without the kit" (Interview no. 20, 7 September 2016).

Officials from the Department of Health pointed out that home-based care practitioners are struggling with transport for patients. 50% of the Programme Managers agreed that Caregivers are facing a problem with transportation to visit their patients and to take them clinic or hospital. One Programme Manager said "Caregivers can only work where their feet can get them" (Interview no. 12, 6 September 2016). The other progamme manager said that "home-based care covers many villages and consequently monitoring is not possible or not properly done" (Interview no. 25, 8 September 2016). 20% of the Caregivers supported this view with one Caregiver pointing that: "there clinics do not have enough ambulances".

The Officials from the Department of Health indicated that that there is lack of coorperation with the Caregivers by some patients and families who are not willing to share their health information. 80% of the Caregivers indicated that stigma about chronic illnesses is a problem in the community. One Caregiver said "we get chased away in other families. Client change their statuses, today they are sick and tomorrow refuse that they are sick, and men do not want Caregivers help" (Interview no. 2, 4 September 2016). 40% of the Programme Managers also indicated that patients do not adhrere to their medical treatment for many reasons. One Programme Manager pointed that "some patients test positive and relocate to Gauteng province and come back to the village bedridden" (Interview no. 9, 5 September 2016). Other reasons mentioned by Programme Managers for lack of cooperation by families involves the influence of religion, traditional healers and witchcraft on the patients. One manager said "ZCC makes patients to stop taking their medication and drink ditaelo (tea) from the church. Traditional healers lead patients to believe that they have ancestoral issues and they are destined to become traditional doctors in future; or that they have been witchcraft or they have slept with a pregnant woman" (Interview no. 1, 4 September 2016).

40% of the Programme Managers and Caregivers indicated that their offices are being rented and they need their own building. One Programme Manager pointed out that "the Department of Health is not giving a grant for building but a standard rate for rent which sometimes is not enough" (Interview no. 21, 7 September 2016). 20% of the Programme Managers also stated that the lack of a 24 hours facility for patients creates a problem. Another Programme Manager said

"some patients get rotten while they are still alive due to lack of care but if residences were available, regular monitoring of patients would be possible" (Interview no. 1, 4 September 2016). This view was supported by 10% of the Caregivers who indicated that they have a challenge with patients who need 24 hours of care and they need infrastructure to provide such services. The other challenge highlighted by few Programme Managers is that board members of home-based care organizations misuse funding from donors, and some members refuse to step down when their term of office expires. 13% of the Ward Councillors agreed that home-based care organizations are led by young board of directors who require training and they delay service delivery. Furthermore, they indicated that there is a lack financial management skills in the home-based care organizations.

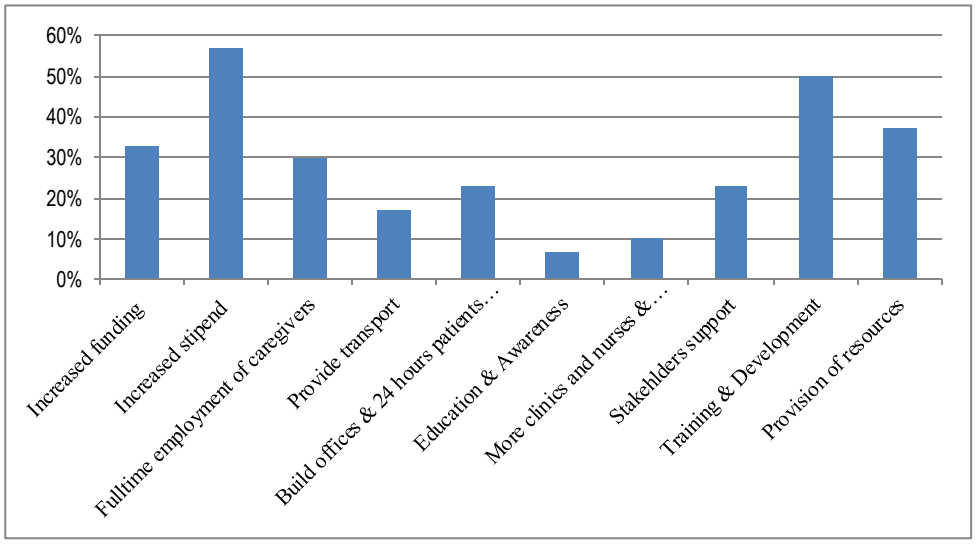
4.5. Stakeholders' understanding about the future of community home-base care programme

Officials from the Department of Health indicated that all community home-based care practitioners should be trained in the Department of Health's re-engeneering programme on primary health care. They also indicated that Caregivers need advanced training in community home-based care and need to fill the positions in the Department of Health. One Official from the Department of Health remarked "you cant volunteer from 2002 until now and you still a Caregiver" (Interview no. 30, 23 September 2016). This view was seconded by 30% of the Programme Managers who indicated that government should employ Caregivers when they are looking for new employees. One Programme Manager said "the government should register and pay Caregivers a living wage and not R1600.00" (Interview no. 9, 5 September 2016). The other Programme Manager said "the Department of Health should take home-based care seriously- they do a lot of work that is important to the community" (Interview no. 21, 7 September 2016). 76% of the Ward Councillors also added their voice to the course with one Councillor saying: "no more non-governmental organizations. If they are not able to absorb them, they must recruit from the non-governmental organizations" (Interview no. 16, 6 September 2016).

Most of the Caregivers and Officials from the Department of Health indicated that the Department of Health must consistently provide funding and monthly stipends. One Caregiver said:"Department of Health must increase salaries of the programme. Caregivers are willing to continue working but the department should also look after them so that they are able to take their kids to school" (Interview no. 24, 8 September 2016). One Official from the Department of Health added that "stipend need to be increased to motivate Caregivers. Villages are far apart and Caregivers have to walk long distance to service their patients" (Interview no. 30, 23 September

2016). This view was supported by 70% of the Programme Managers and Ward Councillors who agree that there is a need for funding especially regarding transport and stipends to strengthen home-based care and the drop in centres. One Programme Manager said "Department of Health should take responsibility and support home-based care, otherwise the programme would collapse, especially the volunteering youth would look for greener pastures (stipends)" (Interview no. 6, 5 September 2016). One Councillor said: "donor funding is required while government is busy sorting their house" (Interview no. 16, 6 September 2016). Another Councillor proposed that: "we need to establish hubs of home-based care due to distances travelled by Caregivers" (Interview no. 11, 6 September 2016). **Figure 17** below provide a graphic presentation on the perspetives of the respondents about the future of community home-based care programme.

Figure 17: Stakeholders perspetives about the future of CHBC.



Almost half of the Programme Managers and Caregivers indicated that there is a need for offices and a 24 hours residence for patients because they only get assistance from Caregivers during the week. One Caregiver said "we need infrastructure such as sports fields and buildings" (Interview no. 13, 6 September 2016). Officials from the Department of Health agrees that there is a need for old age homes for elders to come and spent days doing other recreational activities such as singing and sewing to relieve stress. One Official from the Department of Health said "the villages are far from everything and elder people do not like being moved from their homes but need some recreational activities" (Interview no. 30, 23 September 2016). Majority of Programme Managers indicated that close coorperation with stakeholders is critical to the success of the programme. One Programme Manager pointed out that "stakeholders should also realise the importance of home-

based care programme, especially when talking about offices for home-based care" (Interview no. 21, 7 September 2016).

