GRADUATE ANCILLARY HEALTH CARE WORKERS' PERCEPTIONS OF THE ANCILLARY HEALTH CARE LEARNERSHIP PROGRAMME IN ETHEKWINI DISTRICT

Submitted in partial fulfillment for the requirements for the Masters in Nursing Research, School of Nursing, Faculty of Health Sciences, College of Health Sciences of the University of KwaZulu-Natal.

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DECLARATION

I, Lindiwe Rejoice Bhengu declare that this dissertation entitled **'Graduate Ancillary Healthcare workers' perceptions of the Ancillary Health Care Learnership programme in EThekwini district'** is my own work and has not been submitted for any other degree or examination in any other university other than the University of KwaZulu-Natal. I have given complete acknowledgment to the resources referred to in the study.

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DEDICATION

This dissertation is dedicated to my two families, Bhengu and Ngema. My mother, MaNgidi - Hlomuka, Ngiyakuthanda Ma, and my late father, Dlokovu! May your soul rest in peace Ntusi yenkomo, I am doing this for you. My late mother-in-law, Sibiya ngenkomo abafokazana bebiya ngamahlahla, uyisithandwa wena, may your soul rest in peace. My husband Mfuniselwa, Mepho! My three beautiful children including my grandson, for their endless love, support and encouragement.

"BLESS THE LORD, O MY SOUL, AND FORGET NOT

ALL HIS BENEFITS"

ACKNOWLEDGEMENTS

ABSTRACT

Aim

The aim of this study was to describe ancillary health care workers' perceptions of the Ancillary Health Care Learnership programme, and their current employment status within the health care sector.

Methods

A non-experimental cross sectional survey was used that incorporated complementary mixed method data collection (Balnaves & Caputi, 2001; Polit & Beck, 2010). Quantitative data collected during the first phase, a telephonic interview assisted self-report questionnaire was used to inform semi structured focus group interviews that took place during the second phase to obtain richer descriptions and explore response and results of the phase 1 cross sectional survey (Bell, 2005). A Convenience sample of ninety two (n=92) was achieved for the telephonic interview assisted self- report questionnaire, and was substantially lower that the number of potential participants (N=200). Purposive sampling was used to obtain fifteen (N=15) potential key informant participants, a final sample of nine (n=9) achieved for the focus group interviews.

Results

The research revealed that majority (69%) of participants had their expectations of the course met. Subjects such as agriculture and business plan were perceived as not valuable and participants recommended that these be removed from the course. Computer course information was seen as and needed addition in order to bridge the skills gap and improve the opportunities for employment.Despite particpants perceptions of the course being met, expectations regarding emplyment were not. Employment rates were low, specifically within the health care sector.

Conclusion and Recommendations

The Ancillary Health Care Programme has not assisted the graduates in gaining employment. The review of the Ancillary Health Care Programme and some of the unit standards is one of the recommended options that can be done to improve the employment opportunities.

ABBREVIATIONS

AHC	Ancillary Health Care
AHCP	Ancillary Health Care Programme
AHCW	Ancillary Health Care worker
AIDS	Acquired Immune Deficiency Syndrome
ARVs	Anti Retrovirals
CBHC	Community Based Health Care
CCWs	Community Care Workers
CHW	Community Health Workers
CBO	Community Based Organisation
DHET	Department of Higher Education and Training
DoH	Department of Health
DSD	Department of Social Development
EPWP	Expanded Public Works Programme
ETQA	Education and Training Quality Assurance
FET	Further Education and Training
HAART	Highly Active Antiretroviral Therapy
HBC	Home Based Care
HBCV	Home Based Care Volunteers
HDN	Health and Development Networks
HET	Higher Education and Training
HIV	Human Immuno Deficiency Virus
HWSETA	Health and Welfare Sector Education and Training Authority
KZN	KwaZulu-Natal
NDoH	National Department of Health
NGO	Non - Governmental Organisation
NPO	Non-Profit Organisation
NQF	National Qualifications Framework

NSDS   National Skills Development Strategy

NYS   National Youth Service

PHC   Primary Health Care

PLWHA   People Living with HIV and AIDS

PMTCT   Prevention of Mother - to - Child Transmission

RIME   Research, Information, Monitoring and Evaluation

SAfAIDS   South African HIV and AIDS Information Dissemination Service

SANC   South African Nursing Council

SAQA   South African Qualifications Authority

SETA   Sector Education and Training Authority

STIs   Sexually Transmitted Infections

SSP   Sector Skills Plan

TB   Tuberculosis

WHO   World Health Organisation

WSP   Workplace Skills Plan

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CHAPTER ONE
INTRODUCTION TO THE STUDY

1.1.   Introduction and Background

The Health and Welfare Sector Education and Training Authority (HWSETA) is one of the twenty three (23) SETAs formerly established in March 2000, by the then Minister of labour Membathisi Mdladlana, to realize the goals of the Skills Development Act (97 of 1998). In 2010 the Minister of Higher Education and Training (HET), Dr Blade Nzimande, proposed the new SETA landscape. This minister stated that of the existing SETAs; twelve have their mandates extended without change, eight have minimal changes and three undergo significant changes. The announcement followed six months of intense speculation on which of the SETAs would survive skills development's transition from the Department of Labour to the Department of Higher Education and Training (Nzimande, 2010). During this 2010 transition the HWSETA was re-established with no change (Nzimande, 2011). In all, and as anticipated, the total numbers of SETAs were reduced to twenty one (21) for the duration of phase three of the National Skills Development Strategy (NSDS) which began on 1 April 2011 (DHET, 2010; Nzimande, 2011). The vision of HWSETA was, and remains, the creation of a skilled workforce that will be empowered to render quality health and social development services that are comparable to world class standards (HWSETA, 2005). A strategy to realize this goal is through the so called 'learnership programmes' introduced on 23 November 2004.

These learnership programmes can be in any field and of varied duration, they assist current employees, and the unemployed, to; improve skills, have existing skills recognized and assessed, and facilitate the achievement of formally recognised qualifications (Government Gazette number 22370 of 15 June, 2001). The registered health learnerships included; ancillary health care worker (AHCW), nursing auxiliary, enrolled nursing, bridging nursing course, basic pharmacist assistant, post basic pharmacist assistant, social auxiliary worker and diagnosis radiography (HWSETA, 2005). The availability of health related learnerships and the Department of Health's (DoH) commitment to meet the manpower shortage needs in South Africa may explain why, since the development of the learnership programmes in 2004, one of the most commonly utilized learnerships has been the Ancillary Health Care

Learnership leading to a qualification as an ancillary health care worker (AHCW) (HWSETA, 2005).

South Africa's population totalled 52.98 million in May 2013. A general household survey published by Statistics South Africa (Stats SA, 2013) showed that 10. 5 million people reside in KwaZulu-Natal. As the country is faced with a legacy of insufficient resources, specifically human resources, particularly in more poor districts of the country, providing a AHCW qualification was suggested to be a cost effective solution to meet service delivery needs (Government Gazette number 22370 of 15 June, 2001). It was suggested that the value of the AHCW qualification was fourfold. Firstly, to advance the South African Qualifications Authority's (SAQA's) mission of contributing to the full development of each learner and to the social and economic development of the nation at large. Secondly, to meet the manpower needs in South African health care through community based health care. Thirdly, to provide primary health care that is accessible, equitable and acceptable to community members. Finally, to provide cost effective health care workers for step down facilities. For example, old age homes and home based care (HWSETA, 2005). These goals can be understood in light of a paper submitted by Kamilah Qasimi (2011) that reported South Africa's health care sector to be lacking approximately 40,000 nurses. Qasimi (2011) further states that the Health Minister, Aaron Motsoaledi, predicted that it would take twenty years to fill the shortage of the nurses.

Within the South African community, home based care is becoming an increasing need due to the nature of prevalent chronic illnesses and subsequent impairment. Local research reports that home based care is favoured over institutional care (Davidson, 2010; Uys & Cameron, 2003). Family members, the majority (90%) being specifically women and young girls, are becoming informal caregivers when formal health care workers are not available (Davidson, 2010; Uys & Cameron, 2003). In addition, Davidson (2010) argues that research evidence clearly demonstrates that effective home care improves the clients' and families' quality of life. The value of the AHCWs is further supported by the KwaZulu-Natal (KZN) Expanded Public Works Programme (EPWP). This programme implemented another National Youth Service (NYS) project aimed at development of categories of ancillary health care workers. The programme ran for eighteen months (April 2009 - December 2010) to achieve the target of training six hundred and five young people across all eleven KZN districts. The purpose of

the programme was twofold. Firstly, to enable graduates to deliver effective community based health care (home based care). Secondly, to enable young people to access further learning and economic opportunities. For example, a learnership programme at community caregiver level was suggested to enable participants to exit to other higher levels such as Ancillary Health care level 2, Community Health Work level 3, as well as other levels of the National Qualifications Framework (NQF) (KZN EPWP file, 2011). The AHCW learnership, NQF level 1, is designed for the learners who have grade 10 to those who have completed Matric. Clearly these learnerships were considered to be of potential value in reducing the health care and unemployment gap. Their implementation thus included measures of control to ensure an acceptable standard.

In order for an employer to commence these learnership programmes, as of the 1st April 2000, a skill development levy of 0.5% of their total remuneration costs must be paid (Sector Specialist guide, 2000). This amount has since been increased to 1% (Sector specialist guide, February, 2008). In addition, employer participation criteria include: public employers (Government Departments) must pay 10% of 1% of personal expenditure for administration and operational costs of the HWSETA and submit an implementation report (IR) for the previous financial year and report on budgeted expenditure for skills development. All employers (public, private and levy exempt companies) must submit an original tax clearance certificate and workplace skills plan (WSP) for the current financial year with estimated budget for skills development. All employers must submit a letter from a relevant education and training qualifications authority (ETQA) body that the training provider is accredited for the relevant qualification (Expression of interest – Learnership funding, 2010/2011). The learnerships are funded by the Department of labour via specific SETAs and these funds, although they vary between R23000 – R45000 per annum per learner, are generally used for learners' allowance, course fees and uniforms, and are disbursed in three trenches: 50% upon the registration of the learnership agreement, 25% based on report submission, and finally, 25% upon the qualification of the learner. Funding of these learnerships can thus, in the short term, be the burden of the employer until the SETA has made full payment. In addition, the ETQA provided comprehensive guidelines to ensure that the provider provides training that meets all the requirements of the unit standards. The AHCW programme is skills based and it is therefore vital that competencies in all practical components can be demonstrated. The ETQA has to ensure that participating providers are suitably qualified to carry out these tasks

and that they know exactly what is needed for the learners to achieve the required standards (Learnership implementation Policy, 2011).

