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Edited by

Alistair McGuire

Professor of Health Economics, LSE, UK

Joan Costa-Font

Reader in Political Economy, LSE, UK

LSE Health

2 Strengthening community participation in primary health care: experiences from South Africa
Andrew Gibbs and Catherine Campbell

1. INTRODUCTION

The thirtieth anniversary of the Alma-Ata Declaration (WHO, 1978) generated renewed interest in the role of primary health care (PHC) in achieving universal health and reducing health inequalities (Chan, 2008; McCoy et al., 2008; WHO, 2008). However, profound challenges remain in implementing this approach, particularly in poor countries, which experience the poorest health outcomes and face numerous challenges in delivering health services. This has led to growing calls to analyse the barriers that need tackling to implement PHC more effectively to achieve Alma-Ata's goals.

In this chapter we use a case study to focus on a central pillar of PHC – the participation of communities in efforts to improve their health. This aspect of PHC has typically been poorly implemented (Lawn et al., 2008). Yet without proper community involvement, programmes have little chance of succeeding (Campbell, 2003). This case study emerges from the authors' three-year involvement in documenting the efforts of a university-based NGO (HIVAN) to support the Entabeni Project in KwaZulu-Natal, South Africa – a project seeking to strengthen the work of health volunteers providing home-based care for people living with HIV/AIDS (PLWHA), as well as providing health advice to AIDS-affected households in a remote rural area.

HIVAN was invited to work in partnership with the volunteers after undertaking research into community responses to AIDS in Entabeni. The research highlighted the existence of the volunteers, as well as the difficulties they faced. HIVAN's role was one of external change agent (ECA) – helping the community to access the training and support they needed to operate more effectively. In the Entabeni Project 'community participation' was understood in terms of strengthening the participation of this group of volunteers in local HIV/AIDS management. The volunteers' work constituted a 'bottom-up' project, initiated and staffed by local people (mostly unemployed and poorly educated women) in response to the desperate suffering of people dying of AIDS, often with little or no access to any formal health care. These health volunteers were referred to as 'community health workers' in line with international trends (Campbell and Scott, 2011).

The project sought to improve the level and quality of community participation in the delivery of health care, to improve the reach and quality of PHC services in the community and to form the basis for a wider social development agenda. These two aims were actioned via three goals: (i) training the volunteers to improve the care they provided; (ii) helping volunteers to mobilise greater community support for their work; and (iii) building external support for the volunteers.

This chapter provides an overview of the achievements and challenges the project

faced to generate debate about challenges in implementing community participation and highlighting possible strategies to overcome these.

2.   THE ALMA-ATA DECLARATION AND COMMUNITY PARTICIPATION

In 1978, 134 countries signed the Alma-Ata Declaration, recognising the need for primary health care. Community participation was accorded a central role in realising the aims of the Declaration, which emphasised the need for 'maximum community and individual self-reliance and participation in the planning, organisation, operation and control of primary health care' (WHO, 1978, p. 2).

Alongside promoting PHC, the Declaration provided a new political approach to health, reframing health from a biomedical perspective to include an emphasis on health promotion and recognition of how social inequalities shape ill health. In reframing the causes of ill health, the Declaration also reframed solutions to include a social justice approach to health promotion, recognising that health could only be achieved through a combination of top-down interventions and local responses and the central role that PHC should play.

From a top-down perspective health promotion was broadened beyond medical interventions to include tackling social determinants of health, including 'intersectoral collaboration', based on the assumption that health could only be achieved through coordinated action of the health sector and non-health sectors.

The Declaration also emphasised the need to support local responses to ill health. For health systems, this included decentralisation from national health systems to district health systems, allowing decisions about channelling resources to be made locally and supporting a PHC agenda. Alongside this, a strong emphasis was placed on the need for communities to actively participate in responses to ill health. Such participation by communities was seen as a precondition for tackling some causes of ill health and extending the reach of PHC into hard-to-reach communities.