More than half of Programme Managers and Caregivers indicated that there is a need for advanced training and workshops. One Programme Manager said: "the scope of work for Caregivers should be extended to include things such as injections" (Interview no. 9, 5 September 2016). and a Caregiver said "we need to be empowered as the community grows in number" (Interview no. 15, 6 September 2016). Meanwhile more than a quarter of the Ward Councillors proposed a national framework on home-based care, and a formal academic programme. One Programme Manager pointed out that "there should be sufficient supply of proper equipment. Basic tests as high blood pressure or diabetes can be done and doesn't need clinics or hospitals" (Interview no. 25, 8 September 2016). Most of the respondents indicated that the Department of Health should provide sufficient working tools such as uniforms and first aid kit. One Caregiver said: "we need the necessary equipment for protection so that we do not get affected" (Interview no. 15, 6 September 2016). Another Caregiver pointed out: "they should provide uniform for identification within the community so that even in rainy days we can see patients and uniforms will also improves the image of Caregivers" (Interview no. 4, 4 September 2016). 20% of the Programme Managers stated that all villages should have clinics especially where there is a high number of people with chronic and non chronic conditions. One Programme Manager indicated that "they have taken the clinic to Seshego Zone 4 instead of Zone 1 where there are more elderly people without medical aid" (Interview no. 1,4 September 2016).

39% of the Ward Councillors said that the Department of Health must take full responsibility on the home-based care programme. One Councillor elaborated: "home-based care cannot be under Department of Social Development. The impact is more health than social, and the Department of Health should give support and fund them where possible. We have never seen an official from the Department of Health visiting the home-based care organizations" (Interview no. 5, 5 September 2016). Another area of improvement pointed out by almost a quarter of the Programme Managers and Caregivers is that monitoring of home-based care programmes is important for judging their merit and worth. They said that the Department of Health and Social Development should take action based on the progress reports submitted to them by home-based care organizations. One Programme Manager said "social workers must monitor the programme especially the orphans and vulnerable children who need food because they head families" (Interview no. 21, 7 September 2016). Few Ward Councillors added that there is a need of food parcels and bursaries for orphans

and vulnerable children, patients and drug addicts. The need for more education and awareness about health issues was also highlighted by the few respondents. One Caregiver indicated that "there should be more education and awareness campaigns on chronic illnesses due to dealdly viruses" (Interview no. 15, 6 September 2016).

Chapter 5: Analysis of stakeholders perspectives about the practice of community home-based care programme

This research reveals many factors which were also highlighted by previous studies regarding the practice of community home-based care. It shows that there are similarities in the design and intended purpose of community home-based care programme. A proposed programme theory was developed in the conceptual framework based on the findings by many studies reviewed by the researcher in Chapter 2 of this research report. As outlined in the conceptual framework, this chapter will focus on the analysis of the research data in line with the proposed programme theory by firstly looking at the rationale behind the formation of community home-based care. This will provide an understanding of what the programme was planned to achieve when it was introduced. Secondly, the analaysis will explain in practical terms what this outcomes mean to the patients with chronic and non-chronic illnesses. The analysis will also share information on how community home-based care programme is designed and implemented to achieve the intended outcomes. The gaps and challenges facing the practice of community home-based care are also given attention in the analysis.

5.1. Stakeholders' understanding of the logic behind the community home based care programmes

According to research conducted by Hatlane (2014) on the creation of work opportunities for the poor in South Africa, the country remains with the highest number of HIV/AIDS infections in the world with at least five million people living with the disease. While this present a picture at the national level, the rate of HIV/AIDS infections in the Capricorn District Municipality is part of national statistics recorded by the Department of Health annually. Between the years 2000 and 2007, community members and government in the Capricorn District Municipality (CDM) became aware of the health problem that is threatening the society. This awareness was brought about by many deaths related to chronic and non chronic infections, especially HIV/AIDS. The problem has affected communities in the rural areas to a point where clinics are not coping with the increased demand of health services. The community was also concerned about elderly persons, orphans and vulnerable children who were left alone in the houses without care and support. There was a need to take action against HIV/AIDS pandemic in order to improve the wellbeing of the community. HIV/AIDS pandemic is not only a South African problem but it is a threat to many developing countries. This is elaborated in a study by Mamba & Ntuli (2014) on the activities and challenges in caring for chronically ill patients in Soweto. They pointed out that the necessity of community

home-based care especially in developing countries became evident when patients with chronic illness were either discharged or not admitted in hospitals due to shortage of beds, overcrowding, inadequate number of medical and nursing professionals.

Due to an increased number of HIV/AIDS infections in South Africa, the government responded to the need for primary health care services by adopting a community home-based care strategy in the year 2000 (Hatlane, 2014). This study shows how government rolled out the adoption process of community home-based care in the Capricorn District Municipality. The Department of Health came up with an initiative known as Letsema programme to address health challenges facing the community. Various groups in the community such as religious organizations and some families volunteered their services in the programme to support the clinics in providing health care services to the patients. In a research by Phaladze (2003) on the plight of family Caregivers in Botswana, community home-based care is used as a strategy and solution to the capacity challenges facing the health care delivery system for HIV/AIDS management in developing countries. This research shows that with the help of the volunteers, clinic staff members were only required to give service primarily to the patients who were refered to the clinic. It became the reponsibility of the volunteers to care and support patients in their homes and where necessary refer them to clinics.

Chiranga (2011) indicated that non-governmental organizations have become an important part of a development engine as they are able to provide services to peripheral areas that government is not reaching. The research data shows that service provided by volunteers through Letsema programme was appreciated by the government which took an initiative to provide funding, training and workshops to the groups. The Department of Health recongnized this volunteers as an extended arm of government in the provision of health care services particularly in the rural areas. Furthermore, the research shows that early in 2000, the Department of Health and Social Development in Limpopo province assisted volunteers to formalise their structures and register as Non-Profit Organizations (NPO's). This is supported in a research by Naidu, et al. (2008) who indicated that between 2003 and 2004 there were at least 1422 non-profit organizations providing community home -based care to patients with chronic illness in South Africa.

It is evident in **Figure 7** that community home-based care is primarily dealing with the problem of HIV/AIDS, tuberculosis, diabetes and high blood pressure; whereas asthma, ulcer, alcohol and substance abuse are the least of health challenges for the programme. This research shows that community home-based care service has evolved over the years from dealing with elderly persons

and people with special needs to becoming Community Health Centres. This view is supported by Phaladze (2003) who said that when the programme of community home-based care started it was mostly limited to the elderly, children and disabled persons; but this has changed over the years due to the growing number of people infected with HIV/AIDS.

5.1.1. Beneficiaries of community home-based care

Previous studies on community home-based care programme have not documented demographic information about beneficiaries of the programme. While there is not much information on gender and age of beneficiaries of the programme, **Figure 8** shows that at least 83% of patients served by community home-based care programme are females. The research shows that women are more open and able to disclose their health status; whereas men are secretive and in-denial. It is found that men do not consult timeously with the with the clinics but wait until their health deteriorates before seeking medical services. As one Official from the Department of Health pointed out "men wait until its difficult and then decide to consult" (Interview no. 29, 15 September 2016). The research shows that women in the rural areas takes care of households duties while men are looking after the cattles in the bushes. When community Caregivers conducts door to door visits they usually find women in the house. It is also revealed by this research that home-based care is dominated by female employees and men are not comfortable being looked after by women. Another finding by this research is that most women lose self-control especially when they are under the influence of substance and alcohol. However, this research also shows that majority of men have pride which does not allow them to visit clinics for consultation; and that men are as equally affected as women but are not serviced by the programme of community home-based care.

