THE ROLE OF SOCIAL CAPITAL AND NETWORKS IN THE INTEGRATION AND IMPLEMENTATION OF HEALTH AND HUMAN RIGHTS PROGRAMMES AMONGST CIVIL SOCIETY ORGANIZATIONS IN CAPE TOWN SOUTH AFRICA

WENDY M NEFDT

Thesis Presented for the Degree of

DOCTOR OF PHILOSOPHY

Health Sciences Faculty

Department Public Health

UNIVERSITY OF CAPE TOWN

Declaration

I Wendy Muriel Nefdt hereby declare that the work on which this thesis ls based is my original work and that neither the whole work nor any part of it has has been, is being, or is to be submitted for another degree in this or any other University to reproduce for the purpose of research either the whole or any portion of the contents in any manner whatsoever. I authorize the University to reproduce for the purpose of research either the whole or any other portion of the contents in any other manner whatsoever.

Signature

Date: 03 August 2023

ABSTRACT

Civil society organisations are lauded as being key stakeholders for the promotion of health and human rights in society. They are well positioned to engage with communities to address growing inequalities such access to health care, increasing violation of health and human rights, poverty and unemployment in communities. In order to build agency for the attainment of the highest attainable standard of health conducive to living a life in dignity, civil society organizations are encouraged to work in collaboration with each other and with health system decision makers in the development of rights-based policies and programmes.

The research study was located within a Learning Network for Health and Human Rights in the Faculty of Social Sciences at the University of Cape Town. The Learning Network is an ensemble of various civil society organizations and academic partners, conceptualized for the purpose of building agency amongst civil society organizations to realize health and human rights programmes. The research study explored the role of social capital and social networks as vehicles for building agency within civil society organisations. The study questioned whether and how the agency that was developed through participation in the Learning Network co-learning and co-research activities, enabled civil society organizations to integrate and implement health and human rights programmes in communities.

Through a process of qualitative case study methodologies using Semi-Structured Interviews with 13 participants, Focus Group Discussions with three groups of civil society beneficiaries and an extensive Documentary Analysis of the Learning Network documents over the period 2010-2017, the findings of the study show that social capital developed through the Learning Network for Health and Human Rights built agency for action amongst its members. The qualitative methodology of Participatory Action Research utilized in the Learning Network , provided an enabling platform for reflection and review of the activities and relationships in the group. Aspects of social capital such as trust amongst the members were addressed within this enabling platform.

.

The participation in co-learning and co-research activities within the Learning Network resulted in the development of social capital amongst the Learning Network members. Close-knit ties were formed in the process and cohesion within the group was solidified. Through reciprocity, the Learning Network members developed a sense of trust and collaborative efforts strengthened the bonding and bridging relationships amongst the members. The development of close-knit ties often results in the formation of a cohesive and collective identity.

Social cohesion promotes civic- mindedness and a sense of collective consciousness. Collective consciousness results in collective outcomes for redressing health and human rights inequalities in communities.

Collaborative efforts strengthened the bonding and bridging relationships amongst the members. The development of close-knit ties often results in the formation of a cohesive and collective identity. Social cohesion promotes civic- mindedness and a sense of collective consciousness. Collective consciousness results in collective outcomes for redressing health and human rights inequalities in communities.

Policy makers should consider investing in strategies and policies that support civil society actions that build social capital for the realisation of health rights.

ACKNOWLEDGEMENTS

I acknowledge the direction, motivation and support received from my Supervisors Prof. Leslie London and Ass. Prof. Christopher Colvin from the Faculty of Health Sciences at the University of Cape Town. Thank you for walking the long journey with me.

This study was made possible through funding received from the Learning Network for Health and Human Rights Project. From 2010 to 2012, I was awarded a PhD grant from the National Research Foundation -Grant No: 73658. The funding not only initially covered my fees but also provided me with the following opportunities: (i) to undertake two international study trips to Amsterdam, Utrecht and Maastricht Universities in 2010 and 2011; (ii) present a paper at the Institute of Development Studies' (IDS) 'Social Protection for Justice Conference' in Brighton, UK, 11-13 April 2011. The Learning Network funded two visits to Uganda: the first in 2010 to attend a conference in Kampala; and the second in 2015 to assess the development of the Community Health Forums Health and Human rights programs.

The participation of the members of the Learning Network was invaluable: Women on Farms Project; Ikamva labantu; The Women's Circle; Epilepsy South Africa; Metro Health Forum and their beneficiaries, academic members of the Universities of Cape Town, Western Cape, Maastricht (Netherlands) and Warwick (United Kingdom). Thank you all for your time and willingness to participate in the research study.

Gratitude is extended to Jacqueline Thomas who introduced me to the Learning Network and for the ongoing support that I received from her.

Thank you to my family for the support received during the writing of this thesis. To Lindia Trout, my friend, I thank you for your belief in me and for your reassurance when I could not see the light at the end of the tunnel. Gratitude is extended to my friend George Engle for your confidence in me and for being with me from the beginning to the end. Berenice Berry my friend and colleague, your emotional support was unwavering and will be remembered.

"the only inheritance I can give you is education ".