Since the Declaration, community health workers (CHWs) have been given a key role in achieving community participation in the delivery of PHC. The functions of CHW programmes are conceptualised in one of two ways. Their role is sometimes conceptualised as *target oriented*, working to achieve specific health outcomes through their ability to 'reach' inaccessible communities. It is sometimes conceptualised as *empowerment oriented*, viewing CHW programmes as springboards for (a) general community strengthening for prevention and health-enhancing social development; and (b) the empowerment of health vulnerable groups such as youth and women (Rifkin, 1996). Successful programmes typically rely on community embeddedness (Campbell and Scott, 2011; Bhattacharyya et al., 2001).

Since Alma-Ata various efforts to implement PHC through CHW programmes have led to great successes. In urban Mexico one CHW programme achieved universal immunisation through CHWs being able to target individual households and to provide a flexible service (Walker and Jan, 2005). Explaining how CHW programmes have improved maternal, newborn and child health, Rosato et al. (2008) emphasise CHWs' role in engaging in non-health activities such as improved economic well-being and literacy in

their communities. Despite many successful programmes, however, PHC has not been globally instituted and health inequalities continue to rise (CSDH, 2008).

The anniversary of Alma-Ata has led to global calls to 'revitalise primary health care', from politicians and civil society. Politicians view global health and social inequalities as a global security threat (*World Health Report* – WHO, 2008). Furthermore, the Millennium Development Goals – in particular Goal 4, Reduce Child Mortality; Goal 5, Improve Maternal Mortality; and Goal 6, Combat HIV/AIDS, Malaria and Other Diseases – are unlikely to be achieved without significant health system reform (Lawn et al., 2008; Chopra et al., 2009). Meanwhile civil society activists see a return to PHC as a potential pathway to social justice in the context of global health inequalities (McCoy et al., 2008).

There is currently significant international commitment to the approach advocated by the Declaration, as a result of the WHO's Commission on the Social Determinants of Health report (CSDH, 2008). The report echoes the Declaration's emphasis on the social causes of ill health and the need for community participation and empowerment, alongside intersectoral collaboration, in tackling ill health (CSDH, 2008).

3.   HOMING IN ON SOUTH AFRICA

Africa is the continent that has made the least progress in achieving health improvements since Alma-Ata (Schaay and Sanders, 2008). In South Africa health has deteriorated recently. It is one of only 12 countries globally where under-five child mortality has risen since 1990 (Coovadia et al., 2009). Life expectancy at birth in 2009 declined nearly 14 years compared to 1994; from 63 to 50 years for men and from 68 to 54 years for women (Chopra et al., 2009).

Since 1994, South Africa has placed PHC at the centre of its health policies (Barron and Roma-Reardon, 2008). The National Health Plan of 1994 emphasised the need to develop a cohesive, unified health system, based on a district-level system. The Plan removed user fees for PHC and introduced a wave of construction of PHC facilities. Recently, South Africa recommitted itself to PHC in the 2008 Birchwood Declaration, emphasising health as a human right and calling for a doubling of funding to PHC, alongside the need for better alignment between the health and non-health sectors to achieve health improvements (South African Department of Health, 2008).

Despite some successes in South Africa in relation to Alma-Ata and PHC, there is widespread recognition that there is a long way to go (Barron and Roma-Reardon, 2008). In discussions about the barriers to achieving these goals, key obstacles repeatedly emphasised are (i) HIV/AIDS and (ii) HCW shortages (Schaay and Sanders, 2008). Sub-Saharan Africa is disproportionately affected by HIV/AIDS, accounting for 67 per cent of the global AIDS burden (UNAIDS, 2008). South Africa is central to this epidemic, with an adult HIV-prevalence rate of 18.1 per cent (ages 15–49) (UNAIDS, 2008). The impact of HIV/AIDS has undermined the provision of PHC in South Africa, placing additional burdens on health care facilities (Cleary et al., 2008) and reduced the health care workforce – estimates of HIV-prevalence in this sector are 11 per cent (Connelly et al., 2007).