The research shows that the majority of patients served through community home-based care programme are over 35 years old. At least 72% of the patients of community home-based care programme as shown in **Figure 9** are over the ages of 35 years. The research data shows that elderly persons have experienced many challenges in their life and factors such as unemployment, alcohol and tobacco have affected their health. According to the findings, the second highest age group of patients that is served by the programme are patients aged between 18 – 35 years. The research findings shows that alcohol has a bad influence on the youth and exposes them to many threats such as HIV/AIDS. The rural areas are also dominated by elderly persons because youth has moved to the cities for better opportunites. The research data reveals that the youth lack understanding and knowledge of sexually transmitted diseases; while sexual protection is a taboo to the elders.

5.2. Stakeholders' understanding of the purpose of community home-based care programmes

The proposed programme theory outlined in the conceptual framework shows that the impact of community home-based care cannot be achieved without having successfully implemented various activities of the programme. The proposed programme theory shows that an independent and a high quality of life for patients with chronic illnesses can be achieved when there is an increased awareness, knowledge, confidence, ownership and responsibility by patients and the community at large. This outcomes can only be achieved when activities such as education and awareness, identifying, tracing and referral, provision of food for orphans and vulnerable children are successfully implemented. The analysis below shows that the current research findings are in agreement with the causal relationship between activities, outcomes and impact of community home-based care described in the proposed programme theory.

The research data reveals many challenges by the community home-based care particularly regarding funding for the programme. However, as depicted in **Figure 13,** Caregivers continues to carry-out activities that are intended to improve the lives of many people. The research shows that progress towards achieving the goals of community home-based care programme is slow. It is evident from this research that the outcomes of home-based care are diverse but centred around the wellbeing of community members. Research shows that 62% of the respondents indicated that one of the most important activity of community home-based care is to provide care and support to patients with chronic and non-chronic condition in order to improve their health especially in the rural areas. Patients are cared for and supported in their homes by Caregivers to become independent so that they are be able to work and provide for their families. This point is supported by de Saxe Zerden, Zerden, & Billinghurst (2006) who indicated that the primary goal of community home-based care is to instill hope to patients with chronical illness in order to maintain their independence and high quality of life. According to this study, independent and high quality of life is defined as a state of physical, psychological, and spiritual wellbeing where there is care and support. Mamba & Ntuli (2014) explained that the purpose of community home-based care is to promote, restore and maintain patients comfort, function and health towards dignified death. However, this research data shows that through the programme of home-based care, patients can also live longer and some are able to recover from the illnesses. The programme also instill a sense of belonging and care for patients in their homes by the community.

To achieve an independent and high quality of life, there are secondary goals which the programme must satisfy on the part of the patients. The research shows that the care and support provided by Caregivers improves the environmental hygiene that is conducive to patients healing process. Community home-based care organizations provide access to health services to patients in their homes, where they get medical assistance that will improve their health. Furthermore, the study shows that 50% of the respondents indicated that through Directly Observed-Treatment (DOT) support to patients on daily basis, patients will adhere to their medical treatment for healing to occur. Mataure & Thupayagale-Tshweneagae (2013) agrees that community home-based care is the care given to patients in their homes by families and supported by skilled social workers to meet spiritual, material and psycho-social needs. It is evident that community home-based care programme is an extended arm of the Department of Health and Social Development especially in the rural areas where the community does not have much access to health facilities. Research data indicates that the programme provide a helping hand to the Department of Health because many things would not have been achieved without the programme.

Research shows that another important activity of community home-based care is to conduct door to door visits in the households. 62% of the respondents indicated that during this visits Caregivers have an opportunity to identify, trace and refer patients to the clinics for medical treatment to improve their health. They are also able to identify and refer victims of drug, substance and alcohol abuse; orphans and vulnerable children to social workers for help. This is also emphasized by Mataure, Thupayagale-Tshweneagae, & Sibanda (2015) who indicated that community home-based care is underpinned by an effective referal system for follow-up care or hospital re-admission. The research data also reveals that chronic and non chronic illnesses have left many children without parents and the programme of home-based care is facilitating the provision of food and other services to the Orphans and Vulnerable Children (OVC's).

Research shows that 43% of the respondents indicated that education and awareness in also an important activity of community home-based care which create knowledge about health issues and change behaviour of community members. Education and awareness campaigns in the community can reduce stigma, teenage pregnancy, and the rate of infections. Research shows reveals that education and awareness campaigns has helped members of the community to understand the work of home-based care and are able to come in for assistance from community home-based care organizations. It also shows that most people were afraid to do health tests are now willing to know their health status. The programme has allowed more people to be confident about knowing

their health status, take ownership and responsibility of their lives. The research data reveals that the community and patients have become friends with the Caregivers. This relationship has improved to a point where if Caregivers are on leave the patients complain about not being visited. The clinics are also taking ownership and responsibility to provide medical care to patients with chronic and non-chronic illnesses. They now understand and appreciate the work of community home-based care practitioners. One manager pointed out "the relationship has improved because now Officials from the Department of Health are able take an initiative to contact home-based care management when Caregivers are not reporting to the clinic".

The research data reveals that the practice of community home-based care is regulated by the guidelines issued by the Department of Health has regarding the frequency of home-visits conducted by Caregivers in caring and supporting their patients. The guidelines requires that patients are assessed using a tool provided by the Department of Health and be grouped into three categories which determines the frequency of home visits. According to the guidelines as indicated by the respondents, the first category of patients refers to those who are able to help themselves, the second category are patients who are very ill but not bedridden, and the third category are bedridden patients. The first and second category patients are visited at least once a day, while the third category patients are visited three times a day. However, the research data shows that the guidelines from the Department of Health are not adhered to by all community home-based care organizations in the district. The study shows that at least 23% of the respondents indicated that Caregivers do not have a daily target of how many patients should be seen but their visits are determined by the health condition of their patients. The research data reveals that the length of home visit depends on the condition of the patients but Caregivers should spent quality time with the patients.

The research data also shows that community home-based care programme creates employment in the community for Caregivers to provide for their families. It also helps to provide food and improve health of the community through vegetable gardens. Gardening project within community home-based is very important as it is a source of food for patients and a way of encouraging them to eat healthy. According to Uys (2001) the system of care has three components i.e. hospital care, outpatient care, and community-based care. This means that without community home-based care, the system of care is not complete. It is evident is this research that the programme of community home based is relevant in the provision of primay health care especially in the rural areas where there is poverty and poor service delivery. All respondents in the research unanimously agreed that

the programme has improved the quality of life for many people. This view is supported by Mataure & Thupayagale-Tshweneagae (2013) who indicated that South African government realized the significance of community home-based care programme when they gave mandate of supporting and caring for patients in their homes to non-profit organizations.

Research data shows that majority of the respondents values the programme because of its role in educating and creating awareness on health issues throughout the community. This campaigns are necessary to build knowledge and change behaviour of community members to be more positive and responsible. More than half of the respondents indicated that Caregivers are able to trace patients in areas where the Department of Health cannot reach. They stated that people used to hide their health statuses but Caregivers are able to identify them and refer them to clinics for assistance. Furthermore, research shows that need for the programme is growing as patients default on medication when they are not monitored and their health deteriorate. Caregivers are also able to collect and deliver medication to patients in their homes. Since the establishment of home-based care programme, the number of deaths associated with chronic illnesses have decreased.

