

Revitalizing Health for All: New Research and Research Training in Comprehensive Primary Health Care

Project title: The Gauteng Province Community Health Worker Programme: the extent to which it contributes to the provision of Comprehensive Primary Health Care

Final report

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1. Introduction

In the 30 years since the Alma Ata Declaration, various efforts to implement primary health care (PHC) have been met with challenges, limiting the ability to achieve the core values of the Declaration; better health for all; the right to participation and solidarity; and social justice (WHOa 2008). In the attempt to address the growing health disparities, specifically in developing countries, there is increasing effort internationally to revitalize the practice of PHC values. The most prominent of these efforts are the current Millennium Development Goals (MDGs) (UnitedNations 2008), which constitute explicit health-related goals similar to the principles detailed at the Alma-Ata conference (Lawn, Rifkin et al. 2008). Some countries are making efforts to integrate the strengths of their vertical programmes with more comprehensive programmes to strengthen health systems. This has been coupled with emerging discourse regarding a comprehensive health care system approach (WHOa 2008). According to the Millennium Development Goals Report of 2008 (UnitedNations 2008), progression in both developed and developing countries has been made in some of the MDGs. Deaths from measles declined from more than 750 000 in the year 2000 to less than 250 000 in 2006. Added to this, about 80% of children in developing countries presently receive a measles vaccine. A reduction in AIDS deaths was 2.0 million in 2007 from 2.2 million in 2005. Newly infected people were at an estimate of 2.7 million in 2007, down from 3.0 million in 2001. With regards to malaria prevention, the use of insecticide-treated nets has expanded, with 16 out of 20 countries having tripled since 2000.

Despite this reported progress, Sub – Saharan Africa continues to experience poor health outcomes. Half of the deaths of children under the age of 5years in developing countries are found in that part of the continent. Maternal mortality remains significantly high across a majority of developing regions, which is estimated at 99% and Sub-Saharan Africa constitutes 86% of this estimate (UnitedNations 2008). In fact, the aim of the MDGs to reduce child mortality by two-thirds from 1990-2015, is now being predicted to not be achieved until 2065 in Africa (Haines, Sanders et al. 2007).

The practice of PHC recognises the fact that health depends on other non-health sectors. International policy debates have come to the realisation that issues of health and disease cannot be addressed solely through biomedical interventions through the health sector. The burden of illness in communities is the result of their social conditions. Policies and programmes that aim to improve health outcomes therefore need to include other areas such

as water, sanitation, housing and social protection, and not just health programmes (Lawn, Rifkin et al. 2008); (WHOa 2008). Comprehensive health systems constitute therapeutic and rehabilitative, preventative and promotive components to respectively deal with the effects of a health problem; the cause of the health problem that functions at an individual level and the cause of the problem that operates at the level of society (Sanders, Schaay et al. 2008). The renewed interest in comprehensive primary health care (CPHC) is largely because it aims to address social determinants of health through establishing community infrastructures that develop linkages with key sectors such as education, agriculture and housing (Baum 2007). A comprehensive approach to health care also ensures the involvement of communities in defining their own health needs, thus building a health infrastructure that can respond to changing health needs and is resilient to those changes (Baum 2007); (Rosato, Laverack et al. 2008).

In South Africa, despite attempts at providing PHC, particularly by the new government post 1994, there has been a focus on vertical programmes with the aim of developing priority programmes to strengthen its PHC system (Heunis, Rensburg et al. 2006) Some of these priority programmes have relied on the expansion of community health workers (CHWs) to provide outreach services. This cadre of workers provides an opportunity to provide greater community services that address the social determinants of health and strengthen the comprehensive component of PHC. However, currently, it remains unclear to what extent these community workers are contributing to the provision of CPHC.

2. Literature review

2.1 The history of primary health care

The Alma-Ata conference in 1978 provided a platform for the changes of ideas about health care especially with regards to developing countries. At this conference health was recognised as a human right and the goal to achieve health for all was established (Schaay and Sanders 2008); (Baum 2007). The Alma-Ata Declaration on Primary Health Care was launched to provide guidelines for achieving the goals to address the basic health care needs. The PHC approach comprised comprehensive interventions with a key focus on disease prevention and health promotion; community participation, inter-sectoral collaboration for health; universal accessibility and coverage; and attention to cost-effective intervention and appropriate technology (Schaay and Sanders 2008); (Walley, Lawn et al. 2008). With this

broad approach, social justice is at the heart of CPHC (Magnussen, Ehiri et al. 2004); (Schaay and Sanders 2008);(Lawn, Rifkin et al. 2008).

After Alma-Ata, there was a shift away from the comprehensive aspect of PHC to a more selective approach. The justification for this shift was that CPHC was too complex for most governments and that it would be more realistic to target scarce resources to specific diseases (Editorial-Lancet 2008). This selective approach led to the support of a few low cost interventions, mostly in child health care (Schaay and Sanders 2008). Due to the predominance of these vertical health programmes, where health services target specific diseases which account for high mortality and morbidity, the implementation of PHC has been narrow, ignoring the social determinants of health. For many poor countries, especially in Africa, macroeconomic policies led to structural adjustment programmes that sought to reduce budget deficits through the devaluing of local currencies and reducing public spending in all sectors. This was associated with the dominating influence of market driven models of health systems, influenced by the World Bank's report which promoted cost-effective packages excluding the social determinants of health and the integrative aspects of comprehensive health care (Schaay and Sanders 2008). And yet most low and middle income countries had to comply with disease specific global health initiatives as a way of financing health care, a constraint borne out of conservative global economic policies and the burden of the debt crisis (Schaay and Sanders 2008).

Many countries responded to the health crisis through a series of health sector reforms. These adjustments often resulted in a fall in government expenditure on health and the implementation of cost recovery strategies. The policies collectively led to a negative impact on the performance of health systems, which affected the number and quality of health personnel, the supply of resources and equipment and deteriorated the access of the poor to health care (Rohde, Cousens et al. 2008). Many health sector reforms such as the introduction of user fees and decentralisation have resulted in the increase in health inequities and the deterioration of health services (Schaay and Sanders 2008).

2.2 Defining primary health care

Since the 1978 Alma Ata conference where the principles of PHC were defined, the notion of primary health care has been interpreted in various ways. The most common is the notion that PHC essentially refers to the first or primary point of entry into the health system. A second approach, viewed to be a narrow version of the concept of PHC, is selective primary health

care (SPHC), where health services target specific (selected) diseases. The third approach, comprehensive primary health care (CPHC) emphasizes the following factors: universal access and coverage based on need; comprehensive care that focuses on the prevention of disease and health promotion; the participation of individuals and the community including self-reliance; inter-sectoral collaboration in order to deal with issues of determinants of health and relevant technology and resources that are cost-effective (Schaay and Sanders 2008). In order to achieve the aspirations of the Alma Ata Declaration it has been suggested the implementation of PHC include a set of the following eight programme elements, coupled with action in other sectors to support each of these elements, for instance agriculture with regards to food supplies (Schaay and Sanders 2008).

- Maternal and child health care and family planning
- Promotion of adequate nutrition and food supply
- Sufficient supply of clean water and basic sanitation
- Immunization
- Prevention and control of local diseases
- Adequate treatment of common diseases and injuries
- Health education; and
- Availability of essential drugs

After the Alma Ata conference, mental health was recognized as a human, economic and social burden, hence it was included as a ninth element.

One of the components driving PHC in many countries is the use of community health workers. This cadre of workers has enabled countries such as Thailand and Brazil (Labonte, Sanders et al. 2008) to provide comprehensive health care services to a large proportion of its population, ensuring maximum coverage. CHWs have been considered an integral aspect of PHC as they form the link between the formal health sector and the community, with the possibility of facilitating community participation. This study focussed on CHWs, who can play a role in ensuring that provision of PHC services has some of the key characteristics of comprehensive care; the different types of health services (promotive, preventative, rehabilitative and curative as appropriate to their skill level), community participation, and inter-sectoral action (ISA). Since Alma-Ata, different countries, according to their circumstances, have implemented different PHC approaches, some that are more selective in approach, others that are more comprehensive (Lawn, Rifkin et al. 2008). A visual framework of 3 approaches; SPHC; semi-comprehensive; and CPHC, which were determined

in a review by Rohde, et al's, (2008) is represented below (Table 1). The table contains characteristics used in various studies to judge which approach is being used within a particular health system. The framework also provides examples from countries that fall within the different approaches, according to the appropriate indicators. Some of the country examples have been provided by Rohde, et al (Rohde, Cousens et al. 2008) and others were determined by the researcher. This is followed by a brief description of the programmes in each country related to each PHC approach.

Table 1 Primary Health Care Approaches

PHC APPROACH	CHARACTERISTICS	COUNTRY EXAMPLE
SELECTIVE PRIMARY HEALTH CARE	<p>The use of selective intervention in order to address some of the priority challenges of a country, e.g. high child mortality rates.</p> <ul style="list-style-type: none"> ▪ The approach focus on technical solutions to particular diseases. ▪ Mainly focuses on curative care with limited prevention and health promotion strategies ▪ Relies on health sector alone with limited involvement of other sectors ▪ Limited community participation ▪ Referral systems less integrated ▪ Historically focused on vertical programmes such as GOBI* ▪ Limited development of district level structures 	<p style="text-align: center;">Bangladesh</p> <ul style="list-style-type: none"> ▪ Focus on specific programmes for specific disease [<i>Has specific national programmes such as oral rehydration and immunization</i>] ▪ Strong focus on the health sector with limited involvement of other sectors
SELECTIVE-COMPREHENSIVE PRIMARY HEALTH CARE	<p>When a country begins with a more selective of focused approach to its interventions, and then gradually shifts towards a wider range of interventions, moving towards a comprehensive system.</p> <ul style="list-style-type: none"> ▪ Starts with specific focus on intervention ▪ Gradually scaling up interventions to be more comprehensive 	<p style="text-align: center;">Bolivia</p> <ul style="list-style-type: none"> ▪ Started with a specific programme [<i>child survival programme</i>] ▪ In the process of forming linkage with other non-health sectors ▪ Includes a component of CPHC; community involvement
COMPREHENSIVE PRIMARY HEALTH CARE	<ul style="list-style-type: none"> ▪ Focus in on overall health of community and individuals as opposed to specific diseases or health priorities ▪ Strong involvement of other sectors ▪ Emphasizes community participation and self-reliance of communities ▪ Focus on disease through comprehensive approach with curative, rehabilitative , preventive and health promotion that seeks to address the main causes of ill health ▪ Relies on the district health system 	<p style="text-align: center;">Thailand</p> <ul style="list-style-type: none"> ▪ Set up community structures to establish community participation activities to sustain community self reliance ▪ Increased inter-sectoral collaboration for PHC by making it an integral part of comprehensive national socioeconomic development strategies ▪ Universal access to care and coverage [<i>Has 100% area coverage of health centres and district hospitals</i>]

* Growth monitoring, oral rehydration therapy, breastfeeding and immunization

This study used this framework to judge which approach the Gauteng Community health Worker Programme falls within.