Muriel Nefdt (heavenly mother)

LIST OF ACRONYMS

CMHF: Cape Metro Health Forum

CSO: Civil Society Organizations

CSS: Community Systems Strengthening

DA: Documentary Analysis

Equinet Network on Equity in Health in Southern Africa

ESA: Epilepsy South Africa

Exco: Executive Committee

FGD: Focus Group Discussions

HR: human rights

ICCPR: International Covenant on Civil and Political Rights

ICCPR: International Covenant on Civil and Political Rights

ICESCR: The International Covenant on Economic, Social and Cultural Rights

ICT: information and communications technology

IDS: Institute of Development Studies

Ikamva: Ikamva Labantu

LN: Learning Network

MDG: Millennium Development Goals

NDP: National Development Plan

NGOs: non-government organizations

PAR: participatory action research

PHM: People's Health Movement

R2H: Right to health

SAHRC: South African Human Rights Commission

SANGOCO: The South African Non-Governmental Organizations Coalition

SDG: Sustainable Development Goals

SSI: Semi-structured Interviews

TNA: Thematic Network Research Analysis

TWC: The Women's Circle

UCT: University of Cape Town

UDHR: Charter and the Universal Declaration of Human Rights

UN: United Nations

UNDP: United Nations Development Plan

UNPR: United Nations Programme of Reform

UWC: University of the Western Cape

WFP: Women on Farms Project

CONTENTS

CHAPTER 1
RESEARCH TOPIC

THE ROLE OF SOCIAL CAPITAL AND NETWORKS IN THE INTEGRATION AND IMPLEMENTATION OF HEALTH AND HUMAN RIGHTS PROGRAMMES AMONGST CIVIL SOCIETY ORGANIZATIONS IN CAPE TOWN

1.1 INTRODUCTION

My PhD research study explores the role of social capital amongst Civil Society Organizations (CSOs) who are part of a Learning Network (LN) for Health and Human Rights. Specifically, it explores whether the pathway for the development of social capital and the acquisition of skills and knowledge through participation in the LN, has enabled the CSOs to integrate and implement health and human rights programs in their organizations.

The LN for Health and Human Rights is a project of The Health and Human Rights Division of the University of Cape Town (UCT) School of Public Health and Family Medicine. The LN was established in 2008 emerging from a UCT pilot study in which three CSOs participated. It explored CSOs understanding and use of a human rights framework in their health programs. One of the recommendations was that a structure to enable individual and organizational learning for health and human rights be established (Thomas, 2009).

For this PhD dissertation, the researcher utilized the LN as a case study to explore whether and how the LN members accrued knowledge on health and human rights through their participation in the LN, and whether and how the members' implemented health and human rights programs in their communities. The study ran from 2010-2017 and the explanation of the protracted research timelines is presented in section 1.4: Researcher Positionality.

This first chapter includes a discussion of the researcher's positionality and background, a problem statement, research questions and objectives, as well as a brief overview of the research approach used. The research methods are explained in detail in Chapter 5.

As this study was conceptualized within a health and human rights framework, it presents an overview of legally binding international and national health and human rights instruments that hold states accountable for the promotion and protection of health and human rights. More specifically, the South African National and Provincial Health and Human Rights Legislation is presented to gain an understanding of whether and how the legislation enables the realization of health and human rights in South Africa.

Chapter 2 analyses the various legal instruments such as the United Nations Charter, the Universal Declaration of Human Rights, the International Covenants on Economic, Social and Cultural Rights and the International Covenant on Civil and Political Rights. South Africa has ratified the Covenant on Economic, Social and Cultural Rights and is thereby obligated to ensure that human rights and specifically the Right to Health are progressively realized. The problem statement of the research study however shows that despite the range of instruments, people still do not know their rights.

Chapter 3 provides a literature review to generate the theoretical framework utilized in the study, which are social capital and social networks theories. Social capital is multi-dimensional. Various definitions, aspects and dimensions are presented. The theories provided the researcher with a conceptual framework for analysing different types, aspects and dimensions of social capital and networks as well as how networks serve to structure the development of relationships amongst its members.

The LN as a Case Study is presented in Chapter 4 and provides a description of the LN members, the methodology, activities and research undertaken by the LN during the period 2010- 2017.

The research thesis methodology is described in Chapter 5. The rationale for the use of qualitative methodology and more specifically, the use of a case study approach, is presented.

The data generated from Semi-structured Interviews (SSIs), Focus Group Discussions (FGDs), and Documentary Analysis (DA) was analyzed and presented according to the themes constructed by the researcher. They are presented in chapters 6 and 7 as the benefits, co-learning and co-research; and the development of social capital and networks, respectively.

The final Chapter 8 concludes with a critical discussion of the findings, a reflection of what the findings mean for the body of knowledge and theory in the field, some conclusions and recommendations for future research and practice.

1.2 RESEARCH CONTEXT

The researcher used a case study of the Learning Network (LN) for Health and Human Rights located within the Health and Human Rights Program at the UCT. The LN is described in detail in Chapter 4 but is briefly summarized here for context. The LN was conceptualized in 2008 as a space for reflective learning on health and human rights practice and consisted of six diverse civil society organizations in the Western Cape, South Africa (Stuttaford *et al*., 2012). After the initial conceptualization of the LN, one CSO member withdrew, as the member no longer represented the organisation. The remaining five CSOs participated in the various activities during the period of research. In the course of the study, two of the CSOs replaced their representatives due to internal restructuring of their organizations but they remained participants in the LN. One international academic member could not be contacted. Three academic member participants were interviewed.

The methods for studying the LN as a case study are described in more detail in Chapter 5.