The aims of the Ancillary Health Care learnership programme were evaluated, in terms of expected outcomes, as stipulated in the unit standards set by SAQA in September 2010 by Dineo Mokheseng from HWSETA. At 12H45 on 06 May 2011 the researcher phoned Mr Sikhumbuzo Gcabashe, at the Research Information Monitoring and Evaluation (RIME) Department at HWSETA. Mr Gcabashe informed the researcher that the HWSETA had not been conducting research, merely a process of evaluation to establish how the Ancillary Health Care Programme has helped the graduate AHCWs in finding jobs. There seemed to be little focus on the initial goal of filling the community health care needs gap. Unfortunately access to the evaluation report was denied, HWSETA's policy being to not divulge the information to 'people from outside'. The researcher was advised to make an appointment in order to have an access to some of the information, geographically this was not possible. The evaluation instrument used by Dineo Mokheseng, and thus the RIME evaluation, is in the public domain as it was provided to participating training institutions. This instrument consisted of mainly closed questions that related to the following areas: employment status, age category, gender, qualifications, recommendations and suggestions about improvement of the programme.

1.2.   Problem Statement

When HWSETA commenced the health care learnership programmes their goals were to; bridge the skills gap, enable graduates to deliver effective community based health care as well as enable young people to access further learning and economic opportunities. Although the AHCW learnership has been offered since 2002 there has, to date, been no research conducted to determine the extent to which this learnership has facilitated the HWSETAs initial goals, specifically filling the health care needs gap and reducing unemployment. This was suggested as specifically relevant to inform the Government spending within the SETAs.

1.3.   Purpose of The Study

The purpose of the study was to describe AHCW graduates perceptions of the Ancillary Health Care Programme learnership and their current employment situation.

1.4.   Significance of the Study

Research in this area is particularly valuable at this time to inform government spending and provide information on the AHCW learnership effectiveness as a strategy for alleviating unemployment, improving numbers of health care worker, and social poverty. As outlined in the introduction, the vision of the HWSETA is the creation of a skilled workforce that will be empowered to render quality health and social development services that are comparable to world class standards (HWSETA, 2005). The results of this study can add to the available information to illustrate if the training has resulted in an increase in Community Healthcare Workers especially in the rural areas. It is also suggested that the results can stimulate discussion related to policy development and government spending aimed at future training and possibly specifically employment opportunities within the health care sectors for AHCW. Specifically, it is hoped that the need for further research, on a much larger scale, may result from such discussion.

Revision and further development of the curriculum can contribute to AHCW education and community health care needs and it is suggested that the results of this study can highlight, through graduate perceptions, possible revision areas to facilitate a curriculum that more accurately meeting student training needs.

1.5.   Research Objectives and Questions

The research objectives for this study were three-fold and research questions are presented after each research objective for readability.

1.5.1   To describe perceptions of the graduate Ancillary Health care workers (AHCW) of the Ancillary Health Care Programme (AHCP) in preparing for and facilitating employment.

Research Questions

1.5.1.1. Do AHCW graduates perceive the AHCP as preparing them for health care positions?

1.5.1.2. What health care positions do AHCW graduates perceive themselves to be prepared for?

1.5.1.3. Do employed AHCW graduates perceive the AHCP to have assisted them in gaining employment?

1.5.2. To describe graduate AHCW current employment status within the health care sector and outside.

Research Questions

1.5.2.1. How many of the AHCW graduates are currently employed?

1.5.2.2. How many of the AHCW graduates are employed by health care, institutions and organizations?

1.5.2.3. Of those AHCW graduates that are employed how many are providing community and /or home based care?

1.5.3. To describe the unemployed AHCW graduates career and work activities.

Research Questions

1.5.3.1. How many of the AHCW graduates are currently employed?

1.5.3.2. How many of the AHCW graduates are employed by health care, institutions and organizations?

1.5.3.3. Of those AHCW graduates that are employed how many are providing community and /or home based care?

1.6. Operational Definitions (Key Concepts)

The following terms were operationalized for the study

1.6.1. Graduate Ancillary Health Care Worker (AHCW) refers to a student who has completed the AHCW learnership and has been deemed competent on all unit standards assessed by an accredited training organisation.

1.6.2. Learnership is a structured learning programme that leads to a qualification in a certain field. For the purpose of this study a leanership refers to the ancillary health care 1 year structured programme accredited by the Health and welfare Sector education and training authority (HWSETA, 2005).

1.6.3. Perceptions: Perception in humans describes the process whereby sensory stimulation is translated into organized experience (Lindsay & Norman, 1997). Within this study, graduate AHCW (see 1.6.1) perceptions of the AHCW learnerships relate to their subjective experiences of the programme.

1.6.4. Rural area is an area that is not urbanized. For the purpose of this study rural area refers to an area with a community located at least thirty miles from an urban community (Muula, 2007).

1.6.5. Sub-urban is a continuous urbanization that extends beyond the core city. For the purpose of this study suburb refers to an outlying residential area of a city or town or to a separate residential community with commuting distance of a city (Gaurreau, 1991).

1.6.6. Urban area means an area of continuous development which usually includes the historical core municipality and the adjacent suburbs. For the purpose of this study urban refers to an area characterized by higher population density and vast human features in comparison to areas surrounding it (Campanella, 2008).

1.7. Conceptual Framework

1.7.1. Introduction

The study is based on the conceptual framework of Donabedian (Donabedian, 2000). This framework represented in figure 1.1. (Page 8) measures structure, process and outcome standards within an organisation. Donabedian's framework has been universally accepted and used as the basis for much of the work addressing quality and outcomes and is suggested to represent a continuous quality framework (McCabe, 2000). According to McCabe (2000) this model assumes that quality is dynamic, a fluid construct resulting from the relative balance of the three dimensions of care conceptualized as independent but interrelated. The framework proposes that each standard has a direct influence on the next and ultimately on the outcome of whatever the organisation's business.
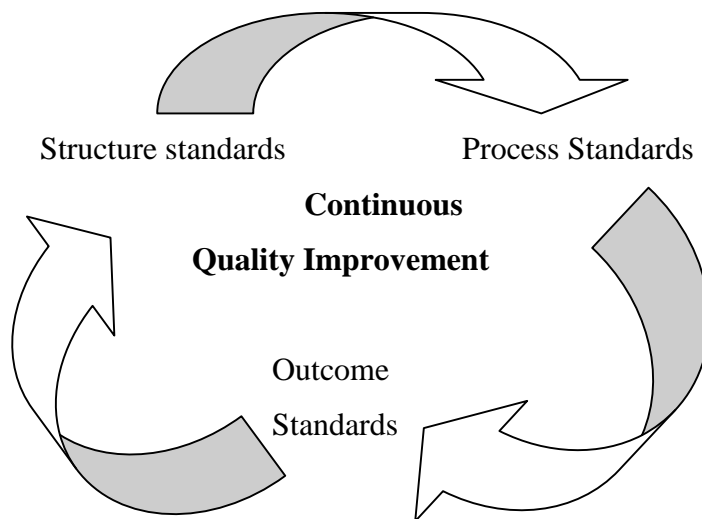
Figure 1: Donabedian's cycle of quality

Although the process appears linear the outcome standards should be fed back, through an information loop, into structure standards, revision of these will in turn influence process and outcome standards.

1.7.2. The Unfolding of the Conceptual Framework in this Study

As displayed in figure 1.2. below, within this study structure and process standards are described from the perspective of successful learners, a retrospective subjective evaluation of structure and process standards. Structure standards refer to prerequisites such as curriculum, physical structures, and human resources such as teachers/facilitators and mentors.
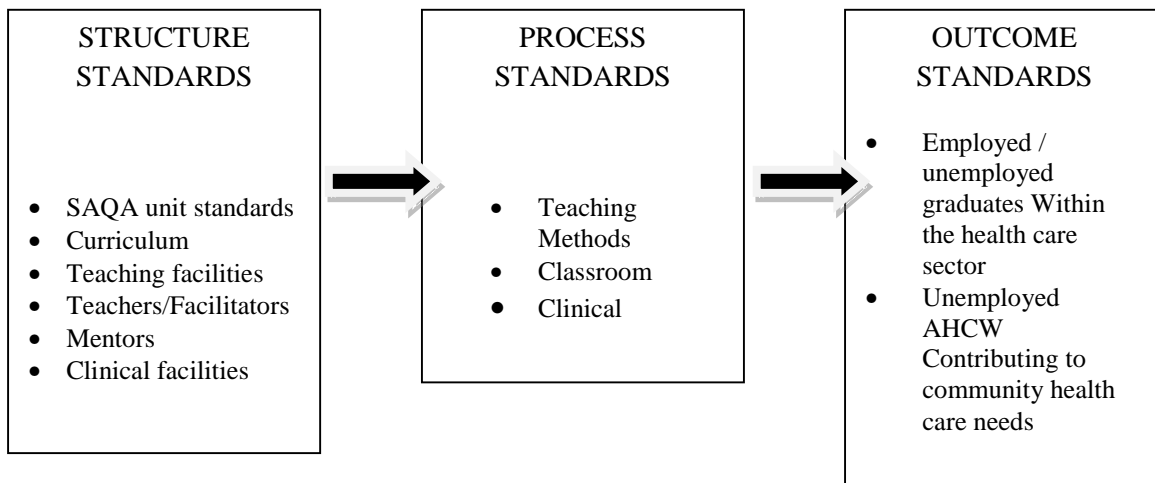
Figure 2: The Unfolding of Donabedian's Framework in this study

Process standards includes teaching methods, both classroom and clinical. Outcome standards refers to the number of AHCW graduates who are employed in a health care capacity, either by official health organisations or unofficially contributing to the health care of the community through voluntary work with non-government organisations (NGOs) and or / non-profit organisations (NPO).

1.8. Summary of Chapter

Chapter one presents the introduction and background to the study. This is followed by the presentation of the; problem statement, purpose of the study, significance of the study, research objectives and questions, and definition of key concepts. The chapter concludes with a presentation of the conceptual framework.

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CHAPTER TWO

LITERATURE REVIEW

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2.1. Introduction

In this chapter the literature reviewed related to voluntary, and AHCW, participation in meeting community health care needs. However, there are limited research studies available regarding outcomes of programmes implemented to train such community workers and or graduate's perceptions. The majority of the literature focusing on the importance of specific health care short courses in alleviating unemployment rates internationally, in African countries, in South Africa and in KwaZulu-Natal rather than the success of such local programs. International perspectives on home based community care are presented; specifically Canada and the United Kingdom. The African and South African perspectives are presented based on the literature available. Specifically within South African literature short courses such as home-based care services for persons with Tuberculosis (TB), HIV and AIDS and primary health care were, in lieu of research directed at AHCWs learnership and graduates, utilised by the researcher to develop an understanding of the African perspective of community and home based care provided by ancillary health care programmes. The chapter concludes with a review of the purpose of the development of AHCWs and policy documents supporting the implementation of such learnerships.