The strength of CPHC lies in a variety of principles which were evidently implemented by Thailand, and if other countries are in the process of strengthening their PHC systems such as Bolivia and Bangladesh, Thailand remains a sterling model to consider and adapt. Since countries and societies can learn from successful efforts from other countries, the strategy of community participation in the examples of countries above deems it necessary to explore and discuss this principle of CPHC further.

2.2.1 Community health workers' role in community participation: an essential component for comprehensive primary health care implementation

This study was based on the premise that community participation and collaboration are the key 'innovative' elements of CPHC and that CHWs are an important component thereof. In the attempt to examine the extent to which the participating CHW case studies in this study provided CPHC and in order to understand the contexts within which they provided this health care model, it is important to understand this concept of community participation, why it is viewed as an important component of CPHC and how it is viewed and experienced in various countries.

2.2.1.1 Community participation: why does it matter?

The Alma Ata declaration on PHC came with the support and emphasis on community participation. Its recognised importance was based on the premise that for any community to achieve the health gains that are purported by the declaration (health for all by the year 2000), communities should have the right to plan and implement their own health care programmes (WHO 1978). Considering the multitude of definitions, this study made reference to community participation as defined in the Alma Ata PHC report; "the process by which individuals and families assume responsibility for their own health and welfare and those of the community, and develop the capacity to contribute to their and the community's development" (WHO 1978), pg 50). Within the discourse regarding community participation, there is a common perspective that the involvement of the community ensures self-reliance, health promotion, empowerment and collective action. These elements, which are considered to relate to the principles of democracy (David, Zakus et al. 1998), enable communities to

identify, determine and implement their own solutions with regards to health and development problems (WHO 1978; Madan 1987; Morgan 2001; Howard-Grabman 2007; Rosato, Laverack et al. 2008). It is argued that due to greater control of the community, more resources can be provided, often appropriately to the 'voiced' needs (David, Zakus et al. 1998). In fact, community involvement in health has found wide political acceptance, especially in the Third World, as it was recognised as not only to be a cost effective strategy, but also a favourable way to providing comprehensive strategies to public health problems (Madan 1987).

Despite all the support and acknowledgement for the role of community participation in the implementation of CPHC and some evidence to indicate the potential of communities to ensure improved health care, the extent to which a community's involvement can really change policies to commit to equity in health care access still remains unknown. It was also evident that projects of this nature are difficult to scale up, where once part of a national intervention, the top-down and bureaucratic nature of government, changes the nature of community participation (Rosato, Laverack et al. 2008). Because community participation can be a process of capacity-building within which individuals and/ or communities are ultimately empowered, authorities in higher levels of institutions such as governments fail to realise that past successes of community participation interventions were often due to them allowing the process to unfold and not only by placing emphasis on achieving performance targets (Rosato, Laverack et al. 2008). The unhurried nature of engaging with communities, which is flexible to their varied contexts, allows growth to be generated from within the community rather than from external financing (David, Zakus et al. 1998; Were 2002).

Although there appears to be a dearth of accounts of successful and sustainable examples of community participation, particularly through CHW programmes (Rifkin 1986a; Lehmann and Sanders 2007) community participation is a complex and delicate process (David, Zakus et al. 1998). It however remains an important component for the success of CHW programmes and the delivery of CPHC. The benefits of community participation are invaluable: People are more likely to respond positively to health services due to that they have been involved in the decision making process about the services and in addition, people are more likely to change their risky health behaviour when they have participated in deciding how that change might occur; individual and collective resources can be used to contribute towards activities to improve health in the community; and there is an element of empowerment where people gain skills, information and experience, such that they are

ultimately able to challenge their social systems (Rifkin 2009). Through community participation, communities are provided with the opportunity to realise their ability to solve their own problems collectively (McKnight 1987; Hawe 1994).

In light of the discussion above, there are factors that relate to the larger communities within which CHWs operate. These factors have been proposed to be key contributors to successful community participation a component that creates a favourable environment for the delivery of effective CPHC services. These factors; such as social capital, social cohesion, empowerment and social networks; are discussed below, however they are discussed in more detail in the thesis.

2.2.1.2 Factors involved in community participation

The involvement of a community in its own health care and in decisions about health services is the heart of CPHC. For communities, whether it be through CHWs or the larger community, to contribute to a useful process of community participation, a number of factors need to be in place. Factors such as empowerment, social cohesion, social capital and accountability are considered to be the building blocks of community participation, hence it is important to understand how they determine and influence the extent of participation in individuals and communities.

a. Empowerment

Participation contributes significantly to the process of empowerment. It enables individuals to gain the experience and capacity to organise people, to identify and access resources and to develop strategies for attaining goals (Zimmerman and Rappaport 1988) as part of a collective.

.The notion of empowerment is therefore important due to that not only do CHWs have to be recognised and supported by the community itself, but they also have to be accepted by other members of the health system such as health care professionals (Rosato, Laverack et al. 2008). Because CHWs are commonly from marginalised communities and are often an extension of the poorest of societies, it is evident that they are part of a workforce that is most disempowered within the health system (Werner 1977; Rifkin 2003; Schneider. H, Hlophe et al. 2008). If CHWs, acting as an extension of their communities are involved in the processes of decision making about health, there needs to be a process of empowerment (Khumalo 2006). The notion of empowerment is viewed as a stronger process in which to achieve

effective community participation as it involves capacity building of those that are viewed to be disempowered (Sen 1999; Rifkin and Pridmore 2001). Ensuring that CHW are viewed as health personnel, who are part of the health system rather than a supplementary component empowers them to be effective voices of the community. Without empowerment, representation within community structures can induce a sense of powerlessness which can have an impact on community participation (Khumalo 2006). If community representatives do not feel that they have the right (and are empowered) to have an opinion about health care as they are not trained in that field, this could render the structures ineffective, including the process of community involvement.

However, it is acknowledged that marginalised communities have limited power to facilitate participation and therefore rely on those that are more empowered and often possibly not part of the community, to initiate and mobilise communities. This is however acknowledged as a positive phenomenon. Rosato et al. (2008) points out how this is in fact the recent form of community participation, where health and development workers for instance, adopt the role of being facilitators who offer support to communities to become involved. It is for this reason, he reports, that this process of capacity-building, with empowerment being the ultimate goal, is more of the objective, than mere participation.

b. Social cohesion

Social cohesion relates to the extent of engagement and the sense of trust that individuals have within their communities (Speer 2001). A more cohesive society, where there is a strong sense of group identity tends to be more sensitive to common wellbeing (d'Hombres, Rocco et al. 2007) A sense of community illicit the extent to which individuals feel that they have an influence on their immediate environment

The concept of social cohesion is important in relation to this study because its relevance lies in the notion that for there to be a healthy society, there needs to be an ability and culture of collective action (Havenmann and Pridmore 2005). More importantly, this ability to act is determined by the individuals who share the same environment and share the same common living conditions. These collective experiences have the ability to strengthen collective. In fact, the efficiency and sense of unity within a community contributes to its ability to galvanise measures to access a variety of resources, such as for instance, services, a phenomenon termed social capital. Social cohesion is therefore a subset of this concept,

which has been explored and proposed to enable communities to challenge their political economies. Social capital is a component that has emerged and is regarded, in the discourse related to health, as a vehicle to accessing health services. The section below delves on this concept further.

c. Social capital

Social capital is a concept that is discussed and treated as a more sophisticated combination of the concepts such as social cohesion, social networks and social integration (Berkman 2000; Berkman and Glass 2000; Kawachi and Berkman 2000). With existing discourse regarding the social determinants of health the public health community's effort to grapple with the manner in which social factors interact with economic ones, there has emerged an interest in the concept of social capital (Baum 1999). Without delving into the plethora of definitions of this notion, the discussion will accept a simpler version which is that it involves the levels of social and civil trust in communities; including the existence of networks. These factor influence coordination and cooperation for mutual gain (Baum 1999; Berkman 2000). Irrespective of the other more complex perspectives of what social capital entails, the ultimate message is that it is a form of mechanism for social support (Szreter and Woolcock 2004) and thus beneficial for; and can be incorporated within the discourse regarding health. Regardless of the perspective on social capital, it is a subject that is awash with complexity and subjectivity primarily because it is a construct of components such as participation, trust, networks and cooperation. In addition to this, it is an important component to consider as it is situated within the discourse regarding social factors related to health, the role of the community and the importance of participation in health.

One of the reasons community participation should be an area of focus for any government that seeks to enable communities to address and challenge their own social systems, especially with regards to issues of health, is the fact that community participation provides favourable opportunities for different groups, such as community organisations to interact and increase their networks and therefore diversify the resources available (PRI 2005). Based on the discussion regarding community participation and its benefits, it is the researcher's view that this form of diverse interaction can not only be at an informal level, but also at a higher level where diverse sectors network and interact to address issues of health and /or social issues in general within a community. The nature of the network can in itself be inter-sectoral. ISA can be facilitated at different level of society, however, the nature and extent of

community participation remains an important vehicle, as it can influence ISA across those different levels.

In the discussion above it is acknowledged that participation in local communities ensures that communities have some influence over access to services and resources. In the effort to constantly remain conscious of the impact of social factors on the health of communities, community participation has emerged as a key mechanism to galvanise communities to hold the different sectors that engage with the social determinants of health accountable.

2.2.1.3 Inter-sectoral action – why does it matter?

ISA has been defined by the World Health Organisation as “A recognized relationship between part or parts of the health sector with part or parts of another sector which has been formed to take action on an issue to achieve health outcomes (or intermediate health outcomes) in a way that is more effective, efficient or sustainable than could be achieved by the health sector acting alone” (WHO 1997), pg 3. It is based on the premise that the health of a nation cannot be relied upon only on the health sector, primarily because health to a large extent is determined by social and economic factors (WHOa 2008). The effort to work across sectors grew in the 1990’s with the progressing growth in the knowledge regarding the social determinant of health.

To clarify and unpack the concept of the social determinants of health and therefore the importance of ISA, the processes in which the impact of social factors affect health, will be illustrated: Take the simple example of the context of the workplace. Any changes introduced in this area, for instance, the loss of employment, can cause an elevation in blood pressure and therefore can have an adverse impact on health (WHOa 2008). The fact of the matter is that the health sector cannot on its own accord change labour relations or employment arrangements. Neither can it independently increase taxes on alcohol or even regulate rural migration. Although these measures have the potential to achieve positive health outcomes (WHOa 2008), they are not within the control of the health sector. They lie within the domains of other sectors. It is for this reason that it remains crucial for the health sector to collaborate with other sectors, not in the effort to establish collaboration to address pre-identified priority health issues, but to ensure the recognition that health is a socially acknowledged outcome that is embedded in all policies (WHOa 2008). Satterthwaite (2007) highlights the importance of this engagement by indicating that good governance for instance

can achieve up to 75 years or more of life expectancy, while only 35 years with poor governance.

Recent efforts of ISA provide a range of strategies, particularly with regards to policy, and in that same vein, provide the successes and challenges that are encountered in this regard.