1.3 RESEARCHER BACKGROUND

The decision to research the LN as a case study was taken because of the researcher's interest in exploring whether the development of social capital in a network could lead to collective outcomes. The researcher has a long history of work in the Social Development sector and networks; is a Director of a Non-Profit Disability Rights Organization and has over 20 years of experience in the sector as well as a master's degree (Cum Laude) in Social Welfare at the University of Stellenbosch in

2003. Her dissertation topic was on the Transforming Roles of Management Boards in Non-Profit Social Welfare Organizations. One of the objectives of that research study was to ascertain whether non-profit management boards had responded to the call for the transformation in keeping with the South African Social Welfare Legislation (White Paper on Social Welfare 1997).

Within the context of an evolving developmental approach to social welfare in South Africa, the researcher transformed her practice and that of the organizations to respond to the need to promote health and human rights programs in communities, particularly, the disability community. Collaboration became an imperative as the sector is under-resourced and a need exists for CSOs to mobilize efforts to redress the imbalances of the South African Apartheid legacy (Nefdt, 2003). As a CSO practitioner, the researcher confronts the reality of disempowered communities. The majority of Individuals and communities lack agency and do not participate in decisions that impact on their health and human rights. Where social capital has been built amongst neighbors and friends, London (2003) states that it is just enough to "*get by"* and not enough to change the conditions that render people vulnerable in the first place.

With the shift to a developmental approach in the provision of services in communities, CSOs started working in collaboration with each other to ensure that an integrated service is delivered. Specialist CSOs promoting the various determinants of health and human rights are uniting through forums and networks such as The Western Cape Network on Disability (Western Cape Network on Disability, n.d.), The Institute for the Promotion of Disabled Manpower (Institute for the Promotion of Disabled Manpower, n.d.) and other CSOs groupings such as Early Childhood and Development, Youth forums, and advocacy networks such as People First foundation (People First Foundation, n.d.). Collaboration between CSOs such as joint awareness programs and projects are also done collectively.

With reference to the development of social capital within networks, the researcher observed that previous attempts to collaborate in programs through networks have not been successful. Bonding and bridging relationships were not developed because of a lack of trust and cohesion. Members retained their individual identities and participated in the networks for individual gain. This could possibly be seen as CSO

members retaining their identity to ensure that they receive funding from Government Departments which prescribes what the service outputs should be, thus creating a 'silo approach' to service delivery.

This brings one to consider the question of how networks might contribute to social capital. Civil society groups form networks to pursue aspirations for sustainable development and democratic governance that they cannot achieve alone. Networks can enhance the power and influence of citizen voice in advocating for policies and improving governance. Successful networks enable citizens to amplify their voices and achieve greater influence and impacts in social change (Vega-Romero and Tova, 2007). Ashman *et al.* (2005), further purport that networks link service providers to exchange information and resources or to develop coordinated delivery systems. They further state that civil society groups form networks to pursue aspirations for sustainable development and democratic governance that they cannot achieve alone.

Developing an understanding of civil society networks and how members work in and with each other to achieve their collective outcomes informed the researcher's engagement with her PhD research. The research therefore focused on the development of social capital between the CSO members of the LN, during the period of 2010-2017.

The researcher became a member of the LN in 2008 and registered for her PhD in 2010. The data collection of the research data took place in two rounds. The first round of SSIs took place in 2010-2011. The second round of SSIs and FGDs) were held in 2017. The DA of the Learning Network documents took place during 2018- 2019.

Factors impacting on the researcher's ability to conclude the study earlier included the impact of illness and the burden of expanded work commitments to her organization. As the Director of a Non-Profit Organization with governance and fiduciary responsibilities, it was difficult to dedicate time to complete the PhD study timeously, UCT granted permission for special leave and annual re-registration.

The following Table1.1 summarizes the timeline of the researcher's participation in the LN and the research study.

Table 1.1 Timeline of participation in the Learning Network and Research Study

Year	Activity
2008-2011	Member of the LN
2010	Registration of PhD study
2010-2011	First Round of data collection – SSIs
April 2010	Research visit to Amsterdam , Utrecht and Maastricht Universities
October 2010	Research visit to Kampala, Uganda
October to December 2011	Research Visit Maastricht, Utrecht and Amsterdam Universities
April 2011	Presentation of a Paper at the Institute of Development Studies (IDS) in Brighton, UK.
2011	Withdrawal as an active member of the LN representing my NPO – responsibility handed to a colleague
2015	Research visit to Kampala and rural areas in Uganda
2017	Second round of data collection – SSIs and FGDs
2017-2018	Analysis of the first and second round of data
2018-2019	Documentary Analysis of the LN documents / materials
2018-2021	Writing of chapters and conclusions of the study
2022	Submission of thesis to the Doctoral Board

As a PhD student, the researcher was funded by the LN for a study trip from March to April 2010 to the Netherlands (Amsterdam, Utrecht and Maastricht Universities). The second scholarship to Utrecht University was for a period of three months from October to December 2011. The purpose of the visits was to build the researcher's knowledge base of international health and human rights and to present discussion papers at the University of Utrecht on her study.

The researcher further presented a paper on Social Protection for Social Justice at the Institute of Development Studies (IDS) in Brighton (Nefdt, 2011).The researcher was funded by IDS as she was invited to present a paper on the South African perspective of social protection and social justice. In South Africa, social protection includes the provision of social security (grants) and social services from the government.

Two additional visits to Uganda and were sponsored by the LN. The first visit in October 2010 was to attend a Regional Meeting on Health and Human Rights. The second trip to Uganda was in 2015. The LN embarked on a series of health and human

rights training sessions for health professionals, particularly in the rural areas of Kampala. The second trip was to join a group of fellow LN CSO members to ascertain the progress in the implementation of their health programs.