2.2. International perspectives on home based community care

Within international health care settings paid activities such as health care and community care services can be publicly funded through government programs, privately purchased through out-of pocket payments or through insurance programs or, can include a mix of publicly and privately funded care (Hermus, Stonebridge, Theriault & Bounajm, 2012). Canadian literature reports that home and community care is a vital part of the Canadian health system (Hermus et al., 2012). The demand for home and community care is expected to grow significantly as the population ages (Hermus et al., 2012). These authors report the need by estimating the economic footprint of home and community care in Canada, highlighting the implications of caregiving employees for businesses, and shedding light on the potential spending implications of shifting some care from institutions to homes (Hermus

et al., 2012). Currently, to meet the needs of home care recipients, the Canadian home and community care sector relies heavily on volunteer efforts and other unpaid care (Hermus et al., 2012). Briefly, unpaid care refers to informal assistance from individuals (neighbours, family, social group contacts) that may include actual caregiving or assistance through donation of money, time or resources. It is estimated that during 2007 3.1 million Canadians provided some level of unpaid service to home care recipients, providing over 1.5 billion hours of home support (Hermus et al., 2012). Factors driving the demand for home and community care include early discharge from hospitals, the aging of the population with a growing preference to remain at home as one ages, and increased prevalence in chronic diseases (Hermus et al., 2012; Uys, 2001). The 'home help' system within the United Kingdom (UK) is an example of a government funded home based care programme that is implemented throughout the UK (http://www.homecare.com). Dr Peter Carter, Chief Executive and General Secretary of 'Moving care to the community', reports that this home based care has been a UK-wide health and social care policy priority for more than a decade. This community home based care programme has evolved over the course of two decades in response to the HIV epidemic and wider availability of anti retro viral treatment (ART) (Wringe, Cataldo, Stevenson & Falcoya, 2009). Evidence is emerging from small scale and well resourced studies that ART delivery can be effectively incorporated within home based care programmes (Wringe et al., 2009).

The terms home care and in-home care are used interchangeably in the United States (US) to mean any type of care given to a person in their own home. Home care aims to make it possible for people to remain at home rather than use residential, long term or institutional based nursing care (http://www.homecare.com). These services may include some combination of professional health care services and life assistance services (http://www.homecare.com). Briefly, life assistance services include help with daily living activities such as meal preparation, medication reminders, laundry, shopping, transportation and companionship (http://www.homecare.com). Estimates for the US indicate that most home care is informal, with the families and friends providing a substantial amount of care. (http://www.homecare.com). In regards to financial expenditure, home nursing care is more cost effective than in-patient nursing home care (http://www.homecare.com).

2.3. African Perspectives on home based community care

In most African countries skills programmes such as home based care are carried out by volunteers and donors usually provide funding for training and integration into sustainable programmes that integrated this approach within public health care systems. The lack of financial resources within low and low-middle income countries changes the implementation and recognition of such programmes, specifically the workers implementing these community home based care strategies.

Although the study by Walker, Aceng, Tindyebwa, Nabyonga, Ogwang, and Kiiza (1998) is somewhat old it is suggested to have offered valuable insights in planning for the community and home based health care needs related to the growing population of HIV AIDS infected persons. Walker et al. (1998) conducted a study that aimed to assess home based care programmes in Uganda with the aim of highlighting strength and weaknesses relating to individual strategies. Using a complementary mixed methods data collection design seven home based care programmes were assessed based on; aims and objectives, provision and continuum of care, staffing, supplies and equipment, education, financing, costs of care, and monitoring and evaluation strategies. The results were evaluated with the best practice criteria of; relevance, sustainability, ethical soundness, effectiveness and efficiency. Results suggested that their period of operation, ten to seventeen years, reflected medium term sustainability. Effectiveness was reflected in reported satisfaction with care and improvement in quality of life among high proportions of beneficiaries. Identified weaknesses included less effective management and financial controls, deficient record management, lack of defined outcome measures, and lack of national policy specific to home based care. These authors concluded that the facility outreach programmes utilising nursing personnel and large numbers of community volunteers for medical and enlarged psychosocial support appeared efficient.

In a joint 2008 publication between Health and Development Networks (HDN) and the Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS) it is stated that since 2005 Irish Aid has supported Home based care initiatives in Zimbabwe and is currently funding 15 home based care programmes throughout the country (Madzingira,

Mamimine, Mkandora, Marimo, 2008). This is in keeping with the findings by Mulogo (1998) that the cost of home based care is borne by the private sector, often religious or charity, and largely from external donors. Home based care programmes in Zimbabwe currently rely on a variety of sources for small funding grants (Madzingira et al., 2008). A number of donors are keen to fund some aspects of these programmes, but few donors provide funding for an integrated approach (Madzingira et al., 2008). Briefly, an integrated approach is a co-ordinated set of activities which are mutually supportive in improving livelihoods and bringing together partners in carrying out these activities (Madzingira et al., 2008). This author argues that what is preferred are short term 'quick fix' initiatives, these predominate funding opportunities rather than acknowledged introduction of acknowledged home based care practitioners with certification and career opportunities (Madzingira et al., 2008). Lynde Francis, a founder and Executive Director of 'The Centre', an organisation run by, and for, people living with HIV/AIDS in Harare, referred to Madzingira et al. (2008) stating that there is a need to completely rethink the concept of primary health care and recognise that this cadre of health workers deserves certification, registration and remuneration and not just a uniform or a kit to use with their clients.

Akintola (2004) in his SA study highlighted that in many of the communities affected by HIV and AIDS community based organizations (CBOs) have stepped in, mobilizing, recruiting and providing training for community members who volunteered their services. These volunteers in turn assisted households and communities to relieve the burden of caring for people living with HIV/AIDS (du Plessis, Morley, Westcott & Wozniak, 2005). Traditionally in Africa, the care giving role has been disproportionately carried out by women (Madzingira & Biriwasha, 2008). Caregivers often forego income generating activities that may benefit their own households in order to take care of people living with HIV and AIDS (PLWHA) and other affected people. Care giving comes at a cost to the caregivers and existing home based care models are based almost exclusively on volunteerism (Madzingira et al., 2008). Although some of these volunteer programmes have been documented there is still very little done to focus specifically on the role played by volunteer caregivers in home-based care for people, even specific to HIV/AIDS (PLWHAs) in their communities. These volunteers are suggested to form the backbone of many community care programmes in African and South Africa. Akintola's (2004) study was carried out to understand and document the role that volunteers play in alleviating the burden of HIV/AIDS care in households and communities.

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The results of this study suggest that although many of them are unemployed and, themselves, living in poverty, they are generally driven by nobility and the will to make the lives of their patients better. They carry out their work with a sense of commitment and dedication, earnestly seeking to end the misery of community members and in the process, often confronting other problems that complicate their lives and that of their families.

This issue of lack of formal structures leading to 'involuntary voluntarism' in Africa is reported in a study in Lesotho. Newman, Makoae, Reavely and Fogarty (2009) in their report on a study of male providers of community based HIV/AIDS care and support in Lesotho state that organisations should adopt a volunteer charter for community health workers and home based caregivers to address conditions of work. Specifically Newman et al. (2009) stated that issues that need to be included are standardized resources and supplies to cope effectively, and protective factors such as; standardized working hours and remunerations, psychological support, response to harassment and violence, and tangible protections such as pensions and child - support grants. This study further challenges gender segregated jobs, such as health care providers, and argues that the advantages of recruiting and training male providers of HIV/AIDS care support may increase the perceived quality of care, especially for clients who want the same sex providers to help with intimate activities of daily living. In the 2010 budget speech, the South African (SA) Health Minister, Dr. Aaron Motsoaledi, announced that human resource capacity was one of the "teething problems" experienced whilst implementing plans to increase the number of health facilities providing Anti-Retroviral medication (ARVs).

Clearly in Africa, specifically SA, the response to the health care needs related to PLWHA has highlighted that what is vital in scaling-up treatment access, while making best use of available resources, is task-shifting in the health sector (Motsoaledi, 2010). This means permitting health care workers to become involved in particular stages of treatment provision where currently they are not allowed (HIV/AIDS in South Africa, 2010). Under task-shifting, nurses, rather than doctors, can initiate antiretroviral therapy; lay counsellors (ancillary workers), rather than nurses, can carry out HIV tests, as well as provide support for orphans, work usually done by social workers (HIV and AIDS in South Africa, 2010). It is believed task-shifting vastly increases the access points to treatment and care by reducing the 'bottlenecks' in the system created by a lack of staff able to perform certain tasks. It may also

involve delegating tasks to healthcare workers who are identified for advanced training to add certain urgent priority competencies (WHO, 2007). Many campaign groups, such as the Iteach programme in KwaZulu-Natal, are training traditional healers (Sangomas) at local health institutions, to gain counseling qualifications so they are qualified to provide counseling and condoms. These initiatives support task-shifting and claim it to be crucial to the goal of making HIV treatment much more widely available. (Motsoaledi, 2010) The introduction of the nurse initiated anti retroviral treatment (ART) is also another example of successful task shifting (HIV and AIDS in South Africa, 2010). In May 2010 South Africa implemented task-shifting. Health minister Motsoaledi approved the new regulations (nurses, rather than doctors, can initiate antiretroviral therapy; lay counsellors, rather than nurses, can carry out HIV tests, as well as provide support for orphans usually done by social workers) on task-shifting to community caregivers (CCGs) who are now able to prepare individuals for, and monitor adherence to, ART (WHO, 2010).

Within KwaZulu-Natal, SA, Naidu and Sliep (2012) present narrated facts about the lack of support for home based care volunteers over a long period, arguing that this undermines the work and the basis of home based care volunteers (HBCVs) identity. Significantly, these authors reported that personal experiences of poverty and the expectations that the government would begin to pay HBCVs was also evident in the women's account. A further local study, Uwimana, Zarowsky, Hausler and Jackson (2012) related to training community care workers to provide comprehensive TB/HIV/PMTCT integrated care in Sisonke, a rural district of KwaZulu-Natal suggested that up-scaling community care workers (CCWs) could be one avenue to enhance TB/HIV case finding, TB contact tracing and linkages to care.

2.4. Purpose of the AHCW learnership

The purpose of the development of AHCWs is to introduce learners to the various aspects of community care and to encourage learners to gain experience of community health care with a view to a possible career in this industry (SAQA, 2002). The South African Qualification Authority (2012) suggests that the learners who complete this qualification (AHCW) will possess the firstly, competence required to perform community health functions under the supervision of a professional health worker, knowledge and skills to provide support services within the multidisciplinary health care team. Secondly, they will also have fundamental

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skills required for employment by a range of health, social and other sector employers. Thirdly, they will be in possession of a recognised qualification that will provide a platform for further education and training in career pathways towards becoming professional health workers (SAQA, 2012). Lastly, that qualified learners in this field will provide a service that will assist communities to better manage their own health and wellness.