ISA has been implemented at different at different levels of authorities and decision- making (Public Health Agency of Canada. 2007), such as:

- At a macro level, through international programs such as those initiated by the World Health Organization or United Nations agencies (Public Health Agency of Canada. 2007).
- At a global level, exemplified by the World Summit on Sustainable Development in 2002 (Public Health Agency of Canada. 2007).
- At a national level, the examples illustrate how ISA as been used to approach complex, multifaceted problems by collaborating efforts at relevant government departments into a single coordinated effort. Cuba illustrates how ISA has been central to its national health system (Serrate, Lausanne et al. 2007).

- Sub-national level efforts include Quebec's 2001 Public Heath Act which states that it recognizes that various polices of other government sectors impact on health and well-being (Berneir 2006).
- At community level, ISA can be implemented in the form of networks which constitute actors such as clinicians, researchers, policy makers from various sectors such as education, health and social services. Networks can mobilize different groups to collectively address areas of mutual interest.

In the attempt to facilitate ISA, various factors have been proposed to be involved in determining success or failure.

2.2.1.4 Factors involved in inter-sectoral action

As expressed within the realisms of community participation, the context and cultural environment is crucial to the success of inter-sectoral initiatives. It is because of this factor that it is also crucial for the different sectors to understand how each other operate particularly from a structural point of view. In simple terms, approaches that achieve results for one sector may not achieve the same results for another sector (Public Health Agency of Canada. 2007) . Partners need to mutually recognise the benefits, feasible implementation

mechanisms and compatible monitoring and evaluation strategies (Rowling and Jeffreys 2005).

a. Political support

The road to successful inter-sectoral collaboration requires what is similarly necessary in community participation; political support. Legislation has been commonly used to formalise institutional arrangements amongst sectors. However, despite this mechanism, Lock and McKee (2005) report that a lack of capacity to implement can hamper inter-sectoral initiatives.

b. Accountability

A shared sense of accountability across all those involved in the different sectors resonates as a factor for successful inter-sectoral action. It is for this reason that the Canadian Agency report (2007) recommends the establishment of an agreed - upon accountability framework, as accountability requirements are different for different sectors. Inter-sectoral collaboration is never self-generating and needs mechanisms to facilitate this process; however a vested interest in this initiative is often a positive start. It is for this reason that inter-sectoral collaboration may be more successful at community-base level, where there are less personal interests to protect one's own sector in relation to, for instance, limited budgets.

c. Social networks at community level

It is in this similar vein that the factor of social cohesion plays a crucial role. Inter-sectoral collaboration requires complex collaborative efforts to address multifaceted issues that have an impact on health (Pheley 2005) and a community-based structure of social networks is one of the necessary ingredients to achieving this effort.

d. Health sector as leader of ISA

Despite there being a drive for the collaborative efforts, Stahl (2006) suggests that ISA should be strengthened within the health sector and it should be the one to take the lead in the collaboration process. This therefore requires sufficient capacity within the sector with regards to administrative and public health training. This more so because other sectors need input from the health sector so as to guide the process that will allow health implications to

be taken into account (Stahl 2006). It is at community level that it is viewed that ISA can be most effective with enough support from the health sector through the promotion of local action and application of political pressure on the higher levels to comply. The critical factor is also to connect community groups with public health personnel. The World Health Organisation emphasises this point by noting that non-governmental organisations can play a crucial role in implementing policies that are developed through inter-sectoral approaches (Gilson and Doherty 2006).

2.2.1.5 Government structures and the policy terrain

Because ISA initiatives also occur within broader social and political settings, it is also important to explore some of the more fundamental factors that determine the extent to which it occurs. The political context of ISA means that it involves different levels of government (Barr, Pedersen et al. 2008). The complex government structures have been considered a contributor to the challenges that of ISA implementation (Barr, Pedersen et al. 2008), mainly because the nature of the relationship between these different levels determine the extent to which joint action is translated amongst the different levels within and amongst multiple sectors. Lack of clarity regarding where the responsibility for the determinants of health lie makes for unclear regulation, which in turn have an impact on ISA implementation. ISA attempts at provincial and national levels in Canada for instance, have highlighted the complexity, mostly embedded within the policy context. Different levels of government have different responsibilities for health and the social determinants of health such as education and labour and these differences in the division of responsibilities are also between its provinces. This is a constraining factor for the implementation of any national initiatives (Barr, Pedersen et al. 2008). An inter-sectoral approach needs to be incorporated at a macro level for it to be regarded across all levels of society. This drives the point that the principle of ISA cannot be far reaching if they are not translated with similar objectives and strategies and commitment across these levels. In England, the establishment of a joined-up-government approach (a concept that is discussed later in the section) to address its health inequalities, achieved limited outcomes. The horizontal integration which originated and strengthened at national level, was not transferred to local levels, hence poorer more vertical approaches and inconsistent ISA mechanisms at local levels (Hiscock and Pearson 1999; Glendinning, Coleman et al. 2002; Barr, Pedersen et al. 2008). Cuba's reported varying outcomes of its ISA efforts have been attributed to the disjuncture between national and local

levels of society. Low involvement, support and consultation has resulted in mixed ISA impact (Barr, Pedersen et al. 2008). This drives the notion that the disconnect that resonates between levels of government creates the difficulty that actors in each level (and each sector) experience with regard to observing and understanding each other's contexts. Mechanisms to approach ISA at national level may therefore not be similar to those of other levels of government and therefore difficult to translate to local level circumstances. It is therefore necessary that national ISA strategies are informed by local level issues and contexts, hence avoiding the top-down approach of ISA development and implementation (Barr, Pedersen et al. 2008).

ISA initiatives that are established at local levels have been recognised to achieve better gains with regards to implementation. The principle of community participation plays a strong role in this regard. A strong level of independence by a community and thus a strong bottom-up approach to ISA can ensure that local level efforts are minimally affected by a government's varying level of commitment and support. This echoes Barr's (2008) view that this approach protects local level efforts from any changes in government.

The discussion above indicates that non-governmental organisations (thus community participation) have a significant role to play in facilitating ISA at local level. With sufficient capacity, they not only have the potential to address specific issues affecting the community, but also have the ability to influence policies that can have national impact

2.3 The South African context

2.3.1 Current population and health outcomes

South Africa's history has had a significant impact the general health of its population, its health policies and its services. After 15 years after apartheid-related discriminatory and restrictive laws and policies, inequity continues to permeate in its development efforts and across all aspects of its society. These inequalities also exist in health status where a disproportionate burden of ill-health is in the black African and rural households (Bradshaw, Nannan et al. 2005; Gilson and McIntyre 2007; Coovadia, Jewkes et al. 2009). Despite various policy changes, the country's government has struggled to realise improved health outcomes. The burden of non-communicable diseases continue to grow while poverty-related diseases such as infectious diseases and maternal deaths remain widespread (Norman,

Bradshaw et al. 2007). HIV/AIDS and tuberculosis remain the concomitant epidemics that present as a major public health challenge, where South Africa accounted for 17% of the global burden of HIV infection in 2007 at an estimate of about 5.5 million people.

These major epidemics have managed to overshadow other public health challenges that have an impact on the current health outcomes of South Africa. Added to this, despite the establishment of progressive health care policies by the post-apartheid government in 1994, such as free PHC, the anticipated benefits have not been attained. Part of this is due to the inadequate quality of health care and inequitable access to services (Coovadia and Bland 2008; Puoane, Tsolekile et al. 2008). Another contributor is the upstream determinants of health that are beyond the role and capacity of the health sector, such as those related to social and economic factors, that lead to poor health (Commission on Social Determinants of Health. 2008; Mayosi, Flisher et al. 2009).

The public health issues and health outcomes faced by South Africa, particularly within its poor communities set the context within which this study was based on. The underlying factors that drive these public health issues and highlight the role of CPHC need to be explored and discussed even further. The section below continues in this regards.

2.3.2 The South African settlement situation and policy context

Informal settlements, homelessness, unemployment, and the lack of access to basic services are but some of the stark features of poverty that post-apartheid South Africa has inherited and to this day, remain its core challenge. Despite the range of poverty alleviation policies, South Africa is considered to be the highest in the world in terms income poverty and inequality, acknowledging that both these phenomena have co-existed for generations in developing and developed societies (World Bank Report. 2006; Seekings 2007; Everatt year not stated). It is estimated that over twenty million South Africans live in poverty (Development Bank of Southern Africa. 2005), however the disparities are embedded within racial, gender, spatial and age dimensions; a direct consequence of colonial, segregationist and apartheid regimes (Seekings 2007; Everatt year not stated). Poverty therefore is predominantly with black Africans, in women, those who reside in rural areas and the black youth (Triegaardt Year not stated (a)). Having considered the extent of poverty in South Africa, its definition is necessary as it will provide a perspective and context that relates to the case studies and most of the participants that were involved in this study. Despite the

various and debatable ways of defining poverty, the researcher will accept the following definitions for simplicity. Absolute poverty is considered a severe deprivation where households are unable to meet basic needs such as access to food, health care, safe drinking water and sanitation, education, shelter and basic items of clothing such as shoes (Sachs 2005; Triegaardt Year not stated (a)). Moderate poverty implies that a household is able to just barely meet its basic needs (Triegaardt Year not stated (a)). Relative poverty is measured at household level where the income level is below a given proportion of the average national income (Triegaardt Year not stated (a)).

The new government post-1994 has made efforts to address these disparities through a series of policies (Coovadia, Jewkes et al. 2009; Triegaardt Year not stated (a)) which have been affected in health care, housing, social security and education (Triegaardt Year not stated (a)). For instance, the national system of social grants has been a major source of relief against the impact of poverty for millions of South Africans (Coovadia, Jewkes et al. 2009). About 12.4 million beneficiaries were receiving social grants in 2007/2008, an increase from 2.4 million in 1996/1997; the increase being mostly due to the introduction of the Child Support Grant. This grant is mainly for the purpose of providing social assistance to children that are in need (Pauw and Mncube 2007) and currently has about 8.2 million beneficiaries (The Presidency. 2008).

The discussed context above is further embedded within the oscillary lifestyle inherited from the apartheid era through the migrant labour system. The continuous migration of individuals within the country and from other neighbouring African countries continues to define the nature of health outcomes in South Africa and with regards to the nature of settlement of households (Abdool Karim, Churchyard et al. 2009). This factor has contributed to the spread of diseases such as tuberculosis and HIV/AIDS (Abdool Karim, Churchyard et al. 2009). In light of this pattern of movement, Johannesburg, one of the cities in South Africa, remains the hub into which there is a high rate of internal migration from those from within the country and from other neighbouring countries (Vearey 2010). This level of inward movement has placed growing pressure on the capacity of the city to provide adequate services, particularly adequate shelter (Vearey 2010), hence the impact on the social determinants of health.

The context within which CHWs function to provide their services, has the potential to have an impact on not only the quality of the services but also the extent to which they can provide the range of services. The history and nature of CHW policies is an important area to explore.