There is also a human resources shortage for the delivery of health. Globally it is

estimated that 57 countries have severe human resources shortages, with a deficit of 2.4 million doctors, nurses and midwives (Schaay and Sanders, 2008). Since 1994 in South Africa the number of registered professional nurses has declined from 251 to 110.4 per 100 000, while the number of doctors has remained constant at 25 per 100 000 (Lehmann, 2008). Declining numbers of health professionals (relative to population) undermine the ability of health systems to provide and expand the scope and reach of PHC.

The South African government's policy response to these crises has been to implement a CHW policy (Clarke et al., 2008). CHWs are allocated multiple roles in South Africa, from home-based care for PLWHA through to counselling people undertaking HIV tests, and adherence support for anti-retroviral medication. This has led to the implementation of a formal CHW system, alongside numerous voluntary groups providing a mixture of services. However, policy implementation has been patchy and many informal groups receive little or no support from the government (Clarke et al., 2008).

In this chapter we contribute to generating debate on PHC implementation through a case study of a project that sought to focus on one aspect of the Alma-Ata Declaration that has been identified as particularly poorly implemented – community participation (Lawn et al., 2008). Recognising that community participation is crucial for achieving PHC (WHO, 1978), for tackling HIV/AIDS (Campbell, 2003) and for addressing the health worker shortage (Schaay and Sanders, 2008), but acknowledging that it is incredibly difficult to achieve, we seek to advance understandings of barriers and opportunities to meaningful participation.

4. CASE STUDY: ENTABENI PROJECT

Entabeni is a remote rural community in KwaZulu-Natal Province in South Africa. Thirty kilometres from the nearest hospital and urban centre, residents make a living either through smallholder farming or migrating to urban centres. About 35 per cent of pregnant women are HIV-positive (Barron et al., 2006). The community is governed through two overlapping forms of authority, the local elected municipality and the *Inkosi* (traditional chief) who inherited his role.

The Entabeni Project was a community-led project seeking to increase the accessibility and quality of home-based care for PLWHA through promoting community participation. The Project emerged after research into community responses to HIV in Entabeni, by the Centre for HIV/AIDS Networking (HIVAN), identified the CHWs' provision of home-based care as a mainstay of the HIV response in Entabeni. The CHWs would walk many kilometres to provide basic care to PLWHA. They would assist families with tasks such as bathing and caring for dying patients, and advise them on accessing health and welfare services and grants. At times they would push patients in wheelbarrows to local roads to get them to clinics (Campbell et al., 2008).

HIVAN organised research feedback sessions to groups in Entabeni, including women, church leaders, local ward leaders, school learners, traditional healers, out-of-school young people, teachers, members of a sewing group, and a local development group (Campbell et al., 2012). Research was also fed back to the area's *Inkosi*. The outcome of these sessions was that HIVAN was asked to work with the CHWs to strengthen their efforts (Campbell et al., 2012). Over three years, HIVAN raised funding

to support the Project's work, and a senior HIVAN researcher with 20 years of community development work experience took on the role of external change agent (ECA) (Nair and Campbell, 2008). The ECA's role was to assist the volunteers in accessing the training and support they needed to maximise the effectiveness of their work, and to advise on project management. Over the three years the ECA aimed to transfer full responsibility for the enhanced Project to the CHWs, supported by external public sector and NGO agencies.

The Project's central goal was to improve the quality of community participation in the spirit of the Alma-Ata Declaration (WHO, 1978), as well as the South African government's National Strategic Plan on HIV (South African Department of Health, 2007). Through strengthening the role of the CHWs, the Project sought to achieve both 'target-oriented' objectives such as improving people's access to care and support, particularly those living with HIV/AIDS, and 'empowerment-oriented' objectives. The latter were to be achieved through using the CHWs as a springboard for general community development, and advancing the empowerment of vulnerable groups such as youth and women (Rifkin, 1996). In order to achieve these, three goals were identified: (1) skills development and confidence building of CHWs; (2) building local community support for the CHWs; and (3) building external support for the CHWs.

Various aspects of the Project have already been written up (Campbell et al., 2007, 2008, 2009a, 2009b, 2012; Campbell, 2010). In this chapter, we draw on this material to discuss the Project's successes and challenges in achieving each of the three goals outlined above. We use this as a basis for a discussion of the barriers and facilitators to strengthening community participation in the provision of PHC, and of potential lessons for future participatory programmes.