Innocentia Masilela, the Executive Manager under skills development planning division at HWSETA stated in her report that the HWSETA, in implementing its sector skills plan (SSP), had set, among others, the following targets for 2003; to implement registered learnerships including AHCW learnership, and to facilitate unit standards generation (HWSETA Annual report, 2003-2004.) Masilela further stated that national workshops were conducted to inform stakeholders of criteria, procedures and closing dates for participation in skills development. The overwhelming response of stakeholders to attend the workshops resulted in a substantial increase in the number of workplace skills plans (WSP) being received. Creative strategies were developed to ensure participation of all stakeholders in the implementation of registered learnerships. In the second year of implementation of learnerships at HWSETA, the number of participating employers increased significantly. This exercise also helped them to understand the challenges employers face concerning the funding of learners on learnerships (HWSETA Annual Report, 2003 – 2004). Although these reports provide information on enrolments and potential funding issues there seems little to no information in the literature related to the success of this learnership in meeting the core goals or reducing unemployment and closing the gap in health care.

2.5. Summary of Chapter

In Chapter two international and local perspectives on community home based care is presented. Much of the research in Africa, specifically SA, focuses on PLWHA and does not focus specifically on the AHCW. To clarify the cadre of health care workers the chapter ends with the purpose of the development for the AHCW learnership and the policy document supporting its development and implementation.

CHAPTER THREE
METHODOLOGY

3.1. Introduction

This chapter discusses the research design used to collect data from the respondents. Potential respondents and actual sample are presented as well as the data collection instruments and methods. The research setting described the two institutions included in the study.

3.2. Research Design

A non-experimental cross sectional survey that incorporated complementary mixed method data collection was used (Balnaves & Caputi, 2001; Polit & Beck, 2010). Quantitative data collected during the first phase, a telephonic interview assisted self-report questionnaire used to inform the semi structured focus group interviews that took place during the second phase to obtain rich descriptions and explore response and results of the phase 1 cross sectional survey (Bell, 2005).

3.3. Population and Target Population

The population was all graduate ancillary health care workers (AHCW) within KwaZulu-Natal. The target population was all graduate AHCWs within EThekwini District who completed the AHCW learnership between 2005, when the first course began, to 2009, when the last group of successful learners completed.

3.4. Research Setting, Sample and Sampling Procedures

A convenience sample was employed to select two teaching organisations that offered the AHCW learnership from its inception, 2005, to its completion, 2009. The two teaching organisations were selected on the basis of accessibility and the organisations expressed desire to obtain feedback on graduates' progress. Institution 'A' operating from Pinetown in Durban and Institution 'B' also operating from Durban and centrally situated. Both were accredited by HWSETA. They started their training of AHCP in 2005. They both had

qualified staff with subject matter expertise and experience in running learnerships. The sampling frame within the two selected teaching organisations related to graduate contact information and is described below.

Phase 1: Telephonic interview assisted self-report questionnaire

Within each of these two institutions a census was employed using the service providers training records, specifically completed transcripts of training to identify potential participants. It was estimated that each training institution would have 200 potential graduates (20 graduates per group per year per organisation) thus a potential sample of 200 (N=200). The actual sample totalled ninety two (n=92), from training organization A, a total of fifty five (n=55) and from organization B a total of thirty seven (n=37). This considerable difference between potential sample and actual sample is a result of contact details no longer being valid, despite complete and accessible records at both training institutions. It is possible that this is related to mobile phone usage as ninety eight percent of the records were for mobile phone numbers. The reason for including all graduate AHCWs throughout the five year training period was, firstly, an attempt to include representative demographic and social characteristics of the group and secondly, to ensure sufficient numbers to produce statistical power (Polit & Beck, 2010). In chapter four the researcher describes the sample and presents statistical data.

Inclusion Criteria:
- Successfully graduated the AHCP from one of the two training institutions sampled.
- Has a phone number on file.
- Answers the phone on the first three attempts.
- Agrees to participate in the study.

Phase 2: Audio recorded in depth focus group interviews

Purposive sampling was used to select key informants from the phase one survey to attempt to achieve representativeness within the group, taking into consideration demographic data and voluntary participation. A total sample of nine (N=15) respondents were to be selected to achieve 3 focus groups (5 respondents per group). Division of respondents to one of the three focus groups was determined by employment status; employed in the health care sector;

employed but not in the health care sector; and not employed. The respondents who finally participated were nine (n=9), three were working in the health care centre, two were working but not in the health care centre and four were not working. These were interviewed in one focus group. There were different reasons given for non participation. Some apologized that they were living very far and did not have money for transport to come for focus group interviews and some did not want to participate because they said they were not working and did not think the interviews were going to help them get the jobs.

3.5. Data Collection Instrument

Phase 1: Telephonic assisted self-report questionnaire (Appendix 1)

The questionnaire was offered in English only as graduates study in English and it is assumed that their command of the English language is acceptable. The questionnaire was structured and had two sections.

Section A includes demographic data and included; firstly, age and gender, to determine the representativeness of the student population in KZN. Secondly, rural or urban livings to allow for cross referencing with employment statistics. Thirdly, the year of study was requested to enable analysis of differing outcomes for differing learnership groups and finally, the unemployment history prior to enrolling for the learnership and current employment or unemployment history.

Section B included items that cover the following categories: motivation for entering the learnership (items: 11), expectations of the learnership (items: 12, 15, 16, 17, 26, 27), perceptions of classroom teaching (items: 13, 14, 18) and clinical aspects of the learnership (Item: 19, 20, 21, 22, 23, 24, 25). Face validity was established through the expert opinions of teachers involved in the delivery of this learnership. Content validity was established through the extent to which the items were reflected in HWSETA evaluation instruments (2010).

Phase 2: Audio recorded in depth focus group interviews (Appendix 2)

Semi structured questions were finalized on the result of phase one (1) data. These questions are outline in Appendix 6 (p, 53).

3.6. Data Collection Process

Once ethical permission was granted from UKZN (Appendix 9) and permission granted from the chairman of each of the training institution to access student records (Appendices 2 and 3) data collection began.

The researcher is involved in the training at one of the institutions and thus she employed a research assistant to implement the telephonic assisted self-report questionnaire and focus group interviews for participants from that institution. The rationale was an attempt to reduce social desirability bias and reassure respondents of anonymity. The research assistant was trained in the implementation of the telephonic assisted questionnaire and focus group interviews. In addition a standard operating procedure was used to ensure reliability of the data collection process and thus the data.

Phase one: Quantitative Interview Assisted Questionnaire

All records for the graduates from 2005 to 2009 were accessed from both institutions. Two hundred records were chosen, one hundred from each institution. Telephone calls were made but only 92 potential respondents were available at the phone numbers on record. The following process was followed for each potential respondent
- The phone numbers were accessed from the graduate AHCW's transcript records by the researcher.
- The researcher and research assistant made three attempts to telephonically contact potential participants

Potential respondents who answered the phone were:
- Given the caller's name, the researcher or research assistant introduced self by name before identifying who the caller was wanting to speak to
- Identity confirmed by asking the potential respondent their name, surname, the course they had done and the institution and the year.
- The researcher or research assistant then gave information regarding the study. This was read verbatim from the information sheet to ensure standard operating procedure (Appendix 4). Within the information sheet (Appendix 4) voluntary participation was

stressed as well as confidentiality and anonymity and it was made clear that answering of questions will constitute implied consent

- After being given an opportunity to ask questions the graduate was then invited to participate in the study.

- Once verbal agreement was given the research or research assistant began to read each item on the questionnaire, only moving to the next question once an answer had be provided by the participant to the previous question.

- When requested to the researcher or research assistant repeated a question but did not explain potential answers nor discuss answers with the respondents to prevent influencing respondent's responses.

- As respondents answered the questions the researcher and research assistant transcribed directly onto the questionnaire the verbatim answers of respondents.

- At the end of the interview the respondent was asked if they would be willing to participate in the phase two (2) focus group interviews by reading, verbatim, of the brief information sheet (Appendix 4). Their response was recorded on the completed questionnaire as a 'Yes' or 'No'. Those who indicated 'Yes' had their contact telephone numbers recorded on the completed questionnaire and were told that they would be contacted telephonically to confirm the date and time of the focus groups.

The researcher, research assistant discussed and determined the semi structured interview questions for phase two (2) to improve reliability.

Phase 2: Audio recorded in depth focus group interviews

- The respondents for in depth interview were contacted telephonically by the researcher or research assistant and invited to the focus group interview.

- The information sheet was read verbatim over the telephone

- The time and venue for the focus group interview were provided (was conducted on a Wednesday at 307 Absa Building, Pinetown at 09h00). Graduates who were in active contact with the schools and geographically close to the phase 2 venue accepted the invitation to participate in the phase 2 data collection. Ten respondents agreed, nine arrive at the venue on the agreed upon time and date.

- On arrival at the venue for the focus group interview respondents were given the information sheet (Appendix 5) and consent sheet (Appendix 7), given time to ask

questions, and reimbursed with R20 for travel expenses *before* being asked to sign the consent form.

- None refused. Those who gave consent were gathered in a private room, the audio recorder activated and the focus group commenced.

3.7. Data Analysis

The researcher only handled all collected data. Phase one data, the telephonic interview assisted self-report questionnaire, was coded and entered into excel. Descriptive statistics was performed through the uses of ranking, frequencies and cross tabulations to quantify responses and associate responses with demographic data. Phase 2 audio recorded data from the focus group interview was transcribed accurately, respondents coded and the researcher checked the transcripts against the audio recording before destroying the audio record. A content analysis was employed according to the process outlined by Elo and Kyngas (2008). This process has three distinct phases. Firstly, the researcher engaged in the preparation phase where she familiarised herself with the raw data content. This was followed by opening coding where the researcher used target phases to identify possible categories (codes). From this categories were created by using the codes to create groupings. This was followed by the final stage of abstraction where themes were defined and categories allocated to themes. A description of the application of this process is given in Chapter 4 (point 4.4.4.).

3.8. Ethical Considerations

Once ethical approval was received from UKZN ethics committee (Appendix 9) a letter was written to the chairman of each of the teaching organisations to ask for a permission to use their training records (Appendices 2 and 3).