1.4 RESEARCHER POSITIONALITY

Regarding the researcher's positionality in the research study, the researcher withdrew from direct participation in the LN meetings and activities in 2011 and was replaced by her colleague as the representative of the researcher's CSO. The reason for the exit was to minimize bias in the study. The researcher had worked with some of the LN CSO members prior to her participation in the LN. On commencement of the study, the researcher clarified her research role as an 'insider' and 'outsider'. Maycut and Morehouse (1994) refer to the paradoxical nature of being an 'insider' and 'outsider'. A researcher must be self-aware regarding his or her own potential biases or perceptions as well as being sensitive to the meaning systems of others and their experiences when trying to understand a social phenomenon. Bias distorts truth and could slant and skew data (Galdas, 2017). It further affects the validity and reliability of findings, and consequently, affects the conclusions of the research study. Peak and Trotz (1999) and Holmes (2020) support the view that the researcher should be aware of her positionality in the research process. Holmes (2020) describes 'positionality' as an individual worldview and the position the researcher has chosen to adopt in relation to a specific research process. Not only should the researcher be aware of her positionality, it must also be disclosed in the research process (Peak and Trotz,1999), to promote ethical research (Buckle, 2007 and Galdas, 2017). According to both Buckle (2007) and Galdas (2017), clarification of the researcher's personal motivation is vital when applying reflexivity in the context of qualitative methodology.

Exiting the LN was a difficult process for the researcher as she had been involved in the LN since its inception. Relationships were established with all LN members and to minimize bias, the researcher discussed her exit with all the CSO members individually. The researcher positioned herself as a researcher which was accepted by all. The members were also aware that it was a difficult process for the researcher as she had immersed herself in the activities of the LN. Fortunately, the researcher had no further contact with the CSO members in her professional practice thus minimizing further bias.

The following sections present the problem statement of the research study, the research questions, objectives, and methodology.

1.5 PROBLEM STATEMENT

The adoption of the South African Constitution (1996) represented a milestone in the history of human rights in South Africa (Liebenberg, 2000). Chapter 2 of the Constitution consists of the South African Bill of Rights (1996). The Bill of Rights is the cornerstone of democracy and affirms the democratic values of human dignity, equality and freedom. Chapter 9 of the Constitution further makes provision for the establishment of Institutions to protect democracy, the rule of law and respect for human rights. Such Institutions included the South African Human Rights Commission (SAHRC), the Gender Commission and the Public Protector. The South African Department of Health makes provision for The Patient's Rights Charter (2007) and proclaims the Charter as a common standard for achieving the realization of the right of access to health care services. The Department of Social Development promoted a development approach to service delivery (White Paper for Social Welfare, 1997).

Despite the adoption of a range of international and national legislative instruments, Reynolds, London and Sanders (2006) purport that research done in the field of health and human rights has shown that health status and access to health care has declined in many developing countries, particularly in South Africa. Regardless of the enabling legislative instruments for the promotion of health and human rights in South Africa, people are not only uninformed of their rights, but the majority who attend public health facilities are not aware of these legislative instruments; and many struggle to access services as well as information about health services in their communities (Thomas and London 2006).

According to Equitas (Equitas, n.d.), the notion of building agency amongst community members to take control of their own lives and the decisions that affect their lives through knowledge, skills, values, attitudes and behaviors, enables people to assert and defend their human rights as well as to respect the rights of others. This should be done at community level. For example, CSOs in health systems who work directly with the community should be the catalyst for the promotion of health and human rights. CSOs provide numerous valued programs and services to members of their

communities, particularly to the most marginalized, disadvantaged and or stigmatized members (Wilson, Lavis and Guta, 2012).

CSOs are further called upon to collaborate with health system decision makers and stakeholders in the development of policy, programmes and services. Such activities help to facilitate the involvement of communities and the public in planning and implementation of their health care, which is a key principle of the Declaration of Alma Ata (1978). The Alma Ata declared that Primary Health Care is essential health care and should be universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford.

Research studies show that the development of social capital within a network could be viewed as a catalyst for change and collective outcomes, particularly for the promotion of the right to health. According to Vega-Romero and Tovar (2007), civil society has been acknowledged as a source of social capital not only because of the value of social interaction and empowerment to promote and improve health, but also because of its capacity to challenge fundamental societal issues such as social inequality and exclusion, the unequal distribution of power and wealth which forms the basis of most unjust health inequalities and inequities in access to healthcare. The authors further contend that civil society is important for the transformation of the state and society as a whole. Eriksson (2010) supports the notion that there is growing evidence that individual social capital accrued through networks can influence health and health behaviors in a positive way through social support, social influence, social participation and access to material resources. The improvement and maintenance of health is dependent not only on an individual's behavior, but also on the behaviors of significant others and capacity for positive communication in networks.

Story (2013), however, contends that despite growing evidence of the linkage between social capital and health in recent years, there is a lack of research from poor resourced countries. Acknowledging that social capital is an important factor for improving health in resource poor settings, the author argues that more research is needed in order to determine the best measures for social capital to elucidate the mechanisms through which social capital affects health in the developing world. Agampodi *et al.,* (2015) concur that the relationship between social capital and health

outcomes is under-researched in low- and middle-income countries in contrast to high income countries, and that social capital is a neglected determinant of health in the former countries.