According to Allwood (1992), the role of non-governmental organizations in the new South Africa, should be to mobilise community action and provide linkage of community needs to state resources. The author is of the view that it is for this reason that community home-based care organizations have become an extended arm of the Department of Health because it helps to reduce the load on the local clinics. Hospitals are already overloaded with patients and there are many patients who need to be visited in their homes. The clinics refer patients to the Caregivers for care and support to ensure they adhere to their medication. Nurses and doctors cannot leave patients who are admitted in hospitals and conducts home visits. Since the establishment of community home-based care programme, non-governmental organizations have become the hands and eyes of the clinics in community. Caregivers are very patient and show that they love caring and giving support to the patients even those that family members refuse to care for.

The research data shows that the Department of Health takes the programme of community home-based care as priority. More than half of the respondents indicated that the department is aware that patients are cared for by Caregivers and without home-based care programme, the clinics would not have patients. Tembo, Pengpid, & Peltzer (2012) indicated that community-based organizations provide fundamental support to government in the fight against HIV/AIDS pandemic. They assist with the implementation of programmes aimed at behavioural change in the

context of HIV/AIDS and empower marginalized communities through training and peer educations programmes. To show that government takes community home-based care seriously, the Department of Health has given Caregivers access to the clinics and hospitals to educate people about their work. The Caregivers are also being trained in primary health care through a re-engeering programme so that they are able to perform other tasks such as testing hypertenstion, tuberculosis, and describing symptoms. The new re-engeneering programme will grow the services of the home-based care programme. Furthermore, the Department of Health continues to provide medication, funding and training to Caregivers and managers. The programme is also voluntary and to demonstrate the Department of Health is committed to health care, it provide stipends to the Caregivers.

Naidu, et al (2008) found that community home-based care is largely dependent on volunteers as they are less expensive to maintain as compared to professional personnel. However, more than half of the respondents indicated that the biggest challenge is that the Department of Health does not pay satisfactory stipend and Caregivers do not grow in the programme. Job opportunities in the Department of Health should be filled by Caregivers as this would encourage other community members to volunteer their services in the programme. The Department of Health is not providing sufficient funding, working equipment such as medical aid kit supplies and transportation for home-based care programme. It should take full responsibility of the programme and meet the minimum needs of Caregivers before the programme of community home-based care collapses.

The research shows that the health situation would be worse if the programme of community home-based care is closed. The community is already struggling to gain access to private health centres or proper health facilities. Naidu, et al (2008) indicated that home-based care is more cost effective than hospital care. This means that many people, especially in the rural areas, will not afford the cost of transportation to government facilities and/or treatment from private clinics and hospitals. Majority of the respondents indicated that mortality rate would increase and this will lead to a high number of orphans and vulnerable children. Discharged patients will default on their medical treatment and die because nurses will not leave patients admitted in hospitals to conduct home visits. The cure rate for diseases such as tuberculosis will also decline as there will no longer be direct observation treatment (DOT) support by the Caregivers. Almost half of the respondents indicated that education and awareness campains will not be conducted and the community will suffer from many diseases due to lack of knowledge. The number of people infected with diseases will increase because infections would be out of control. Stigma will also continue due to lack of

health talks and the patients will continue to be isolated by the community. This will bring pain to the elders who cant walk and read because Caregivers help them with their treatment. Most patients will have to hire transport to go to hospital since that will the only place they can get medical assitance. The youth will also not have a better future due to alcohol and substance abuse. Majority of the respondents indicated that most programmes of the Department of Health will not succeed and the programme should continue to operate and be supported.

In a research conducted by McCreary, Mkhonta, Popovich, Dresden, & Mndebele (2004), it is pointed out that Swaziland hospitals have experienced their own share of overloading with HIV/AIDS, TB, and Malaria patients necessitating that they be cared in their homes. Now if the other countries have been in a situation like that in Swaziland as highlighted in the research, South African government should be proactive and give full support to community home-based care. The serious impact the closure of the programme will have on the health system should not be undermined. The clinics will be overloaded with patients and the community that have put their trust on the programme will suffer. One Councillor indicated that should the programme collapse, "we will demonstrate until the president of the country intervenes because the Caregivers are doing a very good job". The programme also creates employment for volunteers especially in the rural areas. They are able to buy food for their families but if the programme collapses it will leave them in poverty and hunger. de Saxe Zerden, Zerden, & Billinghurst (2006) indicated that government already has its challenges of the high turnover of professional nurses leaving the country to work abroad. The question is whether the government is willing to lose the knowledge and skills gained by Caregivers over the years. If they lose Caregivers in the system, government will have to employ and train more nurses to conduct regular home visits to ensure treatment adherence.

5.3. Stakeholders' understanding of the link of community home-based care activities to the goal of the programmes

The proposed programme theory outlined in the conceptual framework shows that activities of community home-based care cannot be implemented without the necessary support from stakeholders. The support is required in the form of transportation, funding, trained and skilled personnel, equipment and medication. This resources are needed to make it possible for Caregivers to provided care and support to patients with chronic and non-chronic conditions. This also include being able to provide education and awareness; and identify, trace and refer patients for necessary help at the clinics and other service points. The following sub-sections provide an analysis which

shows that the current research findings are in agreement with the causal relationship between activities and inputs of community home-based care described in the proposed programme theory.

5.3.1. Programme resources

Funding represent the most important resource in development programmes and non governmental organizations depend on financial support from donors. Funding ensures the sustainability of development interventions and makes it possible for many other activities to take place. Caregivers are paid monthly stipends and salaries as a compesation for the work they do in the community. Although the compesation is too little and Caregivers feel that it is not equal the work they do, without salaries the activities of home-based care would not take place due to lack personnel/volunteers. While it is general knowledge that community home-based care is voluntary, without the support from government and donors the programme cannot be sustained. Transportation for both the patients and Caregivers is equally important for conducting door to door visits and taking patients to hospitals. Villages in the ruaral areas are far apart and this requires Caregivers to travel long distances for home visits. Transport allows for constant monitoring of patients to ensure that they adhere to their medication. There are not enough ambulances in the clinics especially those located in the rural areas to transport patients to hospitals.

Resources such as the first aid kit and uniforms for Caregivers are very important in the work of community home-based care. The availability of this equipment ensures the safety of Caregivers during home visits. The work of the Caregivers involves among others, bathing the patients, cleaning their wounds and cooking which all requires first aid kits at all times. Naidu, et al. (2008) indicated that quality home-based care service is dependent on the use of home-based care kits and the frequency of their replenishment. Lack of medical kit will expose Caregivers to possibilities of getting infected; and Caregivers will have to send back patients to the clinic. One Caregiver indicated that: “sometimes they are required to wear condoms as hand gloves in order to help patients or family members have to buy the medical kit”. Parents who look after their children without safety kits are also exposed to infections. There is a also a threat of a deadly Multi-Drug Resistance (MDR) tuberculosis to the programme, and without the first aid kit, Caregivers remain highly vulnerable to the disease.

Most families in the rural areas have patients who are bread winners and sometimes they are forced to look for work in order to provide for themselves and their families. Food parcels for patients, orphans and vulnerable children makes it easy for patients to adhere to medication.