To ensure informed consent an information sheet was used for each of the phases that explained the purpose of the study and stressed voluntary participation, anonymity and time commitment required for each of the phases (Appendix 7). Once the information sheet had been read, verbatim, to the potential participants they were asked if they had any questions, if they were prepared to participate and their verbal consent signified the beginning of the telephonic assisted self report questionnaire, the participant answering questions indicated

implied consent to participate. Implied consent was used for phase one as potential participants were being contacted per telephone. Implied consent was assumed when the respondents verbally agreed to participate and answer the questions from the self report questionnaire (Polit & Beck, 2010). Phase two, audio recorded focus group interview, included written consent. Potential participants were provided with an information sheet, verbally read at the invitation to participate and provided with a hard copy on arrival at the venue for the focus group interviews (Appendix 4). On the day of the focus group after being given time to ask questions and being reimbursed for their travel expenses, potential participants were asked to sign the consent form indicating their willingness to participate before the focus group commenced.

Voluntary participation was stressed in the information sheets, again verbally before commencing data collection and implied with the reimbursement before the commencement of the second phase focus groups.

3.9.   Summary of Chapter

In this chapter methodology was discussed including research design, target and target population, sample and sample procedures, data collection instrument, data collection process, proposed data analysis, ethical consideration and limitations of the study. It was difficult to get some of the learners due to the problem that their phone numbers had changed.

CHAPTER FOUR
PRESENTATION AND ANALYSIS OF DATA

4.1. Introduction

In this Chapter the research findings are presented. As described in Chapter 3, the proposed sample of 200 participants (N=200) was not achieved, a final sample of ninety two participants (n=92) was achieved for phase one. The chapter begins with a description of the phase one sample followed by participants' responses to the phase one telephonic assisted self-report questionnaire. This questionnaire can be found in Appendix 1 (page 44). The data from the telephonic assisted self-report questionnaire is presented according to questionnaire layout. Phase two data is then presented, beginning with a description of the sample, followed by the presentation of the analysed data from the focus group.

The quantitative research data, demographic and section B of the telephonic assisted self-report questionnaire was analysed using excel for Microsoft office 2010 and descriptive statistics produced. Qualitative data obtained from the phase two focus group was analysed using the content analysis process outlined by Elo & Kyngas (2008). This process is presented in chapter three (point 3.7., p, 22).

4.2. Description of the *phase one* sample

The sample, illustrated in table 4.1 below, included graduates from differing years and is suggested to then provide a useful overview of the AHCW learnership. The participants from earlier years are limited; 7% (n=6) of respondents completed the AHCW learnership between 2005 and 2006, 25% (n=23) between 2006 and 2007, 23% (n=21) between 2007 and 2008 and finally the majority (45%, n=42) of respondents completed between 2008 to 2009. This distribution is suggested to be related to changing of contact details and thus unavailability of participants rather than intake numbers. The participants (n=92) included male graduates (5%, n=5) and female graduates (95%, n=87). This is an indication that the health related courses are still dominated by females. The majority of participants were in the 20-29 age category (65%, n=60). The remaining participants included 40-49 age category (8%, n=7), only one participant reported being in the 10-19 age category (1%, n=1). At the time of

registering for the AHCP the majority of respondents (71%, n=65) came from urban areas followed by those from rural areas (25%, n=23) and a small percentage (4%, n=4) from sub – urban areas. This suggests there are lot of people in urban areas probably because many people move to this area from rural areas after matriculation to seek for employment and tertiary education (Goldin, Cameron & Balarajan, 2011).

Table 4.1. Sample demographics

Year AHCP completed	Freque ncy n (%)	Educational level n (%)			Catchment area n (%)		
		St 8	St 9	St 10	rural	Urban	Sub-urban
2005 – 2006 (1 non response)	6 (7%)	0(0%)	3(50%)	2(33%)	4(67%)	2(33%)	0 (0%)
2006 – 2007	23(25%)	1(4%)	2(9%)	20(87%)	7(30%)	16(70%)	0(0%)
2007 – 2008	21(23%)	0(0%)	3(14%)	18(86%)	6(29%)	14(67%)	1(5%)
2008 – 2009	42 (45%)	0(0%)	2(5%)	40(95%)	6(14%)	33(79%)	3(7%)
TOTAL	92 (100%)	1(1%) 1non response 2006	10(11%) 1non response 2006	80(87%) 1non response 2006	23(25%)	65(71!%)	4(4%)

As illustrated in table 4.1. above, respondents level of education revealed the largest percentage (87%, n=80) to have completed standard 10, or matriculation. In addition ten respondents (11%, n=10) had completed standard 9 and only one respondent (1%) reported their highest level of education to be standard 8. This suggests that many learners, despite completing the available school education, were unable to continue to tertiary education or gain employment. This is further illustrated by the number of intervening years between graduates' completion of schooling and registration for the AHCW learnership. The majority of the respondents (75%, n=69) enrolled after one to five years after completion of school; twelve (13%, n=12) respondents enrolled between 6 to 10 years after school completion and the smallest percentage (5%, n=5) of respondents registered between 11 & 15 years after school completion. The second small percentage (7%, n=6) of respondents enrolled for AHCP within one year after completion at school.

Current employment rates, reflected in Table 4.2. (page 26) were very low (n=18, 20%). Employment as per the different graduate years included; 2006 n=2 (33%); 2007 n=4 (17%); 2008 n=8 (38%); 2009 n=4 (10%). Within this employed group employment in the health care sector ranged from 25% - 50%; 2006 n=1 (50%); 2007 n=1 (25%); 2008 n=2 (25%);

2009 n=2 (50%). National population, estimated at 52.98 million, unemployment statistics suggest an unemployment rate of 25.6% (Statistics SA, July 2013).

Table 4.2. Employment rates

Graduate year	Sample	Current employment rate n (%)	Employed within health care sector n (%)	Employed outside of health care sector n (%)
2006	6	n=2 (33%)	n=1 (50%)	n=1 (50%)
2007	23	n=4 (17%)	n=1 (25%)	n=3 (75%)
2008	21	n=8 (38%)	n=2 (25%)	n=6 (75%)
2009	42	n=4 (10%)	n=2 (50%)	n=2 (50%)
Total	92	n=18 (20%)	n=6 (7%)	n= 12 (13)

Population estimate in KwaZulu-Natal is 10.456 million with an estimated unemployment rate of 22.5% (Statistics South Africa, 2012)

4.3. Quantitative data achieved from Section B

This section presents data related to respondents' response regarding; motivation for entering the learnership, aspects of the academic and clinical portions of the learnership, and perceptions of facilitator's knowledge and skills. It also deals with further information which participants think should be added or removed from AHCP. Table 4.3., below, presents respondents' motivation for entering the learnership.

Table 4.3. Respondents Motivation for enrolment

Year	Sample	Wanted education, Learnership n(%)	Love for Nursing n(%)	Love for Community n(%)
2006	6	n=0 (%)	n=6 (100%)	n=0 (%)
2007	23	n=5 (23%)	n=18 (78(%)	n=0 (%)
2008	21	n=7(33%)	n=11 (79%)	n=3 (21%)
2009 (1 non response in 2009	42	n=1 (2%)	n=26 (65%)	n=14 (35%)
Total	92	n=13 (14%)	n=61(66 %)	n= 17 (18%)

A desire for education as the reason for enrolling for the AHCW learnership was reported by n=5 (23%) of respondents in 2007, n=7 (33%) in 2008 and n=1 (2%) in 2009. Those respondents who had love for Nursing were n=6 (100%) in 2006, n=18 (78%) in 2007, n=11 (79%) in 2008 and n=26 (65%) in 2009. The respondents who reported 'love for the

community' included 2008 n= 3(21%) and 2009 n=14(35%). In addition to motivation for entering the learnership respondents also reported on their expectations of learnership experience. These results are outlined in table 4.4. below. This table presents respondents' expectations of the course and reveals that n=3 (50%) of respondents had their expectations met in 2006, n=20 (87%) in 2007, n=20 (95%) in 2008 and n=40 (84%) in 2009.

Table 4.4. Respondents' Expectations and Time allocation of AHCP

Year	Expectations met n(%)		Learnership facilitator knowledgeable n(%)		Respondents given course notes n(%)		Adequate time allocated to the learnership n(%)	
	Yes	No	Yes	No	Yes	No	Yes	No
2006	3(50%)	3(50%)	5(83%)	0(0%)	5(83%)	0(0%)	4(67%)	1(17%)
2007	20(87)	3(13%)	22(96%)	1(4%)	22(96%)	1(4%)	21(91%)	2(9%)
2008	20(95%)	1 (5%)	21(100%)	0(0%)	21(100%)	0(0%)	20(95%)	1(5%)
2009 (1 non response)	40 (84%)	2(16%)	42(100%)	0(0%)	42(100%)	0(0%)	42(100%)	0(0%)
Total	92		91 (1 non response 2006)		91 (1 non response 2006)		91 (1 non response 2006)	

Those respondents whose expectations were not met were accounted for half of the 2006 participating graduates from 2006 (50%, n=3).Later groups had lower rates; (13%) n=3 in 2007, (5%) n=1 in 2008 and (16%) n=2 in 2009. The table further shows that the majority of respondents reported the facilitators to be knowledgeable; (83%) n=5 of 2006, 96% (n=22) in 2007, 100% (n=21) in 2008 and 100% (n=42) in 2009. This further suggests that the facilitators were qualified and subject experts. The table further shows that the majority of respondents were given course notes; (83%) n=5 2006, (96%), n=22 in 2007, (100%) n=21 in 2008 and (100%) n=42 in 2009. The respondents who agreed that time allocation of the programme was enough made accounted for (67%) n=4 in 2006, (91%) n=21 in 2007, (95%) n=20 in 2008 and (100%) n=42 in 2009, the majority of respondents were satisfied about time allocated to AHCP.

Respondents who reported the need for additional information in the AHCP included; n=3 (50%) in 2006, n=9 (39%) in 2007, n=11 (52%) in 2008 and n= 16 (38%) in 2009. There was one non-response in 2006 n=1 (17%). Those who felt there was no need for addition content included the majority in some years (n=14 (61%) in 2007, n=(62%) in 2009)and the minority in the other years(n=2 (33%) in 2006, n=10 (48%) in 2008). There were some respondents who felt that some aspects of information needed to be removed from the learning

programme; they were n=3 (50%) in 2006, n=2 (9%) in 2007, n=2 (10%) in 2008 and n=2 (5%) in 2009. One respondent n=1 (17%), did not respond in 2006. Respondents who felt no information must be taken out were n=2 (33%) in 2006, n=21 (91%) in 2007, n=19 (90%) in 2008, n=40 (95%) in 2009 and n=1 (17%) did not respond in 2006. This item, based on respondent division over inclusion or exclusion, was used to develop semi structured questions for the focus group.