The South African National Development Plan (NDP) (2012) also reports that the performance of South Africa's health system since 1994 has been poor, despite good policy and relatively high spending as a proportion of gross domestic product. Services are fragmented between the public and private sectors. The NDP emphasizes the need to design policies between now and 2030 to ensure that individuals are engaged in meaningful activity and vulnerable groups and citizens are protected from the worst effects of poverty. The NDP further states that while apartheid destroyed opportunities for the majority of the population and trapped them in poverty, the challenge for the next 20 years is to rebuild the opportunity structures and help individuals develop the capabilities to live the life they wish to lead

> *"We say to one another: I cannot be without you, without you this South African community is an incomplete community, without one single person, without one single group, without the region or the continent, we are not the best that we can be..." (South African Government, 2012)*

Given the paucity of research on the impact of social capital on the promotion of health in developing countries, the researcher aims to contribute towards building the knowledge base by focusing on the question of whether and how social capital amongst CSOs in a Learning Network could help rebuild structures, and help individuals or CSOs to develop agency to bring about health and human rights programs in under resourced communities.

1.6 RESEARCH QUESTIONS

The study sought to address two main research questions:

- Has the Learning Network for Health and Human Rights provided a platform for knowledge sharing and collaboration amongst the CSO partners?
- Has the collaboration developed social capital to build agency for the integration and implementation of health and human rights programs in their organizations?

1.7 RESEARCH OBJECTIVES

1.7.1 To analyze the member organizations' motivation for participation in the LN.

1.7.2 To explore whether and how social capital was fostered within the member organizations of the LN and if so, to analyze:

1.7.2.1 How social capital contributed to the integration and implementation of health and human rights programs.

1.7.2.2 Whether alternative pathways of knowledge, skills and values acquisition contributed to the integration and implementation of health and human rights programs.

1.7.2.3 What the facilitation factors or barriers were in the integration and implementation of health and human rights programs by LN members.

1.8 OVERVIEW OF THE RESEARCH APPROACH

An overview of the research approach is presented here. A detailed description is given in Chapter 5.

The researcher adopted a qualitative methodology due to the complexity of the phenomenon of social capital and networks. It enabled the researcher to explore numerous dimensions of the phenomenon. As the participants in the study were members of a network, a case study approach was utilized.

1.9 SUMMARY

The Chapter has introduced the research study and located it within the historical context of Apartheid in South Africa. This is important because Apartheid, with its segregational policies and unequal distribution of resources and services based on racial lines over decades, resulted in fiscal constraints that hindered the post-1994 new government's ability to implement and integrate health and human rights programs. The Apartheid legacy further shaped civil society agency, post 1994. International funding was directed to the new government. A consequence was that civil society organizations became more fragmented and worked in 'silos' because government determined funding for services. It is within this context that the

researcher aimed to explore whether and how networks of CSOs could build cohesion for collective outcomes.

To gain an understanding of how health and human rights instruments were developed over time, and to understand what health and human rights are, the researcher presents a historical overview of international and national instruments in Chapter 2.

CHAPTER 2
INTERNATIONAL AND NATIONAL HEALTH AND HUMAN RIGHTS INSTRUMENTS LAWS AND POLICIES

2.1 INTRODUCTION

This Chapter presents an overview of international and national health and human rights instruments. It further examines the South African health and human rights laws and policies and whether they make provision for the promotion of health and human rights in the country. The purpose of the review is to understand international and national human rights instruments as the context for the work done by the Learning Network on Health and Human Rights (LN) in South Africa because the research study is located within the LN.

The right to health and human rights is embedded in the South African Constitution (1996). Chapter 2 of the Constitution makes provision for the Bill of Rights that details the rights of all people in South Africa and affirms the democratic values of human dignity, equality, and freedom. The section on South African Health and Human Rights presents the political context, key health challenges, laws and policies, human rights institutions, the National Health Act, and civil society participation in the attainment of health and human rights.

2.1.1 Human Rights

Human rights are entitlements that people can claim because of their inherent humanity. These rights are universal across all cultures (London and Schneider, 2012). They are reflected in legally binding covenants, conventions, treaties, and other instruments adopted at the global, regional and national levels.

These legally binding instruments are highly formalized statements of belief and action. Once adopted and ratified by governments in various countries, they commit themselves to the incorporation of these instruments into their own legislation. The framework for human rights is grounded in the United Nations (UN) Charter and the Universal Declaration of Human Rights (UDHR), which was adopted in the years following World War II. The International Covenant on Economic, Social and Cultural

Rights (ICESCR) and the International Covenant on Civil and Political Rights (ICCPR) adopted in 1966 constitute the International Bill of Rights (World Bank, n.d.). Other programs such as the United Nations Programme of Reform (UNPR) and the United Nations Development Plan (UNDP) emphasize that people should be recognized as key actors in their own development. Following the UNDP, the Millennium Development Goals (MDG-2000-2015) and the subsequent Sustainable Development Goals (SDG-2015-2030) were formulated.

The following sections present a discussion of the UDHR, ICESCR, ICCPR, UNPR and UNDP as core human rights documents at international levels. The section further sets out the MDGs and the SDGs and how they align with the UNDP.