Home-based care organizations need to have their own offices and a 24 hours facility to accommodate the patients. Some patients stay alone in their houses and they need care and support for 24 hours. The programme of home-based care should be turned into a residence based facility which will make it possible for Caregivers to conduct regular monitoring. A rehabilitation center for the victims of substance and alcohol abuse should also be incorporated into the programme of community home-based care.

5.3.2. Training and development

The research data evidently shows that the work of community home-based care organizations involves many aspects of health care services hence they are an extended arm of the Department of Health. Therefore training and development of community home-based care practictioners in the health profession is very important to the success of government programmes. This point is emphasized by Naidu, et al. (2008) who indicated that the proportion of community Caregivers with formal home community-based care training determines the quality community home-based care. The research data clearly shows that it is necessary for home-based care practitioners to be trained to become community nurses although not employed by the Department of Health. In any sector of employment there are rules and regulations to be complied with and a qualification in nursing will definitely go a long in improving the professionalism and service delivery of community home-based care organizations.

In the research conducted by Tembo, Pengpid, & Peltzer (2012), it is clear that community home-based care organizations do not have the capacity to deliver the service to many patients outside the hospital. However, the presence of community home-based care practitioners in the community necessitate the broadening of the scope of work for community home-based care organizations. Community home-based care practitioners are easily accessible and provide health care services that is convenient to the community. Research data shows that there are some activities that do not necessarily have to be done only at the clinics and hospitals but they can also be done by home-based care organizations. Health tests for blood pressure, diabetes and HIV tests can also be administered by community home-based practitioners. They require accredited training in all aspects of primary health care related to chronic and non chronic conditions especially HIV/AIDS and Multidrug resistance tuberculosis (MDR). This demonstrates how important community home-based care programme has become in the community and besides facing many challenges, they have become a solution to government's health care problems. Research also indicates that community home-based care organizations should improve in the areas of financial management, project management, report writing and computer literacy. With majority of health care

practitioners not having a post matric qualification, they need to be trained in various aspect of management.

According to the research, the Department of Health has initiated a re-engeneering programme that seeks to change and improve how home-based care organizations function. The government has partnered with the Foundation for Professional Development (FPD) to provide primary health care training to Caregivers in with the intention of contracting them to work under the Department of Health. The department intends to shutdown community home-based care organizations and have community health workers who are working and reporting directly with government. While this is a good initiative by government, it is not clear how this proposed "new model" of community home based care will work and how it will benefit the patients. The research, however shows that there will be some benefits particularly to Caregivers who will become employees of government and earn a living wage.

5.3.3. Stakeholders support to community home-based care programme

According to Uys (2001) the components of an integrated community home-based care model are community Caregiver team, hospitals, hospices, clinics, patients and their families, support groups, care for orphanage and vulnerable children, and the community at large. Research data shows that local tribal authority and Ward Councillors are the most important stakeholders of commmunity home-based care programme. More than half of the stakeholders indicated the need to be supported by the tribal authority. The tribal authority is able to organize community meetings to give home-based care workers a platform to talk to the community about health issues. The community must understand and be receptive to the work of community home-based care organizations so that they cannot be afraid to disclose their health information to Caregivers. This point is emphasized by Ingle (2012) who indicated that the cornerstones and drivers of community home-based care programmes are a powerful civil society movement and volunteers. The chief must always be informed about all events organized by home-based care organizations in order get support and approval. In some areas, home-based care organizations are given permission to use halls and offices belonging to the tribal authority. The tribal authority also have the ability to intervene and resolve many disputes in the households. The role of Ward Councillors and tribal authority is similar in that they are able to bring the community together. Their role is primarily to facilitate service delivery on behalf of the beneficiaries of community home-based care programme i.e. water, electricity, toilets and housing among others.

The support from the Department of Health and Social Development is also considered to be important success factor in the programme of community home based care. More than one-third of the stakeholders indicated the need to be supported by government with training and development, stipends and working equipment. The most important agency of government that support the programme is the South African Social Security Agency (SASSA) which provide social grants to its beneficiaries. Social workers from the Department of Social Development also play an important role in the programme by assisting community members with their personal and family issues. The research data shows that the schools are also important to the programme of community home-based care. The schools are seen as a platform where many young children can be reached through health education and awareness programmes.

Holtzhausen (2013) indicated that donors have injected large amount of resources in the not-for-profit sector to fight the HIV/AIDS pandemic. This research shows that the private sector, churches and clinics also have a role to play in the success of community home-based care. The private sector and donors provide support to the programme in the form of food, salaries, uniforms and furniture which improves service delivery in the programme. The pastors are leaders in the community and become influential on how their church members comprehend health talks from the community home-based care practitioners. Through pastors, the programme can reach out to many people attending various churches in the community.

The clinics are equally important in the programme especially in the role of mentorship, training and development of community home-based care practitioners. They also make orders for resources such as first aid kits from the Department of Health on behalf of home-based care organizations. Nurses give mentorship to Caregivers during household and school visits when administering tests such as blood pressure and tuberculosis. Other important role players in the programme of community home-based care are the South African Police Service (SAPS) (SAPS), non-governmental organizations, municipality and traditional healers. However, traditional healers have not accepted Caregivers in the community, whereas the municipality is not providing enough support to the programme. In most cases, the municipality only assist with the venue for organizing meetings in the community. It is eveident from the research that there is no collaboration among stakeholders of community home-based care. An intergrated support system for the programme should be desinged to improve the home-based care service.

5.4. Stakeholders's perceived gaps in the implementation of community home-based care programmes

Swartz & Roux (2004) indicated that community home-based care practice has many challenges which need to be addressed urgently. This is supported by the findings of this research which highlights many challenges facing community home-based care in the Capricorn District Municipality. Majority of the respondents accused the Department of Health of not taking community home-based care practitioners seriously. The main challenge facing the programme of home-based care is the lack of sufficient funding which leads to many other challenges. Holtzhausen (2013) indicated that the high number of non-governmental organizations has created an environment where they become highly dependent on financial support from donors. More than half of the respondents indicated that the department does not want to pay Caregivers money that is equal to the work that they do. The compensation is too little and Caregivers do more than what nurses in the clinics do. In some cases, Caregivers would continue working for six months without stipends. Caregivers are told by the Department of Health that they chose to volunteer and must accept what they are being paid. They are also told that if they want greener pastures they should look elsewhere because the department also depends on other donors. Caregivers sometimes spent their own money to visit the patients but the department still expects them to meet their monthly targets. Vetten (2017) found that from 2012 to 2017, volunteers in the Eastern Cape and Limpopo were paid stipend of between R500.00 and R600.00 per month by the respective provincial Departments of Social Development even though they were working hours similar to those those classified as employees; and this was paid with below inflation increases or without any annual increment.

Majority of the respondents indicated that stigma remain one of the main challenges of community home-based care programme. Some members of the community do not want to be associated with people who are diagnosed with chronic illnesses. There is lack of coorperation by many families who refuses Caregivers with access to their households. This presents a problem when there is patients in that household who require monitoring by Caregivers to ensure that they adhere to medication. There are family members who are not willing to give out confidential information especially on HIV/AIDS patients. Families must understand that the patients do not belong to the Caregivers who are only there to assist. The family must agree that the patient be refered for care by the Caregivers. Those refered for HIV testing by Caregivers and are found to be positive do not go back for treatment, instead some relocate to the cities. Patients are still in denial of their health

status and they end up dying due to lack of medical treatment. There is really a need for community home-based care organizations to improve their education and awareness campaigns in order to change the mindset in the community.