Respondents answers related to practical placements are outlined in table 4.5. (below). The table shows that the majority of respondents agreed that procedures related to the course were demonstrated, n= 5 (83%) in 2006, n=23 (100%) in 2007, n=21 (100%) in 2008 and n=41 (98%) in 2009. This further suggests that the majority of respondents received quality education and training. In keeping with procedure demonstrations almost all of respondents did receive a practical placement component during the learnership (5% (n=83) in 2006, n=23 (100%) in 2007, n=21(100%) in 2008 and n=42(100%) in 2009) and that the practical placement accounted for seventy percent (70%) of the learnership (83% (n=5) in 2006, n=19 (83%) in 2007, 62% (n=13) in 2008 and 100% (n=42) in 2009).

Table 4.5. Respondents' practical placement experiences

Year	Were Procedures demonstrated? n(%)		Was there a practical placement included in the learnership ? n(%)		Did practical placement account for 70% of the learnership ? n(%)		Was clinical accompaniment provided? n(%)		Were practical placement site staff supportive of the learner ? n(%)		Was equipment needed available in the clinical placement ?n(%)	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
2006	5 (83%)	1 (17%)	5 (83%)	1 (17%)	5 (83%)	1 (17%)	6 (100%)	0 (0%)	6 (100%)	0 (0%)	4 (67%)	2 (33%)
2007	23 (100%)	0 (0%)	23 (100%)	0 (0%)	19 (83%)	4 (17%)	23 (100%)	0 (0%)	20 (87%)	3 (13%)	19 (83%)	4 (17%)
2008	21 (100%)	0 (0%)	21 (100%)	0 (0%)	13 (62%)	8 (38%)	21 (100%)	0 (0%)	20 (95%)	1(5%)	17(81%)	4(19%)
2009	41 (98%)	1 (2%)	42 (100%)	0 (0%)	42 (100%)	0 (0%)	41 (98%)	1 (2%)	42 (100%)	0 (0%)	42 (100%)	0 (0%)
Total	90 (98%)	2 (2%)	91 (99%)	1 (1%)	79 (86%)	13 (14%)	91 (99%)	1 (1%)	88 (96%)	4 (4%)	82 (89%)	10 (11%)

During this practical placement the majority of respondents reported receiving clinical accompaniment (100% (n=6) in 2006, 100% (n=23) in 2007, 100% (n=21) in 2008 and 98% (n=41)) and that staff within the practical placement site were supportive (100% (n=6) in 2006, 87% (n=20) in 2007, 95% (n=20) in 2008 and 100% (n=42) in 2009). Respondents'

reports of the practical placement experience are suggested to be generally positive. The least positive responses related to availability of equipment, the availability of needed equipment reported by 67% (n=4) in 2006, 83% (n=19) in 2007, 81% (n=17) in 2008 and 100% (n=42) in 2009.

The venues used for practical placements are outlined in Table 4.6. (below). The majority of respondents who did their practical training at old age homes (100% (n=6) in 2006, 96% (n=22) in 2007, 100% (n=21) in 2008 and 79% (n=33) in 2009) only two graduate groups attending alternative practical placement site (hospital placement = 21% (n=9) in 2008 and community placement = 4% (n=1) in 2007). It is suggested that the majority of respondents did their practical training at old age homes due to both institutions having long term agreements with the old age homes rather than hospitals and other institutions. This state of affairs may be related to the AHCW learnership being National Qualifications Framework (NQF) level 1 qualification which limits the students to basic nursing care mostly provided in old age homes.

Table 4.6. Respondent's places visited for practical training in the workplace

Place	Sample	Old age home n(%)	Clinic n(%)	Hospital n(%)	Hospice n(%)	Community n(%)
2006	6	6 (100%)	0(0%)	0 (0%)	0 (0%)	0 ((0%)
2007	23	22 (96%)	0 (0%)	0 (0%)	0 (0%)	1 (4 %)
2008	21	21 (100%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
2009	42	33 (79%)	0 (0%)	9 (21 %)	0 (0%)	0 (0%)
Total	92	82 (89%)	0 (0%)	9 (10%)	0 (0%)	1 (1%)

Table 4.7. Respondents' Average times for mentor visits and recommendation of AHCP

Year	Sample	More than once per week n= (%)	Once a week n= (%)	Once per month n= (%)	Recommendation of the learnership n= (%)	
					Yes	no
2006 (1 non response)	6	1(17%)	4(67%)	0 (0%)	6 (100%)	0 (0(%)
2007(2 non responses)	23	18(78%)	3(13%)	0(0%)	22 (96%)	1 (4%)
2008 (2 non responses)	21	13 (62%)	6 (29%)	0(0%)	21(100%)	0 (0(%)
2009(3 non responses)	42	21(50%)	16 (38%)	2 (5%)	42 (100%)	0 (0(%)
Total	92	53 (58%)	27 (29%)	2 (2%)	91 (99%)	1 (1%)

Table 4.7. (page 29) represents average times for mentor visits. As represented respondents were given three choices and the majority, for all graduate groups except 2006, reported being visited more than once per week. Finally, this table also illustrates the respondents' willingness to recommend the learnership, right hand column. Respondents who are willing to recommend to friends or relatives almost 100% throughout the graduate groups (in 2006, 100% (n=6), 96% (n=22) in 2007, 100% (n=21) in 2008 and 100% (n=42) in 2009). It is possible that this response represents social desirability bias. In addition, the non- response rate to this item was the highest for the entire questionnaire, one in 2006, two in 2007 and 2008 and three in 2009.

4.4. Qualitative data achieved from phase 2

4.4.1. Introduction

As outlined in data collection process, Chapter three (point 3.6., page 21), at the end of the telephonic interview assisted self-report questionnaire ten (N=10) respondents were asked to join in an audio recorded face to face focus group interview.

This section begins with a description for the sample before a detailed description for the data analysis process and abstracted themes

4.4.2. Description of the sample

These ten were selected on the basis of geographical accessibility. On the day of the group interview only nine (n=9) participants arrived.

The distribution among the graduate years of this sample is illustrated in table 4.9. below.

Table 4.8. Respondents' Current employment inside and outside health sector

Year AHCP completed	Sample	Current employment		
		YES n(%)	In health sector	Outside health sector
2005 – 2006	3 (33%)	2 (67%)	1(50%)	1 (50%)
2006 – 2007	2 (22%)	2 (100)	0 (0%)	2 (100%)
2007 – 2008	2 (22%)	1 (50%)	1(100%)	0 (0%)
2008 – 2009	2 (22%)	1 (50)	0 (0%)	1(100%)
TOTAL	9 (99%)	6 (67%)	2(33%)	4 (67%)

The sample of nine respondents (n=9) focus group were all females. Of these; n=3 (33%) graduated in 2006, n=2 (22%) in 2007, 2008 and 2009. The current employment status of these respondents was; n=2 (67%) for the 2006 graduates, n=2 (100%) for the 2007 graduates, n=1 (50%) for 2008 graduates and n=1 (50%) for the 2009 graduate group. Those respondents employed in health sector totalled two (n=1 (50%) in 2006 group and n=1(100%) in 2008 graduate group. More respondents were employed outside health sector; n=1 (50%) in 2006, n=2 (100%) in 2007 and n=1 (100%) in 2009.

The researcher and research assistant both decided on the questions to be asked based on the responses in the questionnaire because many respondents seemed to be concerned about the issue of not getting employed especially within the health care sector, after completing the AHCP course. The questions are as follows:

1. What are the aspects of the course that should be removed from the course as they were not helpful or useful?
2. Describe the aspects of the course that should have been included in the course and were not.
3. Workplace practical training should cover 70%. Do you think time allocated covered this?
4. Were your expectations met during facilitation of the course?
5. Describe the attitude of the staff in the practical area.

The group interview was audio recorded and raw data (Appendix 6) was analysed according to the process outlined by Elo and Kyngas (2007). In this section the data analysis process is described followed by a description of the sample and then presentation of the themes.

4.4.3. Data analysis process

This data analysis process included transcription of the audio recording verbatim by the researcher (Appendix 8). The audio recording was then listened to as the researcher read the written transcript to ensure correct transcription. The researcher then read the written transcription in order to identify respondents thoughts, statements prefixed with 'I think' were noted related to participant's experience of the AHCW learnership. These were then underlined, using different coloured pens, and grouped into categories. From these categories

themes were derived. At this point three meetings were held with the research supervisor to establish rigour of the analysis process. The research supervisor was given a copy of the raw data and this was analysed separately from the researcher's analysis. At the first meeting, differences were discussed and a third person was asked to code the raw data (Mr A Govender). Agreement was then achieved regarding categories, outlined in Table 4.10. below (Appendix 10).

Table 4.9.: Themes and categories

Themes	Categories
Course structure	Content of training
	Staff attitude
Self improvement	Improvement in self-confidence
	Increased opportunities for employment and further study

The initial coding included identifying opinion statements related to research objectives. The researcher looked for words / phrases such as; 'I think', 'I don't think', 'I can say', 'I don't see anything', 'I did not see problems'; 'according to my opinion'. Initial identification of codes identified through opinions of the learnership included; course content; context of training; knowledge; attitudes; willing to teach; amount learned; taught at school; got what I wanted; everything is included; check blood pressure; checking blood sugar level; doing it physically; practical training; how to care for patients; satisfied; taught. Different coloured pens were then used to underline and facilitate groupings into categories. These were then transcribed to a coding sheet and included: acquiring knowledge, improvement in skills, getting another opportunity, learning the computer skill, improvement in technology, having positive and negative attitude, provide encouragement, and looking down upon. At the third meeting with the supervisor and co-coder (Mr A Govender) these sub categories were agreed on, and the following emerging themes were identified; course content that included categories of content of training, staff attitudes; self-improvement that included categories of self-esteem, staff attitude, learning experience, satisfaction. The final themes abstracted are presented below, the categories within each theme clarified and supported with extracts from the raw data (Appendix 8) the responds identified by their code.

4.4.4. Abstraction

Theme 1: Course structure

The respondents' comments revolved around the course content, such as business plan, maths and agriculture that were included in the current training and were perceived as either useful or not useful. Computer skills were identified for inclusion for future training. This theme includes two categories; content of training and context of training related to AHCW.