2.1.2 Universal Declaration on Human Rights

In 1948, the UN General Assembly proclaimed the UDHR as a common standard of achievements for all peoples and all nations. The preamble of the UDHR confirms that every individual and every organ of society 'shall strive to promote respect for human rights' and to 'secure their universal and effective recognition and observance'. This extends to business, international, and multilateral organizations, and other non- state actors. This milestone document strives to promote respect for these rights and freedoms. It recognizes human rights as the foundation of freedom, justice, and peace. This Declaration further recognizes that human rights should reflect the moral conscience of the world. The UDHR prescribes that all member governments must guarantee the economic, social, and cultural rights without prejudice against humanity.

The UDHR consists of 30 Articles that focus on the right of all human beings to be born free and equal in dignity and rights (United Nations, 1946). It affirms individual rights and is the first step in the process of formulating the International Bill of Rights. Table 2.1 presents the 30 Articles as found in the UDHR and as summarized by the researcher.

Table 2.1: UDHR Articles (1956) (Summarized by the Researcher)

Articles 1-5	Articles 1-5 establish the basic aspects of dignity, liberty, equality. They state that everyone is entitled to all rights and freedoms as well as the rights to life, liberty, and security of the person.
Articles 6-11	Equality before the law and protection from arbitrary arrest, detention or exile is captured in articles 6-11. These articles ensure that everybody has the right to an effective intervention by competent national tribunals for acts violating the fundamental rights granted to him/her by the constitution of the law.
Articles 12-24	Articles 12-24 cover the individual rights to privacy, freedom of movement, freedom of peaceful assembly and association, right to work and social security.
Article 25	Article 25 refers to the social determinants of health that are required for the adequate health and wellness of the individual. These determinants include the provision of basic needs and services that are a pre-requisite for a healthy life.
Articles 26-28	Articles 26-28 speak to the right to education and participation in the cultural life of the community, social and international order
Articles 29- 30	Articles 29-30 draw attention to the respect for the rights of and freedoms for others. It highlights that everyone has certain responsibilities in the exercise of rights and freedoms and that everyone will be subject only to such limitations as are determined by law for the purpose of securing the rights of all.

In conjunction with the articles, the UDHR outlined a set of principles that should be applied for the development of a human rights framework in each country.

Table 2.2: UDHR Principles (1948)

1.	Universality and inalienability
2.	Indivisibility and inter-dependence
3.	Equality and non-discrimination
4.	Participation and inclusion
5.	Accountability and rule of law.

According to the UDHR, the principles of universality and inalienability imply that all rights are universal and that all people in the world are entitled to human rights. The human person cannot voluntarily give them up, nor can others take it away from them. Human rights such as civil, cultural, economic, political and social rights are indivisible, interdependent and interrelated and as such, cannot be ranked in a specific hierarchical order. Inter-dependence and inter-relatedness imply that one right often depends on the realization of other rights. For example, the realization of the right to health may depend on the right to the realization of the social determinants of health such as housing, education and access to clean water and sanitation.

Haig (2002) contends that that the principles of the UDHR are rights, not privileges or favors and that the principles provide people with legitimate claims. According to the author, this means that every person has a claim upon his or her government with regards to human rights. Governments are obligated to respect, protect, and fulfill individual rights. The International Covenant on Economic, Social and Cultural Rights (ICESCR) also states that governments are obligated to take steps 'to the maximum of its available resources' to progressively realize economic, social, and cultural rights.

2.1.3 International Covenant on Economic, Social and Cultural Rights (ICESCR)

The UN General Assembly adopted the International Covenant on Economic, Social and Cultural Rights (ICESCR) and International Covenant on Civil and Political Rights (ICCPR) in 1966. Under the ICESCR, a government (including its sub-national levels) has the following obligations, as listed in Table 2.3 (United Nations, 1966).

Table 2.3: ICESCR Obligations (1966)

1. Refrain from any violation as found in ICESCR
2. Prevent third parties from violating ESCR
3. Take necessary measures to promote the economic, social and cultural rights of people through legislation, administration, budgetary and other processes.
4. Seek and provide international assistance and cooperation in the realization of ESCR.

ICESCR further identified minimum core rights to which people are entitled. Table 2.4 lists the minimum core rights.

Table 2.4: Minimum Core Rights

1. The Right to work and to earn a living under conditions that are just and favourable
2. The Right to provision of the highest possible standard of physical and mental health
3. The Right to an adequate standard of living, including adequate food, clothing, and the continuous improvement of living conditions
4. The Right to social security including social insurance
5. The Right to education, including compulsory primary education
6. The Right to take part in cultural life.

In general, the ICESCR specifies the rights to which people are entitled. In addition, the ICESCR comprise elements for the understanding of the minimum core rights, as presented in Table 2.5.

Table 2.5: Elements of Minimum Core Human Rights (ICESCR)

1. Rights are primarily about the relationship that develops between Governments and its citizens
2. Governments are obligated to protect and fulfil the rights of its citizens
3. Rights are fundamental and they cannot be arbitrarily taken away
4. Rights can be limited if done in a manner that is consistent with a rights framework (e.g., to secure others' rights)
5. Rights are indivisible as each right is instrumental for the attainment of other rights.

Modern aspects of health are more substantial than that which pertained in 1966 when the two International Covenants were adopted. The social determinants of health have been widened and the following need to be taken into account: gender differences, armed conflict and violence as well as uneven distribution of resources (ICESCR: General Comment No. 14. 2000).

Referring to the right to the highest attainable standard of health, Potts (2009) adds that there are some core underpinning rights that require immediate attention: minimum, essential levels of primary health care, food, housing sanitation, essential drugs and the preparation of a national health plan. The author argues that even in the presence of limited resources, the governments are required to give first priority to the most basic health needs of the populations. Article 12 refers specifically to the right to health.