2.3.3 History and experiences of PHC and CHW programmes in South Africa

In an effort to improve primary health services in South Africa, particularly in light of the HIV and AIDS epidemic and to increase the human resources within the health system, a National Community Health Worker Programme was established and was integrated into the National Public Works Programme in 2004 (Schneider. H, Hlophe et al. 2008). The Expanded Public Works Programme (EPWP) is a government strategy utilized to address unemployment by facilitating opportunities for South Africans to be employed in the different government sectors, thus receiving training and gaining skills while enabling them to earn an income. This strategy also addressed the aim to improve the support and career opportunities for the volunteer workforce within the health sector. The Gauteng Department of Health (DOH) launched its Community Health Worker Programme, as a sub-programme of the EPWP in 2004¹. The programme has over the years relied mostly on non-governmental organizations (NGOs) and/or Community Based Organisations (CBOs) to coordinate and manage the activities of community health workers who provide a range of services with a primary focus on HIV/AIDS and TB care. The EPWP has played a critical and cost effective role in the delivery of holistic HIV/AIDS and TB related services². However, with the focus on HIV/AIDS and TB, the broader functions of CHWs have been sidelined, such as engaging with the community on issues such as water disposal, clean water, family planning and nutrition (Friedman 2005).

Primary health care is considered to have been the backbone of health care in South Africa since 1994, with the objectives of the policy governing health care aiming to develop a district-based, comprehensive PHC. The historical legacy of profound inequalities in health and health care influenced the South African government's policy of selective PHC which allowed it to focus on immediate needs and disparities (Sanders and Chopra 2001). The objective of the government was to use these selected programs, such as HIV/AIDS, TB and nutrition as foundations to develop the district health system and to priorities PHC services. However, as in the tradition of SPHC, this approach leads to a shift away from the broader determinants of health to more focus on technical health care such as antiretroviral treatment (Baum 2007).

¹ www.gpg.gov.za "The Expanded Public Works Programme." [Accessed 26 October 2007].

² Ibid

Failure to implement PHC has been due to a variety of reasons which are similar to international experiences reported above. These reasons are illustrated through the discussion of the examples relating to CHWs below.

a. Inadequate training and supervision

In an Eastern Cape study of its CHW programme (Lehmann and Matwa 2008), health facility managers were expected to oversee training and supervision of CHWs. However, due to lack of formal instructions, training and related resources to undertake this responsibility, supervision was confined to reports and addressing any ad hoc queries from CHWs. Community Health Committees were meant to participate in the managing and supervision of CHWs, but none had even received any information on the policy or about its intended implementation, or any training to prepare them for these roles (Lehmann and Matwa 2008).

Formal training often leaves nurses and related professionals ill prepared to work in a community context and with a weak understanding of community based programs (Friedman 2002). In Schneider et al's study (2008), although CHWs indicated that they found the program useful as a stepping stone to accessing formal employment and found some of the relationships established with nurses supportive, they reported their unhappiness with the disregard for their contribution to health care. CHWs working on the outskirts of Cape Town felt that the lack of understanding of their training by the local nurses made it difficult to establish a working relationship, with nurses showing reluctance to accept referrals from them (Doherty and Coetzee 2005).

b. Top down implementation

A poor consultation process can run the risk of the staff either undermining the policy or implementing it selectively. A study of the CHW programme in a South African province of the Eastern Cape, illustrates this. Facility managers in this study selected aspects of the CHW policy which they were comfortable with and wanted to see implemented, thus interpreting it in the narrowest possible way (Lehmann and Matwa 2008). The policy was a document that was imposed on the managers rather than one that they should have had a say on the content, thus enabling them to implement it.

c. Lack of integration

The lack and/or inability to establish integration between CHWs and the PHC facilities was left unattended and remained an unanswered question (Heunis, Rensburg et al. 2006). This has implications for the quality of service that CHWs provide. A lack of integration between support systems such as drugs and finance, and service delivery components have been experienced widely by health district managers in South Africa (Modiba, Gilson et al. 2001). Poor integration of PHC services are a manifestation of weak district health systems development. According to Friedman (Friedman 2002), poor linkages with the district health system have resulted in a lack of understanding of the role of CHWs and their lack of recognition by health care professionals in the health facilities.

From the discussion above regarding the challenges and experiences of PHC implementation in South Africa, summarised in Table 2, it is evident that the way in which PHC is practiced and applied has a direct effect on the ability of CHWs to function and carry forth the values of PHC. Therefore, it is also evident that a supportive and efficient PHC system that recognizes the principles of comprehensive services is necessary for CHWs, to not only ensure the quality of service provision, and their ability respond to the changing needs of communities but also to ensure the practice of CPHC.

Table 2: Key issues emerging out of the South African experience

Key challenges	Details	Reference/s
Inadequate training and supervision	<ul style="list-style-type: none"> ▪ Lack of training regarding changes in policy ▪ Lack of training health professionals about community work and its role and therefore role of CHWs ▪ Therefore lack of recognition of CHWs by health professionals 	(Lehmann and Matwa 2008) (Friedman 2002) (Schneider. H, Hlophe et al. 2008) (Doherty and Coetzee 2005)
Top-Down Implementation	<ul style="list-style-type: none"> ▪ Poor consultation process therefore staff undermined policy ▪ Policy was imposed on middle level managers; Lack of support from broader health system ▪ Poor managerial skills led to poor implementation of policy 	(Lehmann and Matwa 2008) (Schneider. H, Hlophe et al. 2008)
Lack of integration	<ul style="list-style-type: none"> ▪ Inability to establish integration between CHWs and PHC facilities ▪ Lack of integration different layers of the health system thus lack of support experienced by district health managers; Poor linkages with district health system led to lack of understanding of role of CHWs 	(Heunis, Rensburg et al. 2006) (Modiba, Gilson et al. 2001; Friedman 2002)
Community involvement constraints	<ul style="list-style-type: none"> ▪ Community involvement the weakest in many developing countries ▪ Lack of empowerment of CHWs made it difficult for community-based initiatives to mobilise communities. ▪ Weak mechanisms of accountability; Poor mechanisms to generate community participation 	(Heunis, Rensburg et al. 2006) (Sen 1997; Lawn, Rifkin et al. 2008) (Sen 1997; Rifkin 2003) (Gilson and Erasmus 2006)

2.3.4 The South African Health System: the three tiers of government

Although community-based activities primarily occur at local level and ideally should function in collaboration with local government structures as a means fostering effective ISA and community participation efforts, local government is still part of the macro structure of government, which in the case of South Africa is three-tiered. The responsibility of the National Department of Health is to develop policies and to oversee the overall coordination of the health system while the provincial departments mainly provide health services through hospitals and primary health care (PHC) clinics (Gilson and McIntyre 2007). Local governments provide environmental health services and some facility-based primary health care services. It is against this backdrop that CHWs, at the employ of non-governmental organisations (NGOs) play a role in the provision of PHC.

2.3.5 Current policy shift and emphasis on PHC

Inclusive in the efforts to overhaul the health system, the post apartheid government ensured that primary health care, delivered through the district health system, was the central aspect of its health policy (Coovadia, Jewkes et al. 2009). This was established along the principles of PHC as promoted at Alma Ata, in which it envisioned and established a system that was based on community health centres. This vision is reflected in its policy in which children less than 6 years of age and pregnant mothers receive free treatment (Coovadia, Jewkes et al. 2009). As with other governments that have attempted to transform its health system and implement PHC, the South African government has been met with challenges. Diverse factors such as a shortage of health professionals, the historical inequity in the distribution of resources and weak managerial capacity and health system leadership have contributed to the challenges (Kautzky and Tollman 2008). In response to the inefficiencies thereof, however mostly to the neglect of the remnants of apartheid, civil society through mostly non-governmental organisations have overtime come to being. Despite the challenges, there is visible continuation of the efforts to strengthen PHC. Central to the efforts of the revitalisation of PHC was the service agreement that was signed between the Minister of health and the President of South Africa in October 2010 (Downing 2010). A further output of the efforts was reflected when the Minister of Health established a task team to provide advice on the re-engineering of PHC in South Africa (Barron 2010).

2.3.6 Current CHW policy shift and revision

Due to the realisation that Community Health Workers, now referred to as Community Care workers in the current policy space (from the revised CCW policy which is not for public distribution as yet) are crucial to the provision of PHC and a range of other caring services (van Pletzen, Colvin et al. 2009). A parallel process to the revitalisation of PHC has been the revision of the CHW policy which is still under a process of review (Researcher's own knowledge).

Having discussed the various aspects of CPHC and the context within which the CHWs in this study function and provide services, the results provided are discussed in light of these factors.

3. Research Questions

The main research question was to what extent are the services provided by CHWs in Gauteng Province, South Africa contributing to comprehensive primary health care? The sub-questions, are presented as specific objectives and in the effort to explore the extent of CPHC in the services of CHWs, they were related and based on the key principles of this PHC model; the provision of a wide range of services, the facilitation of ISA and community participation. The inclusion of a question regarding the policy environment and context within which the CHWs provide these services was essential to understanding the policy space. Documenting the lessons learned from addressing the objectives is considered the primary component of the study is aimed at informing policy. The objectives were as follows:

1. To examine the types of services that are rendered by the CHWs, whether they are comprehensive in nature (curative, rehabilitative, promotive and preventative as appropriate to their skill level), and to explore patient/beneficiary experiences with regard to these CHW services;
2. To examine the policy environment within which CHWs operate and how this impacts on the delivery of services (how the different levels of government interpret the CHWP policy, implementation, training, consultation);
3. To examine the nature and extent of inter-sectoral action (ISA) and community participation (CP) facilitated and conducted by the CHWs and the role of the

institutional contexts of various stakeholders in providing opportunities for ISA (institutional policies around ISA, management capacity to facilitate ISA);

4. To draw out the lessons learned for policy recommendations.

The process of exploring the literature regarding CPHC and the initial exposure to the context within which CHWs functioned required the researcher to refine the objectives of the study. Over time, the institutional context of the various stakeholders and the policy space within which all these actors operated within proved to be important facets to explore. The objectives were therefore refined to reflect this realisation.

The researcher had initially planned to interview the patients in the study regarding their perception of CHW services. This was not possible because during data collection, the researcher was advised that it was unsafe for her to visit the household alone. Due to that the CHWs accompanied the researcher to all visits; it was likely that the patients would not be able to provide a true reflection of their perceptions. The patient interviews were therefore not conducted.

4. Methods

4.1 Selection of Case studies

The study used a comparative case study design, comparing and contrasting the experiences of 3 different community health worker organizations. The initial process of case study selection involved a semi-structured interview with a representative from the Gauteng Province (Department of Health-District Health Systems Support) to obtain information about NGOs in a selected district. A similar process occurred with a Regional Manager from the selected district (Johannesburg). This process allowed the researcher to get a sense of; the different types of NGOs, their differences and/or similarities and their performance. The district was selected because it has a wide variety of contextual differences in its sub-districts. The selection of the case studies was based on mostly the organisational contextual differences, including types of services and types of CHWs employed. The researcher then selected 5 CBO/NGOs, 2 from an area which was considered rural and 3 an urban area. These organisations were visited to conduct key informant interviews with the managers and out of those, **2 CBOs/NGOs** from each respective sub-district of Johannesburg, were selected as case studies (Fig. 1). A **third case study** (Fig. 2) was selected and is situated in another province of the country, the Eastern Cape, in a small town called Alice.