Category 1: Content of training

Some respondents considered all the course content as important. R108 "*I don't think there is anything that must be removed, every subject is important.*" Others however target specific aspects of the AHCP curriculum, business plan and agriculture, as not very useful in this course. R100 "*... agriculture...is not very important in Ancillary Health Care Programme (AHCP)*" and "*...people are sick in hospital, they do not care about business plan.*"

There was agreement that maths was seen as a useful subject that related to skills required in an AHCW. R100: "*Maths does help in a way ... because we were expected to count tablets...*" In addition, respondents agreed that the inclusion of specific clinical skills was critical to basic nursing procedures. R105 said: "*... we know how to check blood pressure and we know how to care for the sick person, it is like you are in the hospital.*" R103 said, "*...I learned a lot, I was scared of a sick person but when I did AHCP I learned and I was taught how to nurse sick people... how to lay out a dead person.*" R106 said, "*...body temperature can be added in this course because AHCP is a basic nursing training ... and to check the blood sugar level if it is low or high.*"

Several respondents said that the AHCW course lacked important content such as information technology. R101 "*In my opinion things which were supposed to have been included are the computer skills.*" R107 said: "*May be what can be added is computer course to make things easier, because nowadays technology is important.*"

Category 2: Staff attitude

The attitude of the staff in the practical area was noted as a core aspect of the clinical experience, though it was not always positive, the majority of respondents reported positive experiences related to clinical placement areas staff attitude. R103 said: "*... there were those who had negative attitude, but if you were lucky you would get somebody with positive attitude...*" R100 said: "*... there are those who were alright and those who were not...*" R104 said: "*... when we first came there they had good attitude ... it gave us encouragement that we can also reach their standard. I did not see problems.*" R102 said: "*... when it is your first time in the new place they have their own way to do things and they told us how they did things... we did not have a problem because we told ourselves that we were learning and growing in terms of knowledge.*"

Theme 2: Self improvement

The theme of self improvement seemed to be evident in two categories; improvement in self-confidence and opportunities for employment. Both categories are related to respondents' gaining confidence and skills.

Category 1: Improvement in self- confidence

Increased skill in communication ability was noted as impacting on skills related to caring and was seen as a benefit of the course. R106 "*When I first came I was very shy... today I know how to communicate ... but if I can get another opportunity I can gain more improvement.*". R105 "*I did not know how to do bed bath and care for the sick person...I can now differentiate from the sick and very sick person...and how to take care of them*". R100 "*... even when I did nursing course I did not have a problem, I have learned a lot*". P104 "*... I learned that you do not contaminate bed linen, even if you do bed bath there are steps that are followed*". R108 "*... we were doing as nurses... you know how to check blood pressure, pulse, bed bath,, offer a bed pan to a patient...got all what I expected... with less knowledge I had from the beginning*". R107 "*... I gained more knowledge on what I expected to know*". R102 "*... we came without knowledge on how to take care of a sick person, we were taught and we were satisfied*".

Category 2: Opportunities for work and further study

Some subjects such as HIV/AIDS and home-based care were seen as very important in this course as some respondents had the impression that they could get employment because they had completed these subjects. R107 *"HIV/AIDS was very important because even in the clinics it is important and it can open opportunities for employment."* R105 *"… home based care helps to give employment opportunities... ".* R104 *"… when you are looking for a job you happen to get it".*

4.5. Summary of Chapter

In this chapter analysis of data and representativeness of the sample were discussed. In the qualitative study ten respondents were invited to the interview and one participant did not come. Most respondents agreed that they felt business plan and agriculture should be removed from the training. Computer training and other skills such as checking the blood sugar levels were identified as subjects to be included in future training. Maths and nursing skills such as checking of body temperature were viewed as being important. Most of the learners agreed that the staff had a good attitude towards them most of the time and were often always willing to help them. All the learners also agreed that they had covered the required 70% of practical training.

CHAPTER FIVE
DISCUSSION AND RECOMENDATIONS

5.1. Introduction

Chapter five concludes the study with discussion and recommendations for future research as well as study limitations.

The objectives of this study were to; describe perceptions of the graduate Ancillary Health care workers (AHCW) of the Ancillary Health Care Programme (AHCP) in preparing for and facilitating employment. In addition, the researcher described graduate AHCW current employment status, within the health care sector and outside, and the career and work activities of the unemployed graduate AHCW.

5.2. Discussion

The discussion that follows focuses on aspects of the AHCP, specifically graduates' perceptions related to content and aspects of the programme that built confidence related to potential employment. This is followed by a discussion of actual employment of these graduates.

As presented in chapter four, respondents had specific comments about course content; the lack of value of business plans and agricultural content, perceived value of maths. What was significant was that respondents had perceptions that HIV/AIDS and home-based care subjects were very important in the AHCP, perceiving this content to open opportunities for employment in the health sector. The majority of respondents thought that all aspects of the course, including and specifically workplace practical component, were very important and they were graduating feeling confident that they can get employment in the health sector and have opportunities to further their studies, employment and study opportunities that clearly was not present for the majority of the respondents.

Higher Education and Training minister, Dr Blade Nzimande, speaking at a New Age Business Breakfast in Johannesburg said businesses must boost learnerships for FET

graduates. He called upon the employers to come and take FET college graduates and give them twelve to eighteen months internships. He further urged the universities to engage with the FETs to improve the quality of education at these colleges so that the graduates could access universities (Magubane, 2013). Johannesburg-based skills and training organisation Astro Tech Training CEO Liza van Wyk said that businesses and government were not investing enough in developing skills among the youth and graduates to prepare them for the job market (Magubane, 2013).

In 2011 an eThekwini district hospital advertised for 'clinical orderlies', the description clearly related to the AHCW (Ilanga, June 02, 2011). This is however the only advertisement focusing on these graduates that the researcher is aware of. Clearly respondents' employment rate indicates the lack of job opportunities. The respondents reflected an employment rate, after graduation, of 67%, of these only 33% are employed in the health care sector. There is a very low percentage of respondents employed as compared to the number trained so far. Sometimes clinical orderlies posts are advertised in the public hospitals, as illustrated in the preceding paragraph, but they are not many.

Despite the national iniative related to these learnerships the AHCP was not facilitated by the creation of AHCW (or clinical orderlies) posts within the health care sector. Service providers emphasised in their application process that completion of the course with them would not include guarantees of employment on graduation (G.R. Dlamini, personal communication, May 2010). Despite this the results indicate that most graduates assumed that employment within the health care sector would occur. Compounding this problem many service providers emerged and embraced the AHCW learnership, consequently the market was flooded with AHCW.

This has led to some questions asked by parents and guardians, specifically complaining about the money they have wasted on this course as it has not lead to employment. Some service providers failed to explain the difference between nursing and ancillary health care and thereby causing perceptions to learners that they were doing a nursing course. Some of them even phone the South African Nursing Council (SANC) to enquire about registraton with them after completing the course (B.I. Khuzwayo, personal communication, April 28, 2009). Even the white and or navy and white uniform which they wear give them impression

that they are nurses.

HWSETA offers AHCW learnership and they invite the service providers from all provinces to express interest in the learnership programme and yet there is no research that has been done by them to see if the learners were employed within the health sector, in essence did this program meet the HWSETA objectives.

The limitations of this study do not facilitate the results being seen as significant. This is firther explored in the limitation of the study, below and the recommendation that follow.

5.3.   Limitations of the study

The study was confined to EThekwini Metropolitan area in KwaZulu-Natal, two training institution only and thus the results may not be generalizable. The AHCP graduates were scattered all over the province, invalid phone numbers compounding the researcher's access to these graduate. The resultant sample was small and had little statistical power.

Social desirability may occur where the participants have a tendency to misrepresent attitudes or traits that are consistent with prevailing social views (Polit & Beck, 2010). However the fact that they have completed the course, anonymity was verbally ensured and a research assistant was used at the training organisation that is the place of employment of the researcher were suggested to reduce social desirability bias. However, it is possible that those respondents who agreed to come to the focus group do not represent the sample group, those who declined to attend in their refusal suggesting potential negative input while those who attended may have been the 'more satisfied' of the graduates.

5.4.   Recommendations

I recommend that HWSETA should do the further research on this study especially to those institutions who have participated in the AHCW learnership throughout all the provinces in SA for the purpose of generalization. Department of Health (DoH) and the Department of Social Development (DSD) should come together to discuss with HWSETA, about issues

such as job creation for AHCW. The AHCP curriculum should be revisited by HWSETA in order to include and or remove those aspects of the course which are important or not very useful in terms of employability especially within the health sector. Recommendations should be sent to standard generating body (SGB) and sent to SAQA for inclusion in the relevant unit standard. The service providers should include the extensive explanation of differences between nursing and AHC to their orientation programme which must be read to the learners, copies signed and given to them for their records.

5.5.   Conclusion

This chapter discussed lack of employment, specifically in the health care sector, and relates this to structures and resources. Limitations of the study are presented and recommendations that the national bodies involved in the creation and implementation of these learnerships conduct research to determine their effectiveness in meeting stated objectives.

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Appendices

Appendix 1

Questionnaire

Your answers will be recorded accurately and your own words used

Section A: Demographic Data

1. Gender

Male	
Female	

2. Age group

10 - 19	
20 -29	
30-39	
40-49	
Other:	

3.Area of residence

Rural	
Urban	
Sub-urban	

3. Level of education prior to starting the AHCW learnership?

Standard 8	
Standard 9	
Standard 10	
Other, specify	

4. Between which years did you do Ancillary Health Care Course?

2005-2006	
2006-2007	
2007-2008	
2008-2009	

5. Before enrolling for Ancillary Health Care course, for how long had you completed at school?

Below 1 year	
Between 1 and 5 years	
5 and 10 years	

10 and 15 years	
Other, specify	

6. Are you currently employed?

Yes	
No	

7. If yes describe your current employment

_____

_____

_____

_____

8. If no, are you involved in health care within your community in any way?

_____

_____

_____

SECTION B:

9. What motivated you to enrol for this course?

_____

_____

_____

10. Were your expectations met during facilitation of the course?

Yes	
No	
If no, please specify	

12. Was the facilitator knowledgeable in terms of programme delivery?

Yes	
No	

13. Were you given notes during your training?

Yes	
No	

14. Is time allocated for this programme enough?

Yes	
No	

15. Is there any information that you think can be added to this course?

Yes	
No	
If yes please explain further?	

16. Is there any information which you think, needs to be taken out of the learning programme?

Yes	
No	
If yes please explain further:	

17. Were procedures related to your course demonstrated to you at school?

Yes	
No	

18. Did you go for practical training in the workplace?

Yes	
No	

19. Which of the following places did you visit (may tick more than one)

Community	
Hospital	
Old age home	

Hospice	
Clinic	
Other	

20. Workplace practical training should cover 70%. Do you think time allocated covered this?

Yes	
No	
If no, please explain:	

21. Did the mentor accompany you while you went for your practical training in the workplace?

Yes	
No	

22. On average how many times did the mentor visit you?

More than once per week	
Once a week	
Once per month	
other	

23. Were the staffs in the workplace supportive?

Yes	
No	

24. Is there enough equipment for the learners to get proper training in the workplace?

Yes	
No	

25. How did you feel after doing this course in terms of future employment?

Extremely confident	
Very confident	
Confident	
Not confident	
Unconfident	

26. Would you recommend your friend or a relative to do this course?

Yes	
No	

Appendix 2: Letter to the Chairman

P.O.Box 4813

Durban

4000

05/05/2011

The Chairman

Siyathuthuka Health Services

67/73 Crompton Street

406 – 409 Arbour House

Pinetown

3610

Dear Sir

Re: Permission to have an access to graduate Ancillary Health care Workers Records.