2.1.4 Right to Health

Article 12 of the ICESCR describes health as a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. The realization of the right to health may be pursued via numerousapproaches, for example, the formulation of health policies, or the implementation of health programs developed by the World Health Organization (WHO), or the adoption of specific legal instruments. Moreover, the right to health includes certain components that are legally enforceable (ICESCR: General Comment No. 14. 2000).

The human right to health is recognized in numerous international instruments (United Nations,1966).
Article 25.1 of the Universal Declaration of Human Rights affirms that:

> *"Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services".*

The right to health in international human rights law is most comprehensively covered in ICESCR Article 12.1. In accordance with article 12.1, state parties recognize the following:

> *"The right of everyone to the enjoyment of the highest attainable standard of physical and mental health".*

While Article 12.1 focuses on the right to the highest attainable standard of health, Article 12.2 includes a number of steps that governments need to take to achieve the

full realization of this right. Additionally, the right to health is recognized, inter alia, in Article 5 (e) (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination (1965); Articles 11.1 and 12 of the Convention on the Elimination of All Forms of Discrimination against Women of 1979; and in Article 24 of the Convention on the Rights of the Child of 1989. Several regional human rights instruments also recognize the right to health. The European Social Charter of 1961 as revised (Article 11), the African Charter on Human and Peoples' Rights of 1981 (Article 16) and the Additional Protocol to the American Convention on Human Rights in the area of Economic, Social and Cultural Rights of 1988 (Article 10). Similarly, the right to health has been proclaimed by the Commission on Human Rights, as well as in the Vienna Declaration and Programme of Action of 1993 and other international instruments.

ICESCR Article 12 provides strategies that should be used to monitor the implementation of ICESCR at the national and international levels. These strategies should include appropriate health indicators and benchmarks. The following health indicators and benchmarks are identified in General Comment No.14 on the Right to Health.

Table 2.6: General Comment No.14 Health Indicators and Benchmarks

1. Availability	Meaning functioning public health and health care facilities, goods and services, as well as programs, in sufficient quantity
2. Accessibility	Meaning all facilitates, goods and services must be accessible to everyone
2.1 Non-discrimination	Accessible to all, especially the most vulnerable or marginalized persons as defined in law or exist in fact
2.2 Physical Accessibility	Within safe physical reach for all sections of the population, especially the vulnerable groups
2.3 Economic accessibility	Affordability
3. Acceptability	Ethical and culturally appropriate and respectful.

Chapman (2015) argues that without the indicators and benchmarks, countries that ratify specific human rights instruments cannot assess their own performance in promoting effective realization of the rights or be made accountable for the violations thereof. Hence, to assist State parties in fulfilling their obligations and to enable international monitors to evaluate a country's performance, each of the major international human rights covenants requires the regular submission of reports. Shadow reporting is an important tool for non-government organizations (NGOs) supporting various human rights. These reports are written by NGOs to supplement or present alternative information to reports that governments are required to submit under human rights treaty obligations.

General Comment No. 14 further stipulates that in order to operationalize specific enumerated rights, measures must be developed so that one can identify potential violations. Where governments fail to do so, aggrieved rights-holders are entitled to institute proceedings for appropriate redress through a competent court or other adjudicator in accordance with the rules and procedures provided by law. Chowdhrey (2009) concurs that human rights instruments seek to confer minimum legal content for such rights, and states that for courts to effectively empower people to realize their socio-economic rights, attention to the implementation of judgments is essential.

According to Chapman (2002), the realization of all the human rights is a parallel process, and one right cannot be ignored above others. Wilson, Lavis and Gut (2012) concur that this is no different from arguing that one cannot choose which rights to observe and ignore what is inconvenient. Ramkisson (2016) supports the view that all rights are based on the inherent right to dignity and therefore cannot be placed in any hierarchical order. One right cannot be prioritized over another unless the right was historically neglected and in need of disproportionate attention. A single right may be an enabler for another right or conversely; the lack of access to a right might heavily impact on the realization of another. The principles of equality and non-discrimination imply that all individuals are equal as human beings and are entitled to their human rights without discrimination of any kind. States have to comply with the legal norms and standards that are enshrined in human rights instruments. Ramkisson (2016) emphasizes that retrogressive measures cannot be implemented in the face of

resource constraints. A retrogressive measure is one that directly or indirectly, leads to a backward movement in the enjoyment of the rights recognized in the Covenant.

> *"Any deliberately retrogressive measure would require the most careful consideration and would need to be fully justified by reference to the totality of the rights provided for in the Covenant and in the context of the full use of the maximum available resources" (United Nations, 2015).*

Progressive realization requires Governments to adopt measures towards the full achievement of the socio-economic rights. In order to qualify, such steps should be deliberate, concrete and targeted as clearly as possible towards meeting this goal (Mann, Gruskin, Grodin and Annas, 1999). According to the authors, services for the marginalized people in a country must be provided immediately. Chapman (2015) argues that if economic, social and cultural rights are to be taken seriously, there is a need to change the paradigm for evaluating compliance with the norms established in the ICESCR.

While the ICESCR provides the principles for the promotion and legislation of economic, social and cultural rights, the International Covenant on Civil and Political Rights (ICCPR) recognizes 'the inherent dignity and the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world' (United Nations, 1966). Because human rights are indivisible, it is important to review the International Covenant on Civil and Political Rights (ICCPR) to show its interrelatedness with ICESCR and how the ICCPR intersects with the promotion and protection of civil and political rights.