4.2 Rationale for the method

In order to understand the practices that are required to implement a CPHC programme that works, the researcher is of the view that evaluating an NGO that is known to be successful in this regards can offer valuable lessons that can also be part of drawing up recommendations to inform policy. The third case study was therefore been identified as a best – practice model with regards to providing community-based services in line with comprehensive primary health care. The three case studies differed in their models of service. Case study 1 mostly focussed on home-based care, preventative, health promotion and rehabilitative services. Case study 2 only provided households with information on anything from various diseases such as HIV/AIDS, cancer, TB to guidelines on how and where to apply for a child care grant or how to apply for an identity document. These differences are further summarised in Table 3 below.

One of the NGOs in the Gauteng Province was used for a pilot study to test the data collection instruments.

Initial interviews were conducted with the organizations to confirm the characteristics that informed the selection. Over and above this variation, these 2 case studies were also selected on the basis of their vast contextual (organisational) differences.

4.3 Data collection

In order to obtain a rich description of the experience of CHWs and their organization, and to document the activities of CHWs, a range of qualitative methods are being used: 1) key informant interviews; 2) focus group discussions; 3) participant observation, and 4) network maps.

- ***The Key informant interviews*** were conducted, using semi-structured interviews, to collect data with various key individuals who are involved in the CHW sector and terrain. The in-depth interviews allowed the researcher to focus and clarify key issues that emerged during other areas of data collection.
- ***The Focus group discussions:*** The initial plan was to conduct the FGDs with CHWs 2 groups of CHWs in each case study. The groups were to be separated by age because the researcher was of the view that this workforce was made up of a mixture of older people (who have been working in their communities as volunteers out of the desire to

contribute, long before the implementation of the CHWP), and those that are younger (who may have started community work as a way to gain skills and initiate a career). It was therefore deemed important to document the differing views and experience of the CHWP of these two groups. However, in reality this was not the case. Almost all the CHWs across the three case studies were considered to be fairly new to the work. The maximum that some of them had been working in the NGOs ranged from 4 to 7 years. The FGD were eventually not separated. The only case study where there were two groups was Case study 1. Here, the researcher separated the CHWs who were still considered volunteers (and thus not receiving a stipend) and those who were CHWs as it appeared that their experiences of 'employment' differed. This method also allowed the researcher to obtain collective views of CHW experiences from each of the case studies.

- **Participant observations** involved spending 4 days with 3 CHWs from each case study (one per 4 days). During the 4 days, the researcher discussed with the CHW the issues emerging from the observations as they walked from one patient's home to another. A researcher diary was used to record all the daily events and experiences of each CHW. It must be noted that all of the CHWs across all the three case studies were women and due to safety reasons, they were to travel in pairs or in groups. The CHWs who were identified for the purposes of the participant observations led the respective pair or group. This method of data collection allowed the researcher to experience the daily lives of the CHWs. This included the challenge of walking from one household to another to the responses of communities at their arrival. Residents often expressed their discomfort of being visited by CHWs as they were associated with HIV/AIDS.
- A **network map** is a visual representation of the network of individuals and organizations the CHW interacts with during his/her activities, as well as the purpose and the nature of the different interactions. The three CHWs from each case study collectively drew network maps that were a description of their social networks. The visual representation provided one with a visual map of the extent of social capital at their disposal.

4.3.1 Ethical considerations

Required ethical clearance was obtained from the University of the Witwatersrand's Medical Ethics Committee on the 23rd March 2009. Informed consent was obtained from all interviews. In order to ensure privacy, the names of the respondents were separated by using identifying numbers.

Due to the evident perception that there was limited support in Case study 1 and Case study 2, there was the potential of heightened expectations of the research. The researcher attempted to address this risk, by explicitly indicating that the benefits of the study would not be immediate and /or direct.

Considering that the areas where the CHWs provided their services were often deemed unsafe, there was a possibility that the CHWs made a concerted effort not to go to areas that they considered unsafe, thus limiting the researcher's exposure to the multiple facets of their experiences. Although prior consent was requested and provided by the patient and the household before the researcher visited a household, there were instances where a household had more than one ill individual. During the initial stages of the participant observations, some of the CHWs would spontaneously disclose the illness of the other household members who had possibly not provided consent. The researcher addressed this by communicating with CHWs and explained the issue of confidentiality with regards to other household members.

4.4 Ensuring rigour and validity of the data

Applying procedures of rigour on one's qualitative data ensures the validity of the data and ensures that the data is a true reflection of the reality from which the data has been sourced (Seale, Gobo et al. 2004). In order to ensure the quality of the data, the researcher applied the following strategies:

- Transcription of the interviews verbatim
- Re-writing of the notes from the fieldwork diary recorded during the participant observations
- Transcriptions and writing of notes conducted immediately after each data collection activity.

5. Results

5.1 Description of participants

This study draws on the data that was collected from two types of participants; a variety of key informants who participated in in-depth interviews and individuals from participant observations who were observed in their households across the three case studies.

Key informant interviews were conducted with 23 participants from a variety of institutions across the 3 case studies. The representatives were from institutions that are involved with the Community –Based Organization (CBO) sector and these provided their insight and experience of the services of the CHWs. This process supplemented the data that was collected through participant observations and Network Maps so as to develop a holistic perspective on the services that are provided by this workforce. The participants that were involved were from the following institution and organizations.

Table 3 Government department participants:

Department	Participant designation
Department of Health	National (2), Province (1), District (2)
Department of Housing	Regional (1)
Department of Social Development	Regional (2)

Table 4 Case study participants:

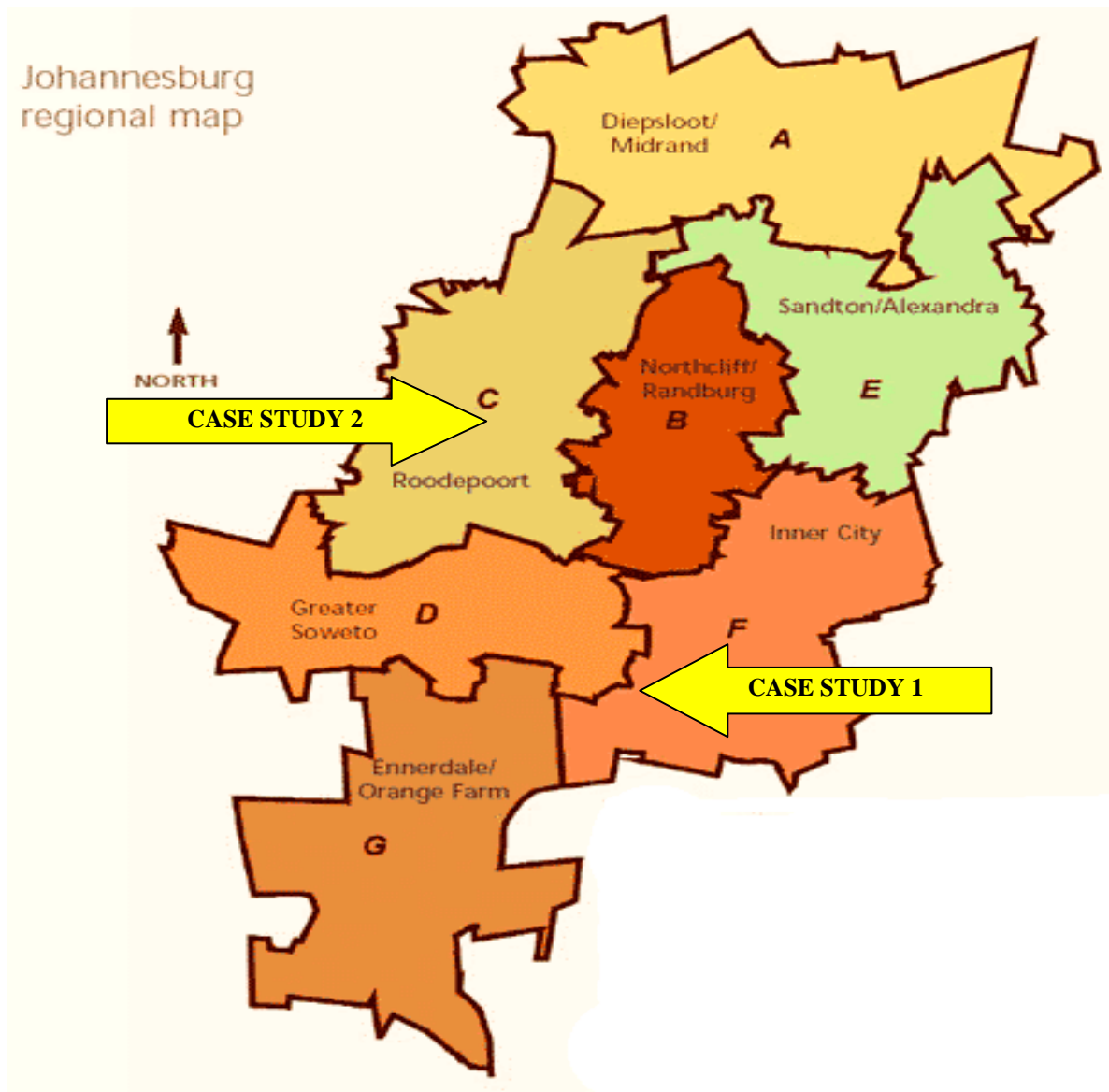
CASE STUDY 1	CASE STUDY 2	CASE STUDY 3
CHW Focus group discussions (2)	CHW Focus group discussion (1)	CHW Focus group discussion (1)
NGO project manager	NGO coordinator	National NGO representative
NGO coordinator	Regional NGO coordinator	NGO /project coordinator
Clinic nurses (2)	Clinic nurse (1)	Project mentor
Community representative (from clinic committee) (1)		Project supervisor
Community representative (Community Development Worker (1)		
District representative (Health Promoter)		
District representative (Ward councillor)		

This included participant observations of a total of 74 households

Table 5 Description of Case Studies:

CASE 1	CASE 2	CASE 3
<ul style="list-style-type: none"> ▪ Small independent and founded by the project manager. ▪ Sought its own funding from variety of sources (e.g. Department of Health, Department of Social Development and the private sector). ▪ The types of services provided are influenced by the needs of the community. Services are primarily home-based care (rehabilitative and promotive) and preventative. 	<ul style="list-style-type: none"> ▪ NGO part of large organisation initiated by the Gauteng Province. Other branches distributed throughout ▪ Receives funding solely from Department of Health via the sub-district of the province. ▪ The types of services rendered are prescribed by the province, governed by the province’s concerted effort to bring multiple services to poor communities. Services only involve information dissemination (promotive) 	<ul style="list-style-type: none"> ▪ Focuses on Child and Youth Care. Services involve home-based care, prevention, health promotion, rehabilitation, advocacy, family counselling, child therapy (rehabilitation through grief therapy and play therapy) ▪ Individual local projects run under the auspices of a national NGO ▪ Selected by South African National AIDS Council as a best practice in responding to OVC needs in Mid-term review (2009) ▪ Pefpar funded child care workers on the job ▪ Training and progression based on a national curriculum
<ul style="list-style-type: none"> ▪ NGO serves poor and marginalised community in a semi-rural area with a range of farms and a community in informal settlements. ▪ Community is situated far from formal services and resources and transport networks/infrastructure. 	<ul style="list-style-type: none"> ▪ The NGO serves a community that resides in what is a combination of urbanised informal settlements surrounding low-income housing. ▪ The community is fairly close to some formal resources and services and transport networks. 	<ul style="list-style-type: none"> ▪ The project serves the needs of children and young people under the age of 18 years through services of child care workers in an urban informal settlement and a peri-urban area. ▪ The integrated nature of the care provided and the multidisciplinary referrals make this a valid case study ▪

Figure 1: Gauteng province Sub-Districts: Case study 1 and Case study 2



Source: www.joburg.org.za/regions

Figure 2: Alice – Eastern Cape province : Case study 3



Source: www.ectourism.co.za

5.2 The communities and their context of the communities

The contextual factors within which the CHWs operated provide a basis within which to understand the types of services that were provided by them and how these played out in reality. The context also provides an account of the complex environment within which the CHWs were expected to provide these services and in turn how their services were received and experienced by their clients. Having provided the definitions of poverty in the literature review (Sachs 2005; Triegaardt Year not stated (a)); a large proportion if not all, of the households lived in what one would describe as *absolute poverty*. This was even more so for all households in Case study 1 and case study 2. A few households in Case study 3 fell in the category of *moderate poverty* while the rest experienced absolute poverty. That is, in one way or the other, they all experienced varying levels of deprivation; some worse than others. The

various stories referred to in the text are all embedded and are somewhat a consequence of this aspect of poverty. From a broader perspective, the fact that most of the households referred to in this study lived in conditions of deprivation, has led to the clients of the CHWs to experience a level of isolation from participating and interacting with the normal social systems such as residing in adequate shelter, accessing basic services such health care, education, social services, employment, regular clean water, sanitation and exercising the right to elect those in the spheres of government and in that same space of exercising their power to challenge those in positions of authority (such as in relation to service delivery).

5.3 Key findings

5.3.1 The harsh conditions

For some the households, living conditions were often what one would describe as squalid and unfavourable for any human habitation. A household in Case study 1 was made up of only a single room (illustrated in photo 1). An elderly couple in the house conducted all functions; eating and sleeping, in the same area. The lack of access to water rendered it even more difficult to maintain any level of hygiene. Many of the households in these informal settlement communities (in case study 1 and 2) arranged their lives within cramped spaces, either sharing a shack with extended family members or creating extra” rooms” to rent out as a way of generating some income. Part of the data collection occurred during the winter season; hence many of the shacks retained the temperature of the day and were often extremely cold and damp. One household visited typified this context:

The home is a shack that is occupied by 11 people. Some are related and some share for the sake of cost-effectiveness. From the outside, the shack looks like one single big shack, but when one enters, one notices that there are different “rooms” which are separated by a combination of sheets, wooden doors, cardboard and steel objects. The one room which is closer to the entrance is full of wood and there is an indoor fire that is being prepared. All the rooms look damp, cold and dusty. (A household – Case study 2 – Participant observation)

Some households made a fire in a corrugated iron bucket and kept it in the rooms in an effort to keep warm. The rooms were therefore sometimes filled with smog.

Photo 1: Households in case study 1 (taken by the researcher)



Photo 2: Communal tap in Case study 2 informal settlement (taken by the researcher)



Photo 3: An informal settlement in case study 2 (taken by the researcher)



The living conditions of the households provided an in-depth context within which the CHWs had to provide services. The context also provided enough reason for the dire need for comprehensive services that acknowledge not only the health needs of these families but services that have an impact on health.

5.3.2 The nature of services to the communities

5.3.2.1 *The extent of comprehensiveness of the services*

The CHWs across the case studied provided a range of services, and depending on the type of services the case study aimed to provide, the range varied in terms of comprehensiveness. All of the case studies provided information to households either on certain health issues, on how to take treatment or on the availability of particular services and/or on how to access them. Often, the services extended to providing secondary services, such as cleaning up a client's home.

The CHW spent some time asking about the patient's health. She ensured that he takes his medication and explained that if he does not take his treatment as directed, his TB will get worse such that even the medication will not be effective. She tried to sort out his home by gathering all the dirty dishes and fetched water from the tank [communal water source] to wash the dishes. There was no soap or a rag to wash with. There was a cloth in her bag which she used. (Participant observation – Case study 1)

However, in the one case study, secondary services were purposeful and were specifically part of the intervention to ensure that the clients were self-sufficient and independent.

“If the parent is sick and maybe he's got 2 or 3 children, what you do is you visit there as early as possible, maybe 6am or 6.30am, where you are going to prepare the children for school. You are going to clean the house but also showing them to clean the house before they go to school then what you do there, they know that you are coming as a CYCW, but you don't want them to depend on you. You want them to be independent so you show them how to wash the dishes, how to clean the house; how to prepare themselves for school then you just help them with the homework because the mother is sick.” (FGD – Case study 3)

5.3.2.2 CHWs as a link to formal services

CHWs across all the case studies played a significant role in identifying clients that otherwise would not have managed to access some type of intervention, clinical or otherwise. Thus indirectly also linking them to formal services.

When they were conducting their door-to-door campaigns a year ago, they found her bed-ridden and “was close to death”. They arranged for an ambulance, which, through the assistance of the clinic manager, took at least 24 hours to arrive rather than the usual unpredictable period (Participant observation- Case study 1 – CHW- An account of how the visited client was found)

This also included being an extension of health care facilities and providing services that was otherwise provided by nurses in the community. This was predominantly the tracing of those individuals who defaulted on treatment.

“Oh yes there would be a difference. I'll tell you how I used to measure this. There was a time when we did not have CHWs at all. Our defaulter rate was so high, which brought

down our TB statistics of those who (were) supposed to have been cured.... Their presence makes a difference as far as tracing those patients that we cannot find and those that are defaulters. (Key informant interview- Case study 1- Clinic representative)

5.3.2.3 The interface between poverty and quality of care

Poverty for the most of the clients across the case studies had implications on a variety of aspects of their lives. Access to food meant that many of them were unable to take necessary medication thus consequently leading to incidences of non-adherence to treatment. This was illustrated in two households in case study 1 where an elderly man and a mother were unable to take their TB and ARV treatment, respectively, as they reportedly experienced severe hunger after taking the treatment. Lack of access to food, made the efforts of the CHWs to enable to the access the treatment and care futile.

“...we have got a lot of our patients coming back and saying, you know what..I want to take the treatment but because I don’t have food...I can’t take it regularly...it just irritates my tummy...I can’t take it” (KII – Health promoter – Case study 1)

The level of deprivation by most of the clients posed as a barrier to accessing services. For instance, the basic inability to be presentable when leaving their homes appeared to be concern for some of the clients.

After having looked at her foot, the CHW reached the decision that the client would need to go to the clinic to have her foot examined as she has a severe cut (because we can offer transport to the clinic), the CHW’s concern is that the nurses would refuse to attend to her because she had not washed. “Now you know you need to get yourself cleaned up. There is no way that Sr X, will see you in this state...she’ll just complain...you know that”. The client explains that the informal settlement has not received water [which the Department of Environment was meant to deliver monthly] for the entire week, hence she has not been able to wash. (Participant observation – Case study 1)

However, this included the aspect of language. After some attempts to communicate with some of the residents visited by the CHWs (in case study 1 and 2), it was evident that they avoided going to any of the services due to their inability to speak any of the local languages.

The one aspect that was common across all the cases was that the clients that received the services experienced them in varying ways, depending on the model within which the CHWs provided those services. The experiences also varied according to their contexts and circumstances. Based on those experiences that have been cited, it was evident that albeit the CHWs' respective models of service provision, all the clients in the observed households required their services to move beyond the scope of health. In order to ensure an outcome of general wellbeing and health, they were required provide interventions that have an impact on health, hence the need for inter-sectoral action and community participation. The majority of cases across the case studies required such multiple services; however, the two cases in Gauteng fell short of providing these paradigms of CPHC, in direct contrast to case study 3.

5.3.3 The woes of community participation: a vehicle to ISA

Although there was the existence of formal local government participation structures such as ward committees, coordinated by a ward councillor, practical functioning was often met with challenges. In case study 1 and 2, this contributed to the minimal participation by the communities.

5.3.3.1 The role of existing formal structures

Recognition of the challenges of attaining inter-sectoral collaboration between and amongst departments by the province is reflected in the existence of community participation forums such as ward committees and clinic committees. These formal structures are meant to foster ISA and to provide communities with platforms to hold service providers accountable. It is these vehicles that CHWs can utilize to facilitate ISA. Community participation is therefore potentially an important component of ISA. The participation platforms can be used to ensure that they are known and recognized by their communities and certainly by the service providers in the community. This can indirectly empower them and deem them important agents of the community. This was evident more so in case study 3.

“...there are ward committees and that is what we use to communicate with the community. For instance when they wanted to open a Safe Park in these locations, they worked hand-in-hand with the ward committees, with the councillor. So it was the councillor who called a meeting and called the coordinator together with the team leaders, then they attended the meeting. So everything was worked through with the councillor.”(FGD – Case study 3)

The potential benefit of community participation was however not well recognized and realized in both case studies in Gauteng. Difficulties regarding the use of community participation as a vehicle to ISA were related to various factors:

5.3.3.2 An ineffective ward committee

The lack of a functioning ward committee often meant that community needs were not addressed.

Regarding a client who was sexually abused in her home: *“Now she cannot report to anyone in the family including the wife of this uncle. If you put yourself in that child’s shoes, do you think you would cope? And then this child contemplated suicide...not once, twice, thrice. What do you do? Social services...nothing. I mean it’s sad, when your own family can turn against you to defend someone who hurts you. Who do you go to? We really all have failed this child. If at least there was a functional Ward Committee where you could vent and report these issues and have people that are supposed to deal with these issues, then that would at least help, but I mean sometimes we don’t hear from Mr X [ward councillor] for months. I am yet to hear of any ward committee meeting taking place. So we survive by the grace of God...”(KII Clinic representative – case study 1)*

5.3.3.3 Political affiliation has impact on commitment of ward councillor

Informants from both case studies in Gauteng expressed challenges regarding the ward councillors. They equally felt that their lack of contribution was due to their political affiliations. It was felt that the ability to access different sectors and services in their respective areas would be easier with management and assistance from the ward councillors.