Goal 1: Building Skills and Confidence of CHWs

The Project's goal of training CHWs in providing AIDS-related care was relatively easy to achieve and very successful (Campbell et al., 2009a). The CHWs were highly motivated, seizing any opportunity to improve their skills. The ECA linked this previously isolated and network-poor group to numerous external organisations willing to provide training. Training included: home nursing skills to optimise the care and comfort of those with AIDS-related illnesses in the absence of formal medical support; how to implement peer education for increased HIV awareness among young people; how best to support people in gaining access to social grants; and skills in financial management and leadership of small projects.

Such training dramatically improved the standard of care for PLWHA. It also inspired and motivated some of the CHWs to take control of aspects of the Project, including staffing an outreach centre that provided counselling services and information on accessing social grants. In addition, some CHWs also took it upon themselves to provide training on HIV/AIDS to school children.

In spite of CHWs taking control of limited Project activities, they did not progress to participating actively in overall project management and decision making. Leadership of the Project and CHW group remained tightly in the hands of an older man – Mr M – who had been integral to setting up the group. Even after three years, and despite many interventions by the ECA to challenge Mr M's dominance, the CHWs (mostly women)

remained nervous of challenging the leadership of Mr M (an older man, supported by the *Inkosi*).

Goal 2: Building Internal Community Support for CHWs

HIVAN's research on community responses identified a key barrier to the effectiveness of the CHWs as the limited support they received from key grassroots community groups within Entabeni (Campbell et al., 2008). The Project worked extensively to develop internal community support for the CHWs among key leaders in Entabeni (including both church leaders and the *Inkosi*) and two other groups, young people and men.

As a group, church leaders were important to involve given their large following in Entabeni, particularly among women who made up the majority of their congregation and the majority of CHWs. They were initially reluctant to become engaged in the Project, often framing HIV/AIDS as a form of divine retribution, and were unwilling to allow the CHWs to talk about condoms or AIDS explicitly in church (Campbell et al., 2007; Campbell et al., 2005).

To develop support from church leaders, the Project ECA arranged a series of training sessions for them, during which they discussed HIV/AIDS. These were particularly successful and over time church leaders became highly supportive of the CHWs, allowing discussions about HIV in church services and inviting the AIDS trainer back repeatedly to talk about HIV to their congregations.

The other key leader in Entabeni was the *Inkosi* (traditional chief), who ruled the community. The supreme community gatekeeper, it was he who allowed HIVAN to conduct research and later to work with the CHWs. He tended to keep a distance from the Project, but occasionally referred positively to the CHWs' work at high-profile community events, giving an important boost to their status.

However, his autocratic patriarchal leadership style, favouring the authority of older men, was at variance with the Project's goal of using the CHWs' growing confidence in their health skills as the starting point for their increased participation in local leadership and decision making (Campbell, 2010). Furthermore, the *Inkosi* was a strong advocate of polygamy and very opposed to the use of condoms by his subjects – ideas that ran contrary to those the CHWs were promoting.

The Project also looked to engage two key local constituencies, men and young people. Neither group was represented among the volunteers, who were typically middle-aged women. Mobilising men was seen as crucial given their dominance in the public and private domains. Husbands and boyfriends often complained that their wife's or girlfriend's involvement in the Project was a waste of time, and threatened to stop it. Additionally, given that polygamy or having multiple girlfriends was widespread among men, women felt very vulnerable to HIV but unable to negotiate condom use in the face of reluctant partners. The Project struggled to get men to attend specific AIDS awareness training events. However, those men that became actively involved tended to be those who managed to secure the Project's limited number of paid leadership positions. Given that most CHWs were women, and a central aim had been to provide these women with opportunities for leadership, this was ironic.

The second group the Project attempted to involve were young people. Given the high levels of unemployment and limited opportunities in Entabeni, project involvement had

originally been seen as an ideal opportunity for advancing young people's skills and employability. Yet despite many young people expressing interest, only five became active participants, the rest leaving shortly after receiving training to look for jobs in local towns (Gibbs et al., 2010).