The clinics have shortage of resources especially the first aid kit, uniforms and transport for Caregivers. They were tasked by the Department of Health to refill the toolkit but they are failing. The problem of lack of medical kit is very serious and it exposes Caregivers to possibilities of getting infected; and sometimes Caregivers send back the patients to the clinic. Some respondents indicated that Caregivers are sometimes required to wear condoms as hand gloves in order to help patients or family members have to buy the medical kit. Parents who look after their children without safety kits are also exposed to infections. There is a also a threat of a deadly multi-drug resistance (MDR) tuberculosis to the programme, and without the first aid kit, Caregivers remain highly vulnerable to the disease. What is concerning is that the clinics are well aware of the shortage of first aid kit but continue to refer patients with MDR to home-based care organizations.

Naidu, et al (2008) indicated that the delivery of community home-based care in urban areas is less costly than in rural areas. This view is supported by majority of the respondents who indicated that Caregivers are faced with greater travelling time especially in rural areas on poorer transport facilities. Community home-based care organizations should be provided with transport because Caregivers cover many villages and without it they are not able to do proper monitor of their patients. The transport for patients to hospital is a problem as there are not enough ambulances in the clinics. Caregivers are limited in their work given that they can only work in places where they can reach walking.

Majority of the respondents indicated that there is lack of cooperation by the clinics who do not immediately refer patients to the home-based care for help but wait until they stop taking medication. Officials from the Department of Health sometimes refuse to sign off patients referral forms for daily care by the Caregivers. They also undermine Caregivers and their attitude towards the programme is not positive because Caregivers behave like qualified nurses when they are not. Some hospitals refuse to help HIV/AIDS patients instead they say that is what home-based care are established. Most home-based care organizations are not equipped to conduct HIV testing on communities and cannot prescribe any medication to the patients. The scope of community home-based care should be expanded to accommodate tests such as hypertension, HIV and others which are not really complicated.

There is a high number of patients who default on their medication. Some patients do not adhere to medication due to hunger and they do not get support from their family members. The Department of Social Development used to provide food parcels for families but they have since stopped leaving most families in hunger. Patients are then forced to look for work in order to provide for themselves and their families. Orphans and vulnerable children used to get food parcels from the social workers but they now rely only on social grant from the Department of Social Development. The lack of funding for infrastructure projects such as offices and place of residence for patients is also a challenge to the programme. There is a need for home-based care organizations to have their own offices and a 24 hours facility to accommodate the patients. But the challenge is that the Department of Health does provide funding for building infrastructure instead they provide monthly allowance for office rental which is not sufficient. In some cases, patients who stay alone in their houses die and get rotten without anyone noticing because they are not being taken care of by their family members. But if residences were available, it would be possible for Caregivers to conduct regular monitoring. Substance and alcohol abuse also leads to uncontrollable behavior and ultimately infections. Rehabilitation centres are always overloaded and there is a need for funding to build more centres to accommodate the victims of alcohol and substance abuse.

There is also a challenge from traditional doctors who make patients believe that they have ancestoral issues and will become traditional healers in future. People are also made to believe that they should not to take medication because they have been witchcraft or that they slept with a pregnant woman. The other challenge to the success of the programme is Zion Christian Church (ZCC). The church allow the patients drink tea while taking medication received from the clinics and this create health complications. ARV's must not be mixed with any traditional medication because the digestion system must not be interfered with. HIV can only be managed by medical doctors because ARV's have improved health of many people. Every month home-based care organizations meet and report to the Department of Health on the issues affecting the programme but there is no improvement. Government departments continue to work in isolation to each other and are not collaborating to resolve the challenges facing the programme.

5.5. Stakeholders' perspective about the future of community home-based programme

The cornerstones of community home-based care are volunteers and they are doing a very good job in the community. They serve many villages which are far apart from each other and have to walk long distances in extreme weather conditions to help the patients. Campell, Gibbs, Maimane,

& Nair (2008) indicated that there should be serious debate about the role of health volunteers and what can be achieved through home-based care programmes without the provision of sustainable stipends to volunteers. Vetten (2017) pointed out that "care workers in the not for profit sector are appalingly badly paid. So are care workers employed by the state to provide home-based care to people living with HIV/AIDS". Research data shows that majority of the Caregivers are not satisfied with the stipend from the Department of Health. The research data revelas that the Department of Health does not provide sufficient funding for salaries and other administration costs. Community home-based care started in 2002 as a volunteer programme and to date there is no improvement even though the programme render an important service to the community. Caregiving requires a commitment of time and effort from community Caregivers that comes at a high price to them without material gain. Community home-based-care is regarded as an extended arm of the Department of Health; and with the many challenges facing the programme, it should take more responsibility and increase its support for the programme before it collapses.

Department of Health should have a budget specifically for Caregivers because home-based care organizations are assisting government. Rosenberg, Mahude, Hartwig, Rooholamini, Oracca-Tetteh, & Merson (2005) indicated that the lack of funding, reliance on volunteers, the difficulty of providing care in the context of poverty, lack of intergration of home-based programmes into government health provision threatens the survival of non-profit organizations offering these services to the community. Caregivers should be given medical aid and satisfactory compensation so that they are able to take their kids to schools. Since the government is not able to hire more nurses in the clinics, they need to provide full financial support to the programme and absorb Caregivers as full-time employees of the Department of Health. Many young people do not stay long in the programme as they resign to look for greener pastures because the stipend is too little. An increased stipend would serve as a motivation for Caregivers to remain in the programme and continue to service the community.

More than a quarter of the respondents mentioned that the stakeholders should realize the importance of home-based care and fully support the programme. Stakeholders involvement in the programme can help with facilitation of certain goods and services especially infrastructure projects and transportation. Donors must support the programme and should assist in building offices and recreational facilities for home-based care organizations. There is a need for a 24 hours residence for patients in all home-based care centres so that care is provided 7 days a week. Stakeholders such the municipality should come on board and provide land to build residences for

the patients. Residential facilities for the elderly persons are required so that they would spend a day with their friends and do other activities such as singing, sewing and others to relieve stress. Elderly persons cannot be moved from their homes but they need a center where they can participate in some form of recreational facilities. The social workers must really come on board to provide help and monitor orphans and vulnerable children. Community home-based care should be given full support by all stakeholders so they can expand and establish hubs of home-based care other villages. More clinics should be build in each each municipal ward so that the patients and Caregivers do not walk long distances to access health facilities. Community home-based care organizations and clinics need to cooperate more closely for the benefit of the patients they are meant to serve.

Hatlane (2014) indicated that the scope of practice for community Caregivers is to promote and help maintain the health of clients; education and awareness on health-related issues; risk assessment of community members; and the provision of palliative care to families and individuals. Research shows that Caregivers find themselves doing similar duties to clinic nurses without proper training and sufficient resources and compensation. It is evident in the research that working equipment for home-based care such as medical aid kit, uniforms, rain coats, umbrellas and other working tools are in shortage. The contagious nature of community home-based care service necessitate that Caregivers be offered counselling and support. It is for this reason that half of the respondents indicated that a national working framework for Caregivers to define their scope of work and a formal academic programme on community home-based care are necessary. The framework will define what and how Caregivers should perform their duties. The study shows that basic services such as testing for high blood pressure and diabetes can be done at home-based care centers and not only at the clinics or hospitals. Furthermore, majority of community home-based care practitioners are not educated and training on various aspects of management will certainly improve home-based care service.