“Politically, our ward councillor this side is a DA councillor, so it’s difficult also to get him on board. He can’t relate to the issues. There’s also a Community Development Worker (CDW), one in the informal settlement who’s also very active and is also a political appointee who is supposed to identify social problems, but he becomes active today and the next thing he disappears.”(KII – NGO manager case study 1)

This included the fact that these community structures were misaligned with regards to the lines of reporting and accountability.

“If your ward committees were well functioning and then link that with all those cadres; the CDWs, the DOT supporters...because really that is where you have access to the different sectors, then we’d be able to address health issues and other issues for that matter. It’s just that our structures are not aligned and then you’re not able to achieve the impact that an integrated structure would be able to achieve.” (KII – DOH – District representative)

The extent of the involvement of the community can have an impact on the extent of ISA. The experiences of the community participation of the different case studies indeed determined the extent and nature of this component.

5.3.4 ISA happen? If yes, why? If not, why not?

Having illustrated across the case studies the circumstances of the communities and the clients; their experiences with regards to CHW services and the contexts within which the services are provided, it is evident that their needs and experiences required the key component of CPHC; effective ISA. It is also evident that a key element to fostering ISA is a community that facilitates community participation. The account of the needs of these communities and clients indicate that the CHWs in all the case studies do not only need to link them to health care services but also to other services that have significant impact on health and well-being. Some of the experiences of ISA discussed below provide some of the factors that enable and/or constrain ISA.

5.3.4.1 Capacity of NGOs to provide support to CHWs

Considering that CHWs across all case studies seemed to assume very limited power with regards to influencing processes and intervention, the availability of support from their institutions provides them the leverage to explore different avenues so as to provide effective services to their clients. Some of that support can be in the form of the type of training provided and in this regards, the extent to which it equips them to cope with the complex context within which they function. In most cases, CHWs seemed unable to determine alternatives in their efforts to assist their clients. This could be as a result of the type of training that they receive, which left unable to deal with the cases they encountered. The care workers in most of the cases were faced with clients that required a range of services. It

appeared that the quality of training would have afforded them the skills to deal with some of the issues. In fact, in the one case study (3), the CHWs regarded their training as an enabling component to their ability to provide effective services, especially with regards to exploring various avenues in the effort to link clients to various services.

”The training does help them to be able to problem solve and refer, when to refer and know who to refer to and give them that kind of training, so that they can look at the situation, do assessment as a professional child and youth care workers and be able to look at the needs and refer when they need to refer and they take on the cases that they can... So the training that they have, the fourteen modules will equip them with an FET for child and youth care work but they have additional training because of the context in where they are. For example they have training in disability, facilitated by the[.....]in Pietermaritzburg in Kwazulu-Natal. So they are able to identify some disability and then refer. We have had a second training with Wits University through the Big Shoes Foundation, where they had a specific training on HIV, ARV and they had other specific training with other service providers who provide them with First Aid, CPR,... it is not only health, sometimes they receive the special training through other service providers. They will help them to address the multifaceted things that happen in social service.” (KII- project coordinator Case study 3)

Another form of support which can contribute to the enabling of the CHWs to deal with the multi-sectoral needs of their cases is the availability, extent and/or quality of supervision. ISA requires a multitude of knowledge and skills. Whether it be on how to circumvent complex referral systems; to decide which service would be appropriate for the problem at hand or to decide which options within the range of services would have a better impact on the client’s status and better mileage on the intervention. Supervision across all case studies occurred in different forms and processes. All of them led to different outcomes with regards to ISA. The one aspect that was evident about the impact of supervision was that it enabled the CHWs to realize the facilitation of ISA. This was exemplified by the CHWs in Case study 3.

The lack resources and lack of support from the CHWs respective NGOs, illustrated that they can limit the extent to which they can foster ISA. Having this component in their offers a tool with which they can influence levels of government which they would consider inaccessible. As illustrated above, the care workers in case study 3, through the availability of resources, whether in the form of organizational support and/or practical resources, provided them the

leverage to foster ISA. However, difficulties to ensuring ISA extend beyond the institutional dynamics of the NGOs themselves. They were also related to the institutional factors of the various sectors that the clients required services from.

5.3.4.2 Response from sectors

With a project manager with drive and initiative one would assume that they would be able to follow through with the work of the organization, especially in relation to CHW and their need to link their clients to various government services. It became evident that despite being able to garner some level ISA at local level, the project manager in case study 1, in an effort to assist the CHWs, was consistently met with lack of or poor response from the different department such as Social services and the Department of Home Affairs. The complexity of the circumstances of most of the clients across all case studies required the intervention of higher levels of government from the different sectors. For instance, most of the clients in both cases in Gauteng were either migrants or people that have moved from other provinces in pursuit of employment. The lack of formal documents was a manifestation of the context within which they live and the history of the country.

“We still need Home Affairs which really seems to be challenged when it comes to these people who have a long history and lineage of not having legal documents. I mean they did come and explain to us why they can’t give the people IDs. They said if they are from Lesotho, they have to have documents from Lesotho but still they can’t give them IDs even if a child was born here...”(KII – Health promoter- Case study 1)

The extent to which the NGOs and the CHWs facilitate ISA, is evidently dependent on the level of response by the different sectors. Poor responses appeared to limit the extent to which the CHWs could foster this core component of CPHC. An integrated system ensures that clients are able to receive multiple services at the same point service. A coordinated system goes even further by ensuring synergy and organized management for users. CHWs and their clients across the case studies navigated a fragmented system.

5.3.4.3 Integration and coordination

One of the most prominent factors that accounted for the limited extent of ISA across the case studies was the poor integration of the various departments. Most of the cases that the CHWs dealt with evidently required a diverse range of interventions from multiple sectors. It was

rare that the care worker came across a case that required services from a single sector. Most of the participants in the government departments cited conflicting mandates with regards to accountability as a contributing factor. The majority of them indicated that at government level, they functioned according to specific targets that they had to achieve. Most of these targets were specific to the respective departments and were not coordinated and aligned to other departments with similar areas of work.

“In terms of the extent of coordination amongst all these sectors, that is a challenge. I think the problem is that there is lack of coordination not only internally but at other levels of government as well. You can go to National and you see that sectors still function as silos, the same for the Province. Now, it is difficult to translate coordination to the lower levels if it is not established in the higher levels”.(KII – District Department of Health representative)

It was equally expressed that this is more so due to the fact that it is translated from the higher levels of government.

“I just think that, coordination can only be achieved if the higher levels are coordinated. You see, if those people that designed the key performance targets for the specific departments to speak to one another, it would be so much easier to coordinate at the bottom, because the coordination would already have been established and developed at the top.”(KII – Regional Department of Human Development representative - Gauteng)

A fragmented and uncoordinated environment with poor community participation poses as a significant barrier for CHWs to fostering ISA. The outcome in most cases was that a large proportion of clients remained unassisted and unable to navigate the complex system of basic service that can otherwise have a positive impact on their health and wellbeing.

The main principle of CPHC is ISA because it acknowledges that health is determined and should be addressed not only by health but by non-health sectors as well. Ensuring that communities access health and non-health sectors can be compromised by multiple factors as indicated in the discussion above.

To consolidate the discussion above regarding CHWs and their role of CPHC, the important components of this model have the potential to be achieved if there is the presence of several factors. These are summarised in Table 6 below: community participation and ISA.

Table 6 Summary of factors for ISA & community participation [the rest of these factors are provided in more detail in the thesis version of this report]

FACTORS	FORM
ISA AT MICRO LEVEL	
Organisational capacity to support CHWs	➤ Sufficient funding
	➤ Managerial support when dealing with higher levels of government
	➤ Quality and sufficient training – updating of information and knowledge relevant to the work and community needs
	➤ Quality supervision – on-site and in-service training
	➤ Providing stipends to support clients (travel, airtime)
	➤ Resources such as modes of communication
	➤ Reporting indicators related to inter-sectoral collaboration
Strong social cohesion	➤ Strong sense of community
	➤ Nurturing of social capital to draw from
Efficient community structures (formal and informal)	➤ Extent of unity with the structures
	➤ Active and politically unaffiliated ward councillors
Support to local structures	➤ Skills , infrastructure
ISA AT MACRO LEVEL	
Integration and coordination -	➤ Effective coordination and communication between and within
	➤ Aligned management (and reporting) structures
Accountability	➤ A specific individual to hold accountable
A champion of the cause	➤ A specific individual to lead ISA processes
Sector leadership	➤ A particular sector to lead ISA efforts according to the specific endeavour.

6. Analysis

The qualitative data was translated and transcribed by the researcher. The data was subsequently analysed using Atlas.ti. A thematic content analysis was conducted to identify common themes that emerged from the key informant interviews, focus group discussions, network maps and the observations recorded by the researcher. The information was analysed

at the level of both individual CHWs/volunteers, and CHW organizations. Comparisons were made between CHWs, and between CHW organizations to identify similarities and differences.

7. Discussion of findings and Conclusion

The study supports a series of studies on CHWs that indicate that they have the potential to link marginalised communities to formal health care and other services that have an impact on the health status of households, such as access to social support, adequate housing, and services that ensure food security (Haines A, D et al. 2007; Lehmann and Sanders 2007; AKHS Kenya. Not dated). It is however also evident, from this study, that CHWs are part of the poor communities that they provide services to and therefore stand to experience the same barriers to accessing adequate and equitable services as their clients . As evidenced in Case study 3, in order for this workforce to provide effective services, it requires adequate support from community-based institutions and the government. Strong organisational support such as adequate training, supervision and remuneration, arms CHWs with the ability and confidence to ensure follow through of their services to their clients. This was often limited in the Gauteng case studies. The lack of resources such as transport and the means to communicate with other sectors (for example by telephone) in order to intervene and support their clients resulted in very little follow through. Due to this constraint, many of the CHWs' efforts to provide services were left unfulfilled. There is much to gain from CHW programmes that have strong managerial skills; including a supportive district primary health care system (van Ginneken, Lewin et al. 2010). This ensures a workforce that is able to employ multifaceted roles, such as acting as advocates for equitable services; providers of a wide range of services as required by their respective clients; and effective support structures for their communities. The CHWs in case study 3 were able to ensure that their clients not only received follow through with regards to health care services, with financial assistance and effective training, they were also able to independently make decisions regarding interventions for the clients. Highlighted by the CHWs in case study 3, the level of knowledge generated by good systematic supervision instilled a sense of empowerment which equipped them to challenge authority in the various sectors. In this way, this case study provided a wide range of services that dealt with the social determinants of health, thus aligning with the principles of CPHC.

Fragmented local government structures provided limited support to community-based organisations in the areas across all case studies, thus rendering them fragmented and offering little support to one another. Although the management structure in case study 1 managed to access and establish networks with multiple sectors, it was often a challenge to facilitate any follow through of services for their clients due to poor response from service providers. An important aspect here is that even though Case study 3's initial focus of their services was HIV/AIDS, they were able to use that single health paradigm to address other areas that have an impact on health status, hence a form of selective PHC. It is this aspect that indicates that even though selective PHC has historically received little praise in terms of its outcomes, if implemented efficiently, it can be applied as a means to ultimately achieving comprehensive PHC.