Overall the Project's aim of developing support for the CHWs from within the community met with mixed success. There was some support from church leaders. While the *Inkosi* allowed the CHWs to do their work, his leadership style contradicted the project ethos. In addition two key groups – men and young people – failed to become meaningfully involved in the work of the CHWs despite many efforts to recruit them.

Goal 3: Building External Support for CHWs

Successful CHW programmes require external organisations to play a significant role in supporting, managing and providing materials (Campbell and Scott, 2011). As such, the Project worked extensively to strengthen links between the CHWs and public sector agencies (Department of Health, Municipality and Department of Welfare) and two NGOs (a missionary NGO and a counselling NGO). HIVAN's initial research highlighted only very limited and sporadic support for the work of the CHWs from external organisations. The rural nature of the community – 30 kilometres from the nearest town – meant that access was difficult. Additionally, Entabeni straddled bureaucratic borders, and community residents often struggled from one government office to the next after being told that they did not fall into that office's area of concern. Despite these difficulties, all external partners approached by the ECA in the early stages of the Project expressed a willingness to support the Project's work (Nair and Campbell, 2008).

In South Africa the Department of Health is formally responsible for managing and supporting CHWs, although in practice such support is often minimal. The ECA worked long and hard to get the regional DoH to action their formal responsibilities to the CHWs. Of particular importance was a nurse, based at the Entabeni Primary Care Clinic, who was directly responsible for providing day-to-day support to CHWs in her clinic's catchment. The nurse was overworked, however, providing support to many different CHWs groups over a large area, and lacked specific training in community liaison to enable her to work effectively. The nurse's main input to the Project was organising occasional training for the CHWs. Despite providing little support, the nurse required the CHWs to provide written reports on their work – incredibly difficult given that many CHWs were barely literate – and instead of giving feedback on what they had written, the nurse simply filed them for 'future reference'.

The Department of Health paid a small stipend for Mr M, the leader of the CHWs, via the District Health Office. The HIVAN ECA encouraged Mr M to visit the Office and discuss problems the group was facing to see what additional support they could provide. When Mr M reached the Office the staff member he spoke to was shocked that a CHW had approached her directly, rather than using the formal communication channels. She refused to discuss problems, saying that he was wasting the Department's money by being away from his work and threatened to 'dock' his pay for 'wasting' a day.

In meetings with the ECA, officials from the District Health Office acknowledged that the CHWs were eligible for home-based care kits and, importantly, stipends. Given the

hard work the CHWs did for no pay, in conditions of extreme poverty, a small stipend would have been highly welcome. This promised stipend failed to materialise, however. For two years, HIVAN raised international funding for a nominal stipend, hoping that a sustainable stipend would eventually be made available from the District Health Office, but this was not to be. The uncertainty and disappointment around the ECA's failure to secure stipends led to much disillusionment among the CHWs, some of whom left in frustration.

In its early stages, the Department of Welfare was also keen to become involved in the Project, seeing it as an opportunity to extend the reach of its social grants to a previously remote and inaccessible community. HIVAN's early research had pointed to the difficulties many community members experienced in accessing these grants (Campbell et al., 2008). A senior manager at the Department of Welfare promised support for the Project, and promised to instruct the area's formally designated social worker to visit the community to advise people on grants. However, this promise did not materialise. When the ECA visited him at his office in a town some distance from Entabeni, he said he was doing several people's work due to staff shortages, and lacked the capacity to support people in such a remote place.

The final government organisation the Project approached was the local municipality, which is formally charged with supporting the extension of health and social development services into under-served areas. A senior official at the municipality was very supportive of the Project in principle, seeing it as a possible 'pilot scheme' fitting closely into his work at the municipality. His initial enthusiasm soon dissipated. Attempts to reach him by phone were deflected by his secretary, saying that he was 'drowning in work'.

Alongside formal government structures, a range of small-scale NGOs operated in and around Entabeni. Two NGOs, a missionary NGO and a NGO that specialised in providing counselling, provided much support to the Project.