Department of Health has initiated a programme known as a re-engeneering programme on primary health care where Caregivers will be employed by government and report directly to the clinics. All Caregivers should be empowered through this programme to be able to serve the ever growing community. Clarke & Dawson (1999) indicated that evaluation information is necessary to make judgements about the merit or worth of the programme. Research shows that donors are not doing monitoring and evalutaion of home-based care programmes they are funding to ensure that they are succesful in improving health of the patients. Regular monitoring by donors,

government and minister is required to see how non-government organizations operate and whether or not to continue funding the programme. Alkin (2013) explained that evaluation is concerned with gathering evidence to support the legitimacy of value claims made about the programme, and that the truth is in fact what people make it to be. If evaluation by government and other stakeholders is done properly, they will be able to understand the important role of home-based care in the community and make efforts to resolve many challenges faced by the programme.

Chapter 6: Conclusion and Way Forward

The first chapter of this research report presents the research problem where previous studies on community home-based care programme has not made it explicit how the programme is designed to improve the quality of life for people living with chronic illnesses. The purpose of this study was to assess how community home-based care programme is designed and implemented to improve the quality of lives for people with chronic illnesses within Capricorn District Municipality (CDM) in Limpopo province. To achieve this task, the research focused on four research questions i.e. (1). stakeholder's understanding of the logic behind the programme; (2). stakeholder's understanding of the purpose of the programme; (3). stakeholder's understanding of the link of programme activities and goals; and (4). stakeholder's perceived gaps in the implementation of the programme.

The goal of chapter two of this research report was to provide a context under which this research was conducted by exploring the broader field of study; and formulate a theoretical and conceptual framework for the study. The chapter described in details the emergence of community home-based care in Africa and South Africa; the role of Non-Governmental Organizations in primary health care; and the broader field of monitoring and evaluation. Chapter three presented the research methodologies applied in this qualitative research. The researcher adopted a descriptive research design and a purposive sampling method for the study; and selected thirty-two programme stakeholders to participate in the study. The research also used semi-structured interviews to gather information about the design and implementation of the programme within Capricorn District Municipality.

The goal of chapter four and five of this research report was to presents, compare and analyse the findings of this study with what other previous srudies have found in the area of community home-based care. The research found that the surge in the number of chronic and non-chronic illnesses has exposed the weaknesses of government health facilities in providing primary health care service. Department of Health has not established health care facilities in all villages within the district municipality to cater for medical needs of people living with chronic and non chronic illnesses; and the existing government health care facilities have a limited capacity to serve all communities in the rural areas. To this end, government adopted a community home–based care programme stragety in an attempt to provide primary health care communities in the rural areas.

Community home-based care is implemented through organizations that are registered with the Department of Social Development as Non-Governmental Organizations (NGO's). The NGO's are recongnized by the Department of Health as extended arm of government which are able to reach out to peripheral areas the department cannot reach within Capricorn District Municipality. Non-governmental organizations have indeed become an important component of a development engine in South Africa as they are able to provide services to peripheral areas that government is not reaching. The NGO's have employed Programme Managers and Caregivers who receive training from the Department of Health in basic primary health care to provide medical and non-medical services to patients living with chronic and non-chronic illnesses. Vetten (2017) indicated that "care is a public good and no society would survive without it. Its neglect sustains and reshapes pre-existing gendered forms of inequality". Community home-based care programme has reduced workload on the clinics and hospitals who were overloaded with patients before the formation of the programme.

The purpose of community home-based care programmes is to promote, restore and maintain patients comfort and health towards dignified death. Through care and support, the programme has improved the health and independence of many people who are infected with illnesses. It is also assisting the elderly members of the community and the orphans and vulnerable children through provision of food and other support services on a daily basis. The programme is largely serving women in rural areas who are over the ages of 35 years. Most men do not use the services of home-based care but majority of them are as equally infected with chronic and non chronic illnesses as women. Community home-based care programme has also created employment opportunities for many people, especially women who are not well educated to find a decent work in the formal work environment.

This research shows that community home-base programme has been faced with many challenges since its inception early in 2000 but it has really achieved a lot since its formation. Chiranga (2011) cautioned that financial support that is not supported by structural transformation of non-governmental organizations will lead to outcomes that are not sustainable. Community home-based care in Capricorn District Municipality largely serves the rural communities of the Limpopo province. The characteristics of many villages in the district include poor infrastructure such as health facilities, roads, electricity, water and housing. This context really makes it difficult for community home-based care organizations to deliver quality service to the patients and the community at large. In most cases, a home-based care organization serves more than five

surrounding villages which are at least 5km from each other and caregivers do not have transport to travel this long distance. The have to walk in extreme weather conditions when conducting home visits to provide care and support to their patients. They ensure that patients adhere to medication and their living environment is conducive to the healing process. They work at least 40 hours a week without satisfactory compensation and many of them have remained in service since the formation of community home-based care.

Although majority of the Caregivers do not have the qualifications to work in the health sector, the Department of Health has done well to train and develop their skills to ensure that they are effective in their work. However, more still needs to be done to improve community home-based care service. Caregivers have found themselves doing more work without proper training in nursing than nurses employed in the clinics. The success of the programme is also limited due to the shortage of medical kits such as first aid in many clinics. Disease outbreaks and multi-drug resistance tuberculosis have really proved that community home-based care cannot be successful without sufficient supply of equipment. There is a need to streghthen relations between the programme and its stakeholders particulary the tribal authority, Ward Councillors, schools, churches, government, community, donors, clinics, and traditional healers. The stakeholders have been supportive especially the tribal authority but they need to increase their support if home-based care programme is to be effective. Issues of service delivery, land, funding, education and awareness, training and development related to the programme requires an intergrated stakeholder support system.

6.3. Perspective on the future

The Department of Health has launched about a re-engeeneering programme on primary health care which is yet to be discussed with other stakeholders on how is planned to be Implemented. Community home-based care practitioners are looking forward to the implementation of the new programme which seeks to improve practices in the sector. All stakeholders of the programme and other interested groups will have to wait and see how this new programme will be rolled out. Department of Health should realize the significant role of community home-based programme particularly in the rural areas. It should take more responsibility and increase its support on the programme before it collapses. There should be an intergrated stakeholders support system developed to support government in its effort to improve community home-based care service.

Department of Health should design and implement an intergrated strategy to deal with many challenges facing community home-based care practice. The following areas of the programme requires immediate attention: (1) community home-based care practitioners should be paid decent salaries and have medical aids. This point was emphasized by Vetten (2017) who indicated that "South African government pays dedicated care workers less than anyone else in its employ – as little as R500 a month. They deserve more respect and better rewards"; (2) supply of equipment such as first aid kits, (3) transport for Caregivers and patients should be provided, (4) community home-based care should be turned into a 24 hours residence programme, (5) more clinics should be build in the rural areas, (6) training and development of Caregivers in nursing, and care for orphans and vulnerable children. To quote from Vetten (2017) "the South African government often recites its commitment to economic transformation, and eradicating poverty, unemployment and inequality. The social care sector is a very good place to start giving life to these slogans".