In order for the CHW programmes to provide these services within the principles of CPHC, this study indicated that strong community involvement was crucial. The CHWs in case study 3 used the support of their communities to provide support for families and children in need of care. The context in this case however provided a favourable environment to develop strong community engagement and involvement. This community has a long history of existence. This factor has contributed to maintaining relative stability, with those leaving for employment to other provinces returning to a strong sense of community. As supported by other studies, a community with strong social cohesion is able to mobilise and engage collectively with regards to its needs and requirements as it reinforces effective social networks and social capital (Berkman 2000; Galabuzi and Teelucksingh 2010). The CHWs in the Gauteng province functioned in communities that were mostly made up of a combination of internal and external immigrants, where a sense of distrust, varying priorities and lack of collective needs and requirements made it a difficult environment to mobilise and engage community members. As illustrated by these case studies (1 and 2), in poor communities with more immediate priorities such as the need for food security, adequate shelter and employment, collective involvement and participation has proven to be a challenge. It highlights a common feature in South Africa where vulnerable communities have sparse social resources to draw on in order to oversee their own livelihood and health (Pronyk, Harpham et al. 2008). It is this aspect that raises the question as to whether in order for governments to implement CPHC interventions, it is necessary for these interventions to incorporate elements of community development mechanisms which assist poor communities to develop social capital. In other words, local government structures need to not only focus

on implementing community-based interventions, but also need to focus on providing social support that enables communities to focus not only on immediate needs but other overarching needs that have an impact on the collective wellbeing of the community.

Having to function within a community with a dearth of social networks, lack of social capital and therefore poor community participation, CHWs in the Gauteng case studies facilitated very poor ISA and therefore could provide a limited range of services. The community participation structures that were ideally meant to be utilised to facilitate this component were weak, with conflicting priorities and weak leadership. This was exacerbated by a local government structures that found it difficult to translate inter-sectoral collaboration at local level. A similar challenge was experienced at the higher levels of government, which often functioned in silos. Government structures across all levels in both Gauteng and Eastern Cape provinces with very few individuals to hold accountable, provided an unfavourable environment to ensure effective and quality services. However, it was interesting to observe how even though with a similar challenge the Eastern Cape case study, its strong organisational leadership and financial support enabled the CHWs to function outside the poor local government context. In fact, it was further evidence that a bottom-up model, where strong local level initiatives are self-sufficient and independent, ensure sustainability as they are not affected by the political context of the present government (Public Health Agency of Canada. 2007).

Community health worker programmes have been part of the effort to provide comprehensive PHC services over many years. Many have provided evidence to indicate that they have the grassroots legitimacy and knowledge to ensure that marginalised communities access to formal services from multiple sectors. This study highlights the fact that CHWs have the potential to be an effective vehicle to ensuring that developing countries address the social determinants of health by linking communities to multiple sectors. Their effective contribution to this endeavour can however be determined by a variety of factors: A supportive environment where there is strong managerial support from the community –based organisations; an integrated district health care system that is able to translate inter-sectoral action from all levels of government; a community that has strong social capital such that it is self-sufficient and is able to mobilise and oversee its own livelihoods by holding those in authority accountable in providing effective services. An overarching factor that can contribute to effective community-based initiatives and a strong CHW workforce is a

government that recognises and provides support with regards to building effective social capital within poor communities.

7.1 Lessons learned

In summary, the study has highlighted the following lessons, which contribute to the body of literature related to primary health care and CHWs.

- Vulnerable communities that often experience a range of needs that have an impact on health status have much to gain from inter-sectoral action.
- Integrated government structures or ‘joined-up’ government enables the translation of inter-sectoral action and/or collaboration across all levels.
- Strong organisational support of CHWs generates empowered, self-sufficient CHWs who are able to provide a wide range of services in line with the principles of CPHC.
- Effective CPHC requires strong local level organisation and effective government leadership, particularly within the district health system.

8. Strengths and weaknesses of study design and research instruments

8.1 Strengths of the research design and research instruments

In order for one to understand the dynamics and nuances of community health worker programs the provision of services, it was important for the researcher to use a method which allows one to describe and explore those nuances in a concentrated entity so as to understand a particular phenomenon. Part of the study was to understand the process of implementing the CHW policy as a means to providing CPHC. It is for this reason that the case study method was employed. The method allowed the researcher to explore and learn about the stories and experiences of the participants in the selected case studies. It allowed the researcher to identify the uniqueness in each case study and thus to understand why comparatively one case study was able to provide particular services and why another could not. Pertinently so, Stake (1995) adds that the main importance of a case study is to learn and this method provided that opportunity. The case study design ultimately allowed the researcher to access the depth of the issues that are involved in the experiences of CHWs and NGOs.

Due the multiple methods of data collection, all the instruments built on the data obtained from another research instrument. For instance, certain aspects that emerged during the participant observations were able to be incorporated into the semi-structured interviews and thus be explored in more depth. The use of multiple qualitative research instruments allowed the researcher to obtain rich data.

8.2 The weaknesses of the study design and the research instruments

Due to the nature of the participant observations, the method does not take into cognisance the possibility of unexpected incidences during the observations, which may have ethical implications. For instance, even though the patients that were to be visited were informed about the study and gave consent prior to the researcher's visit, during the day of the visit there would be other family members and sometimes neighbours in the home, rendering it difficult to continue with the observation due to confidentiality aspects.

9. Discussion of KTE

9.1 Triad experiences

Working within a triad has led to various experiences that have mostly added value to a relationship the group aim to sustain. The experiences are based on the questions posed in the African Team's March 2011 workshop:

- Although the triad was not able to meet physically on a regular basis due to distance and time, we maintained regular communication regarding the development of the protocol and the data collection process. The involvement of the research user in the selection of case studies ensured regular communication.
- The distance between the research user and the researcher and mentor made it difficult to generate regular face-to-face discussions regarding the research. The experience of meeting at the workshops provided us the opportunity to generate those discussions and provided an opportunity for all partners in the triad to contribute meaningfully to the research process.

The researcher/research-user partnership brought forth benefits in preparing the research protocol. The researcher-user has richer knowledge of the contextual issues within government, particularly at district level, where most of the study focussed on. The research-user was able to guide the data collection process as she was able to anticipate the barriers that the researcher would encounter. Often a challenge for researchers, the research-user was able to create better access to government authorities in relation to receiving permission to conduct the research. The research-user also expressed gaining value from the relationship in that she was provided the opportunity to learn the processes of research from the beginning stages right through to the completion of the research including how to analyse the data and interpret the findings. The relationship has therefore strengthened the capacity of local government to use research in a manner that will influence their policies with regards to the services they provide.

Working within a triad has also certainly led to a strengthening of a relationship between our research institution and local government through the research user. For instance, due to the triad, we have managed to establish a district level research project. The project was based on the need by the research user, in her capacity as a district manager to obtain information with regards to a chronic service that is being piloted by her district, called the Kgatelopele programme. A programme that uses CHWs to deliver treatment and monitor long-term chronic patients, the research user needed to evaluate the performance of the services, so as to roll it out to other areas. The project has ensured multiple benefits. It ensured capacity development by involving one of CHP's interns to be the project manager of the project and it provided the research user with useful information from the data. The overall benefit of the project was the establishment of a relationship that will ensure future research work in the same district.

- Due to the research-user's position within government at district level, the triad envisages an opportunity to disseminate the findings of the study through a wide range of government forums which will reach government representatives that have influence at policy decision making processes.
- From the overall experience of working in a triad, the group would use an identical type of arrangement for future research projects. Where it is often a challenge to ensure effective uptake of research by government, this arrangement provides an opportunity for greater collaboration and communication between researchers and government entities.

9.2 Outcome mapping exercise

The outcome mapping exercise enabled the triad to identify some of the partners that would be suitable to involve in the activities relating to CPHC. Subsequent to this exercise, the triad has managed to work at district level and at community level through community-based organisations through the aforementioned chronic care treatment programme. Two other partners have been identified as key to ISA through collaborative partnerships; the province and local government structures such as ward committees. These structures will be involved in the process of research dissemination after the research project has been completed.

9.3 Other dissemination activities and engagement of research users

The dissemination of preliminary results of the research are already underway:

- The study, focussing on inter-sectoral action was presented at the PHASA conference on 29th November – 1st December 2010: A poster presentation of: *“Community Health Workers’ implementation of Comprehensive Primary Health Care through Inter-sectoral action: Is it a pipedream?”*
- It was also presented at Global Symposium on Health Systems Research, Montreux, November 2010; *“The role of community health workers in Inter-sectoral Action”*

Engagement with the triad’s research user has continued and has led to the establishment of a research project, as indicated in section 9.1. The research-user also continues to provide the researcher with information on upcoming government conferences and/or workshops which we consider to be pertinent forums to present the study.

9.4 Indication of any uptake of findings

It is anticipated that this will only be evident once the study is disseminated at a large scale particularly at government forums that are will be conducted during the course of this year.

10. Reflections on the capacity enhancement aspects of the project

The training workshops provided by Teasdale- Corti advanced the research project. The first workshop on research methods contributed to the research design of the study and the literature that was distributed assisted to advance the knowledge of the team with regards to CPHC. The second workshop enabled the researcher to work with the rest of the triad with regards to exploring the data and the analysis of the data.

The overall research study has contributed to the capacity development of the researcher. The project consisted of various components of research that are required as part of the learning process of a researcher. The researcher developed her own research instruments, conducted the data collection, analysed the data and is now in the process of completing a thesis as part of her doctorates. Overall support has been provided by the research mentor. The mentor also guided the process of establishing a research project with the research user.

11. Summary

The overall study which explores the extent to which CHWs in Gauteng province in South Africa contribute to CPHC has led to an in-depth understanding of the CPHC and its principles. Considering that South Africa is in the process of revitalizing primary health care, this study has been completed at a time when the policy context is amenable to research that has the potential to inform policy regarding CPHC. The study is therefore of value currently as it can contribute to the current discourse regarding CHWs and PHC.

12. Future plans

The key theme from the study is inter-sectoral action. It has been recognised as a key area of work for the researcher research unit. The researcher will be submitting a proposal in response to a call later in the year that relates to this area of work. The researcher anticipates the establishment of other research studies that will emerge through the questions that have been posed by the study and require further examining.

The researcher will also publish papers to identified journals as part of the dissemination process.

13. APPENDICES

The research instruments, including consent form and information sheets have been attached as separate folders and sent to the African team coordinator Nikki Schaay at the University of the Western Cape.

14. SOURCES OF SUPPORT:

1. Subsequent to Teasdale-Corti, the researcher has been able to secure other sources of financial support, in an effort to complete the writing of the thesis. The following funders provided the researcher with the awards:
 - Carnegie (Wits) – awarded the researcher 5 months of funding to complete the thesis in 2010
 - The African Doctoral Dissertation Research Fellowship (ADDRF) – provided 2 months of funding for the completion of the thesis in 2010
 - The researcher has currently been awarded 6-8 months of funding in 2011 by the National Research Foundations (NRF), South Africa.
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