The missionary NGO was effectively a single person who coordinated a group of local people setting up a crèche, vegetable gardens and craft projects. The missionary emphasised that her work needed to be located in the community and worked incredibly slowly to ensure that the people she worked with had ownership of activities. From the beginning of the Project, she committed herself to becoming involved, and provided small sums of financial support and significant advice. However, she was constantly under financial pressure and limited by her inability to speak the local language fluently.

The other NGO that became involved was a local branch of a national NGO specialising in counselling. The Director saw the Project as an opportunity to expand her organisation's reach into a remote area previously out of her reach. She participated actively in the Project, listening carefully during meetings and providing resources to support activities. Her NGO provided CHW training of various sorts, and supported the setting up of an 'outreach centre' to provide a base for the CHWs. However, this NGO is poorly funded. At various stages it was unable to get to Entabeni because of a lack of funds to transport its staff.

As the descriptive account of the Entabeni Project has made clear, over the three years it was very successful in achieving Goal 1 – providing training and building the confidence of the CHWs. But its efforts to build internal and external support for the CHWs – Goals 2 and 3 – had more mixed results.

5.   ANALYTICAL DISCUSSION

In this section we provide an analytical discussion of how successes and weaknesses in achieving each of the goals has supported or undermined the Project's 'target-oriented' and 'empowerment-oriented' objectives.

Goal 1: Building Skills and Confidence of CHWs

As discussed above, the Project was very successful in achieving its 'target-oriented' objectives, namely developing the skills of the CHWs. However, the CHWs never played a significant role in the Project's leadership, undermining the Project's empowerment objectives. The major barrier was Mr M, the group's leader, as well as the reluctance of the CHWs to challenge him, despite their frustration with the quality and style of his leadership of their volunteer team. Mr M continued to dominate the CHW group after three years, despite extensive efforts from HIVAN's ECA to encourage him to delegate some of his authority to the female CHWs, and to develop a more democratic leadership style. CHWs remained fearful of him, unwilling to challenge his authority, and Mr M appointed men to the small number of paid leadership positions that were available (Campbell et al., 2009b).

Goal 2: Building Internal Community Support for the CHWs

Throughout the Project a central goal was to build active support for the CHWs from within the community. While there was some passive acknowledgement of their worth from some quarters, this seldom translated into active support for their work. A central reason for limited community support was the Project's failure to mobilise the involvement of men and young people. Three forms of stigma undermined their participation: the continued stigmatisation of AIDS, which the Project failed to seriously challenge; the stigmatisation of caring, which was dismissed as women's work; and the stigmatisation of volunteering. In relation to the last, men and young people often laughed at female volunteers who would 'work for nothing', saying that there was no dignity in unpaid work. Given the Project's inability to secure a sustainable stipend, there was little that could be done to challenge the perception that caregiving and volunteering were insignificant activities (Campbell and Cornish, 2010).

   The Project also failed to resonate with what young people wanted out of life. Research seeking to understand the disappointing levels of youth participation in the Project suggested that young people looked forward to a future of paid work in the urban areas rather than conducting unpaid and arduous work in a remote rural community (Gibbs et al., 2010). In addition, whilst the 'target-oriented' aspects of the Project got some support from the *Inkosi*, both through his allowing the project to happen and through his praise for the CHWs' work in public speeches, his authoritarian and patriarchal style was at variance with the Project's 'empowerment-oriented' dimensions.

Goal 3: Building External Support for CHWs

The ECA devoted a substantial proportion of time to developing external support for the CHWs, both from public sector agencies formally charged with supporting Entabeni,

and from relevant NGOs. Overall, the public sector failed to provide the support that was envisaged. Two small NGOs were the Project's main external support.

The public sector representatives the Project worked with were typically overworked, demoralised by the sheer size of the problems they were tackling, and lacked the specific skills and motivation needed to support community participation. Bureaucratic structures remained rigid and top-down, unable to respond to requests from CHWs. This meant that CHWs did not receive regular health care supplies from the government, or close management and supervision from primary health care nurses – limiting their ability to deliver services.