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Annexure 1: Questionnaire

Dear respondent

I, Chuene Moshi, am a post-graduate student at the University of Witwatersrand conducting an evaluation of community home-based care programmes in the Capricorn District Municipality. This evaluation is intended to assess how community home-based care programmes, which the South African government introduced to support the provision of primary health care, are designed to improve the quality of lives for people with chronic illnesses and also to examine whether the programme has been implemented as intended.

You will be asked to complete a 4-item questionnaire addressing the following areas: Demographics, programme coverage, design and purpose of community home-based care programmes. Your responses will be compared with responses from other practitioners within community home-based care practice. Participation in this study is voluntary. You have the right to withdraw from the study at any time without penalty. This study is confidential and participant identity will remain confidential. I really value your opinion. It will only take about 45 minutes of your time to complete the questionnaire.

Thank you for your participation

Chuene Moshi
Masters of Management Student
University of Witwatersrand

1. Demographics of respondents

We are aware of the sensitivity of the questions in this section, the information will allow us to compare groups of respondents. Once again, we assure you that your response will remain anonymous.

1.1. Which type of organization are you representing?

Home-based care	
Department	
Ward Councillor	

1.2. What is your position in the organization? Please tick in one box below:

Manager	
Caregiver	

1.3. What is your gender? Please tick in one box below only if you working for home-based care:

Male	
Female	

1.4. What is your age range? Please tick in one box below only if you working for home-based care:

18 -35 years	
36 - 55 years	
+ 55 years	

1.5. What is your highest qualification level? Please tick in one box below only if you working for home-based care:

No Matric	
Grade 12	
Certificate	
National Diploma	

Degree	

1.6. What is your marital status? Please tick in one box below only if you working for home-based care:

Single/unmarried	
Married	
Divorced	

2. Programme coverage

2.1. What is your understanding of the history of community home-based care programmes in South Africa ?

……
……
……

2.2. When was your community home-based care organization formed?

……

2.3. What factors led to the formation of your home-based care organization ?

……
……
……

2.4. Which chronic illnesses are covered under home-based care programme?

2.5. What is the predominant gender being served through home-based care?

Male	
Female	

2.6. What do you think are the reasons for this gender category to have higher number of patients?

……

……

……

2.7. What is the predominant age group being served through home-based care?

Less than 18 years	
Between 18 – 35 years	
Above 35 years	

2.8. What do you think are the reasons for this age category to have higher number of patients?

……

……

……

3. Programme design

3.1. What activities are implemented through home-based care programme?

……

……

……

3.2. What training is required to deliver quality home based care service?

……

……

……

3.3. Have you been trained in relation to answer provided in 3.1.1?

Yes	
No	

3.4. What are the challenges facing community home based care service?

……

……

……

3.5. How are home-based care organizations dealing with this challenges?

……

……

……

3.6. Does your organization get subsidy?

Yes	
No	

3.7. Which organization is providing the subsidy?

3.8. What is the view of the Department of Health regarding this challenges?

……

……

……

3.9. What is the view of the Department of Social Development regarding this challenges?

……

……

……

3.10. What support structures are important for successful implementation of a home-based care programme?

……

……

……

3.11. Does home-based care organizations get support from this structures?

Yes	
No	

Please explain your answer provided above:

……

……

……

3.12. What is the minimum number of home visits a patient should receive in month period?

……

……

……

3.13. What is the minimum number of home visits for each Caregiver in a day?

……

……

3.14. What is the average length of a home visit by a Caregiver?

……

……

4. Programme purpose

This section is intended to gather information about the purpose of community home-based care programmes. Once again, we assure you that your response will remain anonymous.

4.1. What is the goal/s of home-based care programme?

……
……
……

4.2. Has this been achieved by the home-based care programme?

Yes	
No	

Please explain your answer:

……
……
……

4.3. Do you think home-based care programme remains relevant in the provision of primary health care?

Yes	
No	

Please explain the above answer:

……
……
……

4.4. Do you think the Department of Health regard home-based care programme as a priority in the provision of primary health care?

Yes	
No	

Please explain the above answer:

……

……

……

4.5. What impact would there be if home-based care programme is closed down?

……

……

……

4.6. How can community home-based care programme be improved?

……

……

……

……

……

……

……

……

……

……

……

…….THANK YOU FOR YOUR PARTICIPATION……

Annexure B: Schedule of interviews

Interview number	Date	Start Time	Finish Time	Positions	Place
0001	04 Sep 2016	09:30 AM	12:00 PM	Programme Manager	Seshego
0002	04 Sep 2016	12:30 PM	12:38 PM	Caregiver	Seshego
0003	04 Sep 2016	14:00 PM	15:15 PM	Programme Manager	Ga Mamadila
0004	04 Sep 2016	15:16 PM	16:00 PM	Caregiver	Ga Mamadila
0005	05 Sep 2016	10:30 AM	11:45 AM	Ward councilor	Tibane
0006	05 Sep 2016	11:46 AM	12:30 PM	Programme Manager	Tibane
0007	05 Sep 2016	12:31 PM	13:10 PM	Caregiver	Tibane
0008	05 Sep 2016	14:00 PM	15:05 PM	Ward councilor	Ngwanallela
0009	05 Sep 2016	15:10 PM	15:45 PM	Programme Manager	Ngwanallela
0010	05 Sep 2016	15:46 PM	16:30 PM	Caregiver	Ngwanallela
0011	06 Sep 2016	10:30 AM	11:00 AM	Ward councilor	Lebowakgomo
0012	06 Sep 2016	09:46 AM	12:00 PM	Programme Manager	Lebowakgomo
0013	06 Sep 2016	12:00 PM	12:35 PM	Caregiver	Lebowakgomo
0014	06 Sep 2016	13:08 PM	13:39 PM	Programme Manager	Malemati
0015	06 Sep 2016	13:40 PM	14:10 PM	Caregiver	Malemati
0016	06 Sep 2016	14:15 PM	14:55 PM	Ward councilor	Malemati
0017	07 Sep 2016	09:40 AM	10:15 AM	Ward councilor	Ga-Ramokgopha
0018	07 Sep 2016	10:55 AM	11:25 AM	Caregiver	Ga-Ramokgopha
0019	07 Sep 2016	11:33 AM	12:40 PM	Programme Manager	Ga-Ramokgopha
0020	07 Sep 2016	13:00 PM	13:46 PM	Ward councilor	Botlokwa
0021	07 Sep 2016	13:48 PM	14:34 PM	Programme Manager	Botlokwa

0022	07 Sep 2016	14:38 PM	15:05 PM	Caregiver	Botlokwa
0023	08 Sep 2016	11:35 AM	12:00PM	Programme Manager	Ga-Manthata
0024	08 Sep 2016	12:01 PM	13:00 PM	Caregiver	Ga-Manthata
0025	08 Sep 2016	13:45 PM	14:22 PM	Programme Manager	Sewabarwana
0026	08 Sep 2016	14:24	15:00 PM	Caregiver	Sewabarwana
0027	08 Sep 2016	15:15 PM	15:51 PM	Ward councilor	Sewabarwana
0028	08 Sep 2016	16:20 PM	16:40 PM	Ward councilor	Ga-Manthata
0029	15 Sep 2016	11:00 AM	12:00 PM	Official from the Department of Health	Mosehleng
0030	23 Sept 2016	13:30 PM	14:15 PM	Official from the Department of Health	Polokwane