My name is Lindiwe Bhengu student number 204520317. I am studying Masters in Nursing Research at UKZN. The Topic of my proposal is '**AN EXPLORATION OF GRADUATE ANCILLARY HEALTH CARE WORKERS' EXPERIENCES OF THE ANCILLARY HEALTH CARE LEARNERSHIP PROGRAMME IN ETHEKWINI DISTRICT**.' Ethical approval has been granted for the study from the research ethical committee at Univeristy of KwaZulu Natal, the approval letter is attached.

I wish to access all completion of training records from 2005 – 2009 with their contact numbers so that I will be able to phone them and ask for their informed consent to participate in the research and interview.

Hoping that my request will meet your favourable consideration.

Yours faithfully

Mrs Lindiwe Bhengu

Appendix 3: Letter to the Managing Director

P.O Box 4813

Durban

4000

05/05/2011

The Managing Director

Sebenzuphile Trust

320 Protea Building

Suite 18

Durban

4000

Dear Sir/Madam

Re: Permission to have an access to graduate Ancillary Health care Workers Records.

My name is Lindiwe Bhengu student number 204520317. I am studying Masters in Nursing Research at UKZN. The Topic of my proposal is '**AN EXPLORATION OF GRADUATE ANCILLARY HEALTH CARE WORKERS' EXPERIENCES OF THE ANCILLARY HEALTH CARE LEARNERSHIP PROGRAMME IN ETHEKWINI DISTRICT**.' Ethical approval has been granted for the study from the research ethical committee at University of KwaZulu-Natal, the approval letter is attached.

I wish to access all completion of training records from 2005 – 2009 with their contact numbers so that I will be able to phone them and ask for their informed consent to participate in the research and interview.

Hoping that my request will meet your favourable consideration.

Yours faithfully

Mrs Lindiwe Bhengu

Appendix 4: Information sheet for telephonic assisted self report questionnaire

To be read verbatim to potential participants over the phone

The information to graduate AHCWs will be as follows:

> You are invited to participate in the research study on the exploration of your
> experiences on the Ancillary Health Care learnership programme.
>
> Your participation is voluntary. Your verbal agreement and answering of the
> questions will constitute implied consent.
>
> The interview will take approximately 7 minutes.
>
> Your name will not be recorded anywhere on the questionnaire nor the training
> institution where you completed your learnership.
>
> Your responses will be kept confidential and anonymity ensures that responses cannot
> be associated with individual people.
>
> I thank you for your participation in the research study.
>
> Would you be prepared to participate in the second phase focus group discussion?

Yes	
No	

> If yes, please provide me with your contact number including your area code:
>
> Home   : _____
>
> Work   : _____
>
> Cell phone no.: _____
>
> Which method will you prefer to be provided with the information?

Method	Tick	Address
By Post		
By fax		
By email		

Appendix 5: Information sheet for focus groups

The information will be read to the graduate AHCW as follows:

You are invited to participate in phase 2 for in depth interview.

Those who say 'Yes' are requested to sign the informed consent.

The purpose of the in depth interview is to describe and explore more information of graduate ancillary health care workers' perceptions of the ancillary health care learnership.

Discussions will take about one hour on Saturday at 309 Absa Building Pinetown.

Your participation is voluntary.

You will be reimbursed with R20 for travel expenses.
You are requested to sign the informed consent.

Those who have consented will be gathered in a private room at 309 Absa Building, 33 Crompton Street, Pinetown at 09h00.
The audio recorded will be activated and the discussion will be commenced.
The audio tape will be transcribed within 48 hours of the completion of the focus group
Codes will be used to identify participants.

Appendix 6: Semi structured focus group questions

1. What are the aspects of the course that should be removed from the course as they were not helpful or useful?
2. Describe the aspects of the course that should have been included in the course and were not.
3. Workplace practical training should cover 70%. Do you think time allocated covered this?
4. Were your expectations met during facilitation of the course?
5. Describe the attitude of the staff in the practical area.

Appendix 7: The informed consent

I _____ (insert name & surname) hereby agree to participate in the research study on the exploration of my experiences on the Ancillary Health Care learnership programme.

I do understand that this is for study purposes and that participation is voluntary. I have been informed that the discussion will be audio recorded for the purpose of data collection and transcription only, codes will be used to identify the respondents and after that the audio record will be destroyed.

Many thanks

_____

The Respondent

Appendix 8: Qualitative Raw Data

Question 1: What are the aspects of the course that should be removed from the course as they were not helpful or useful?

This question relates to research objective 1.6.3. of the research questions.

P100: I think it is Business plan, Maths and Agriculture.I think Agriculture, especially, is not very important in Ancillary Health Care Programme (AHCP). With business plan, I think if people are sick in hospital, they do not care about business plan. Something very few can be said about business plan but not much. Ya, Maths do help in a way, as I have also done Nursing course and Maths was there because we were expected to count tablets that how many we had to use and how many left. It is there but not so much.

P104: in my opinion I think all the subjects are important to this course (AHC). I don't think there must be some aspects remove because when you are looking for a job you happen to get it.

P102: Will you please repeat the question. Ey... except what have already mentioned I don't see another reason that was the only reason I had that there must be some subjects removed from this programme. As others have said health care is about sick people.

P 101: As no. 100 has previously mentioned, agriculture must be removed.

P103: I also think it is Agriculture which must be removed.

P108: I don't think there is anything that must be removed, every subject is important.

P107: I also don't think there are subjects to be removed. HIV/AIDS was very important because even in the clinics it is important and it can open opportunities for employment.

P105. I don't see anything that can be removed because home based care helps to give employment opportunities.

P106: As no. 105 has said I do not see anything that can be removed. What I have noticed is that while we were trained all what we were doing as health care workers was good.

Question 2: Describe the aspects of the course that should have been included in the course and were not?

This question relates to research objective 1.6.3. of the research question.

P101: In my opinion things which were supposed to have been included is the computer skills.

P105: I don't see any aspect which was not involved because to me everything is included, we know how to check blood pressure and we know how to care for the sick person it is like you are in the hospital.

P107: I don't think there is something that can be added because all what is done by nurses such as blood pressure checking, pulse and HIV/AIDS subject. May be what can be added is computer course to make things easier, because nowadays technology is important.

P108: I don' see anything that should be added because all what we learned, we were doing as nurses, we can work in the hospitals. I see AHCP as a complete course. You know how to check blood pressure, pulse, bed bath, putting clothes to a patient, bed making, ya....., offer a bedpan to the patient.

P106: What can I say is that ya.... we learned a lot but what I always observed from the clinic is that checking of body temperature can be added in this course because AHCP is a basic nursing training. Ya, to see how body temperature is, and to check the blood sugar level if it is low or high.

Question 3: Workplace practical training should cover 70%. Do you think time allocated covered this?

This question relates to relates to research objective 1.6.1 of the research questions.

P107: Yes I think the time we got covered 70% because we were taught everything at school and when we went to do practical training in the workplace, it was a matter of doing it physically, so it was not important that we got extra time. The time we had was enough.

P108: I think time was enough because we went for practical training though I have forgotten for how long, but we had enough time and again we had been taught at school.

P105: I can say it was enough because you are first taught at school on how to care for patients. It is just that you have to go for practical training and do the procedures to see that you can manage to do them.

P106: I can say when I did my workplace training I was satisfied that we covered 70% because we did all what was taught at school.

Question 4: Were your expectations met during facilitation of the course?

This question relates to research objective 1.6.3. of the research question.

P107: I got what I expected because when I came to Institution A did not have much knowledge, so I gained more knowledge on what I expected to know.

P108: I got all what I expected from Institution A with less knowledge I had from the beginning. So, the course covered everything.

P106: When I first came I was very shy but I got warmth in the classroom and the facilitator was very good and free. She helped me and today I know how to communicate even at the time when I went for I learned to be careful to do things but if I can get another opportunity I can gain more improvement.

P105: It helped me because I did not know how to do bed bath and care for a sick person but I got more knowledge. I can now differentiate between sick and very sick patients and how to take care for them.

P100: I learned all what I expected such as how a sick person is taken care of because at home we do anyhow. What I was taught, for example, bed bath, bed making, etc, helped me because even when I did Nursing course I did not have problems because I had already learned a lot.

P103: I got all what I expected from AHCP because ....ya... I learned a lot, I was scared of a sick person but when I did AHCP I learned and I was taught how to nurse a sick people. I also know how to lay out a dead person and I am not scared.

P104: I learned a lot because at home, even if you are making bed you throw bed linen on the floor, but I learned that I you do not contaminate bed linen. Even if you do bed bath there are steps that are followed.

P101: All that I learned from AHCP was explained clearly to me.

P102: I got all what I expected because we came without knowledge on how to take care of a sick person, we were taught and we were satisfied.

Question 5: Describe the attitude of the staff in the practical area.

This question relates to research objective 1.6.1 of the research questions

P104: Eeh... when we first came there they had good attitude, it is good because they were showing us how to check blood pressure and body temperature and how to use a thermometer. Their attitude was good, it gave us encouragement that we can also reach their standard. I did not see problems.

P102: When we came there it was alright because we also had previous knowledge from the school and when it is your first time in the new place they have their own way to do things and they told us how they did things. In that case we did not have a problem because we told ourselves that we were learning and growing in terms of knowledge.

P103: They were short staffed but there were those who had negative attitude, but if you were lucky you would get somebody with positive attitude who would show you everything.

P101: They had positive attitude, they were reminding us of what we did not know but there were times when you could see that they were looking down upon us. Of course, we did not have a problem with that.

P100: The staff was alright but when you are new in the area there are those who were alright and those who were not. There were those who were willing to teach us. We did not see anything wrong.

P105: According to my opinion some were helpful because they were showing us especially what to do after you have changed bed linen.

Appendix 9: Ethical permission

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22 December 2011

Mrs LR Bhengu (204520317)
School of Nursing

Dear Mrs Bhengu

PROTOCOL REFERENCE NUMBER: HSS/1307/011M
PROJECT TITLE: An exploration of Graduate Ancillary Health Care Workers' Perceptions of the Ancillary Health Care Learnership
Programme in eThekwini District

In response to your application dated 02 December 2011, the Humanities & Social Sciences Research Ethics Committee has
considered the abovementioned application and the protocol has been granted **FULL APPROVAL.**

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the
Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment
/modification prior to its implementation. In case you have further queries, please quote the above reference number.
PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

Professor Steven Collings (Chair)
HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE

cc. Supervisor – A Smith
cc. Mr Sugen Reddy

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Appendix 10: Themes and Categories

Themes	Categories
Course structure	Content of training
	Staff attitude
Self-improvement	Improvement in self-confidence
	Increased opportunities for employment and further study