The NGOs were better able to provide the close support that was needed to support the CHWs' role in community participation. Small and under-funded, they were not burdened by bureaucracy or excessive workloads, and were often able to be instantly responsive to the CHWs' needs.

The Project's ECA – an experienced and well-networked social worker employed by HIVAN – played a key role in efforts to broker relationships both within the community and external to the community. She also provided a strong focal point for project activities and put great time and effort into supporting and motivating the CHWs, and worked tirelessly in driving forward every aspect of the Project. In a community that placed little emphasis on the role of women, she was often placed in conflict with men who wielded significant authority, however. Furthermore, as an NGO employee on a three-year contract, she lacked the institutional leverage and clout to press public sector agencies to deliver on their verbal commitments to supporting the CHWs.

Finally, despite numerous promises by the Department of Health to provide stipends, these never materialised. The lack of stipends limited the Project's ability to engage men and young people, and caused great distress and disillusionment among the volunteers.

6.   ACTIONABLE LESSONS FROM THE CASE STUDY

We have provided a case study of the immensity of the challenges facing those seeking to strengthen community participation in health care in Entabeni. The Project was very successful in its 'target-oriented' objective of delivering services in a remote, rural area. Yet it struggled to develop the role of CHWs beyond that of simply being 'an extra pair of hands' providing often unpaid services in the context of an overburdened formal health sector (Walt, 1990). The Project failed to achieve its 'empowerment-oriented' objectives of using involvement in HIV/AIDS work as a springboard for the wider social development of female participants. The case study provides us with space to reflect on what can be learnt for actionable 'good practice' in strengthening community participation and what are some 'additional lessons learnt' that need to be taken into account.

Good Practice Demonstrated by the Entabeni Project

The Project provides concrete examples of how projects supporting CHWs can be successful, particularly in achieving 'target-oriented' objectives.

Active involvement of community members in project design, inception and running
Successful CHW projects need to be embedded in communities (Campbell and Scott, 2011). The Entabeni Project was conceptualised and run as a community-led project, with a central role played by local residents in shaping and determining the direction of the Project. Whilst the ECA was heavily involved in all aspects of the Project, she saw her role as one of facilitating volunteer empowerment to strengthen their work and eventually take control of the project – rather than having any stake in exercising any control over project activities in her own right.

Training for CHWs was both medically and socially oriented
The training provided by the Project responded directly to requests from the CHWs. This included home nursing skills (e.g. dealing with bedsores), psychological counselling skills, peer education skills, project management skills and so on. As such, this work was consistent with the Alma-Ata focus on the need to combine a wide range of skills building that goes beyond narrowly conceived physical care.

External change agents (ECAs) are crucial for mobilising support in marginalised communities
The Project also demonstrated the important role an ECA needs to play in mobilising and implementing CHW programmes in marginalised communities. Given the barriers such programmes face, a strong ECA, working to facilitate rather than impose a programme strengthening community participation, opens up opportunities for the brokering of relationships and development of networks that CHWs themselves could not have developed without significant outside support.

Outstanding Challenges

While the Project was successful in its 'targeted-oriented' objectives, it was much less successful in its 'empowerment-oriented' objectives. Of particular importance was the Project's inability to develop intersectoral collaborations between the CHWs and groups internal and external to Entabeni. Given the value placed on intersectoral collaboration in achieving health goals and strengthening community participation (UNAIDS, 2008; South African Department of Health, 2007), this case study provides a series of lessons for similar projects.

Payment of CHWs
A key barrier to project progress was the lack of stipends for the CHWs. Ensuring sustainable and meaningful payment for CHWs is necessary for programme success (Campbell and Scott, 2011). Payments increase retention, and build recognition among community members of the valuable work of CHWs in delivering health services. Furthermore, the promise of payment is likely to draw in a wider range of local groups – particularly men and young people – into projects.

Strong public sector support for CHWs
A key factor identified in ensuring successful CHW programmes is strong public sector support for CHWs (Campbell and Scott, 2011). However, this can only occur when there

are adequate staff in public sector organisations, who have the time, skills, motivation and responsibility for providing this. The Project was crucially hampered by the weak support for the CHWs from the regional health and welfare agencies formally charged with supporting health and social development in Entabeni.

Provide training to public sector employees in community participation
Formal health and social development policy allocates public sector employees an increasing role in facilitating community participation in the delivery of health services. However, as the Entabeni Project has shown, they often lack the necessary training to play this role. Public sector employees therefore need specific training and skills to develop this new area of competence.

Ensure public sector management buy-in
Despite public sector management recognition of the need for greater involvement of communities in service delivery in the Project, incentive structures were not in place to support those charged with implementing this. Management needs to ensure that there are incentives – such as performance measures and job descriptions – that encourage public sector employees to engage in supporting communities.

Greater focus on human resource constraints outside the health sector
While there is significant focus on the human resource crisis in the health sector, there needs to be a similar focus on how human resource constraints in other public sector organisations undermine the types of intersectoral collaboration and support CHWs; their programmes would need to make an optimal contribution to tackling health inequalities.

Programmes wanting to achieve both 'target-oriented' and 'empowerment-oriented' outcomes need to be long term
The Entabeni Project was conceptualised as a three-year project. However, as became increasingly apparent, the challenge of building local capacity through which marginalised women can begin to resist, or at least ameliorate the impacts of, long-term social and economic inequalities cannot be met in three years. Strengthening community participation to achieve 'empowerment-oriented' project outcomes is a long-term process requiring considerable investment from external organisations and ECAs.

7.   CONCLUSION

The failure of health systems to tackle health disparities and the emergence of new issues such as HIV/AIDS and the lack of human resources for health have led to resurgent interest in the Alma-Ata Declaration. Not only does it offer a strong framework for understanding ill health, including recognition of the social determinants of health, but it also outlines a strategy for achieving this, emphasising the need for PHC, closely linked into community participation and intersectoral collaboration.

   Effective PHC can only be achieved with substantial community participation. After Alma-Ata, community participation became formalised through CHW programmes,

with two objectives – targeted-oriented objectives and empowerment-oriented objectives (Rifkin, 1996). Our case study project sought to achieve both these objectives through strengthening community participation. In reporting on the experiences of the Entabeni Project, we have sought to generate debate about the complexity of achieving such objectives. Whilst the Project was highly successful at achieving its target-oriented objectives of improving the access to and quality of care provided by the CHWs, it was much less successful at achieving its wider empowerment objectives.

We conclude by suggesting that strengthening community participation to achieve both objectives requires the development of incentives to engage in and/or support community participation, drawn from our discussion above. The framework of incentives needed to strengthen community participation can be summarised as follows:

1. *Incentives to motivate CHWs and build their skills, confidence and sustainability*   Incentives need to include payment of CHWs. Payments recognise the value of care work, provide validation for those involved and encourage greater participation from men and young people. Additionally there needs to be socially and medically oriented training, developing CHWs' skills and confidence to provide the care they do effectively in community settings.
2. *Incentives to build greater support for CHWs from groups internal to a community*   As mentioned above, payments for CHWs provide clear recognition of the valuable work CHWs provide and also challenges the idea of care work and women's work as having little value. Incentives also need to be responsive to what young people want to achieve out of life, and to tailor opportunities for participation accordingly.
3. *Incentives to develop greater external organisation support for CHWs*   Managers of potential support organisations external to communities, especially in public sector agencies, need to ensure that incentives support the greater involvement of their staff. These need to include the writing of community outreach and volunteer and PHC support activities into public officials' job descriptions. It also needs to be ensured that public officials receive appropriate training and the necessary authority and time to become actively involved in supporting community projects.

We hope that we have demonstrated the need to focus considerably more attention on the identification and provision of appropriate incentives for the effective participation of the three groups mentioned above: community volunteers; potential within-community support networks; and potential external support networks, particularly in the public sector. Without greater community participation, the aims of the Alma-Ata Declaration are unlikely to be realised, and the development of appropriate incentives is a vital precondition for ensuring that opportunities for such participation are optimised.

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