2.1.5 International Covenant on Civil and Political Rights (ICCPR)

The ICCPR recognizes that civil and political rights are derived from the inherent dignity of the human person. According to ICCPR, conditions should be created for everyone to enjoy civil and political rights and the freedom from fear.

Like ICESR that details the Articles for the promotion and protection of human rights, ICCPR presents Articles that aim to protect the civil and political rights of all people. A summary of the Articles is presented in Table 2.7.

Table 2.7: ICCPR Articles

Articles 1-3	**The unifying themes and values of ICCPR are based on non-discrimination. Rights recognized in the ICCPR must be respected and be available to everyone within the territories of those states who have ratified the Covenant. These themes intersect with the ICESCR Article 3 ensur**ing **the equal right of both men and women to all civil and political rights set out in the ICCPR.**
Articles 6-9	These Articles refer to the rights to fundamental freedoms and security. The right to life and freedom from torture is found in articles 6 and 7; Article 8 is the right not to be enslaved and article 9 stipulates the right to liberty and security of the person.
Articles 10-13	Articles 10-13 focus on the legal rights of people. The right to not be imprisoned merely on the ground of inability to fulfill a contractual obligation is found in Article 11. The freedom of movement and choice of residence for lawful residents is protected under Article 12; and Article 13 protects the rights of foreigners.
Articles 14-17	Equality before the courts and tribunals and the right to a fair trial is secured in Article 14. Articles 15-17 protect the rights of people not to be found guilty of an act of a criminal offence, which did not constitute a criminal offence. It further ensures the right to recognition as a person before the law and the freedom from arbitrary or unlawful interference.
Articles 18-24	Articles 18-19refer to civil rights such as assurance of freedom of thought, conscience and religion.. The right to hold opinions without interference, the right of peaceful assembly and the right to freedom of association with others is protected in Articles 20-22. The right to marry is found in Article 23 and children's rights are secured in Article 24.
Articles 25- 27	The political rights of all people are secured in these three Articles. They refer to the right to political participation, equality before the law and minority protection.

2.1.6 UN Conventions that apply to Women, Persons with Disabilities and Children

In addition to ICESCR and ICCPR, there are various UN Conventions that apply specifically to Racial Discrimination (United Nations,1969), Elimination of all Forms of Discrimination against Women (United Nations,1979) and other vulnerable groups

(United Nations, 1979). The Convention on Persons with Disabilities (United Nations, 2007) details measures for the promotion and inclusion of persons with disabilities and the Convention on the Right of the Child (United Nations,1990) protects the child from any harm and abuse.

Human rights are universal as it applies to everyone. Rights are inalienable in that it cannot be taken away from a person, it is indivisible as it is closely connected to other human rights and intersects with each to ensure the promotion and protection of socio-economic, civil and political human rights (Potts, 2009). In addition, Haig and London (2002) refer to the right that all people have to actively and freely participate in processes that promote their fundamental human rights and freedoms. The authors emphasize that the key principles for the realization of human rights are participation, inclusion, equity and non-discrimination.

The following section discusses the role of the UNDP in the development of human rights, the eradication of poverty and the reduction of inequalities and exclusion through participation and collaboration.

2.1.7 United Nations Development Programme (UNDP)

According to the UNDP Policy Document, the sustainable human development paradigm is a holistic strategy for development that embraces all human rights including economic, social, cultural, civil and political. The UNDP Policy Document outlines areas for the UNDP action. These actions include the provision of support to human rights institutions, the building of capacity of human rights governance institutions and the focus on developing human rights approaches to sustainable human development. The UNDP further contains principles and corresponding commitments that aim to provide a coherent foundation for partnerships between the UNDP and Civil Society Organizations (CSOs) (United Nations, 2015). The following principles and commitments are listed as follows:

2.1.7.1 Partnership founded on horizontality (equality), trust, inclusion, and mutual capability:

Partnership with CSOs is founded on the principle of a horizontal relationship between parties that, while institutionally different, are of equal standing in

promoting the same development objectives, especially poverty reduction through sustainable human development. The relationship is premised on mutual trust that must be earned by both sides. UNDP is committed to investing in enhancing trust with CSOs that share its goals. In doing so, UNDP acknowledges the frequent asymmetry between its capabilities and those of CSOs with which it wishes to engage. Consequently, the UNDP contribution to CSO capacity development remains a cornerstone of its approach to development and partnership.

2.1.7.2 Recognition of obligations as a duty-bearer:

In adopting these principles and a policy on human rights, the UNDP implicitly recognizes its responsibility as a duty-bearer towards member governments, in terms of supporting their fulfilment of public obligations, and simultaneously towards civil society as legitimate claimants on governments and UNDP as a public body. Correspondingly, interacting with civil society is a duty and not an option for UNDP at all levels of its work. UNDP is committed to engaging with CSOs as an expression of their right to development, not simply because of institutional convenience.

2.1.7.3 Negotiation and mutual agenda-setting with individual accountability:

Neither UNDP nor CSOs are required to accept or endorse each other's agendas, interpretations of events or methods. Engagement with CSOs must be founded on the principle of negotiation towards a common interest that recognizes complementarity of roles, not a sharing of institutional responsibilities. Each party is individually accountable for its behaviour to its owners or constituencies. While not imposing its own agenda, UNDP is committed to seeking mutual ground for action that respects the agendas of the civil societies where it is present.

2.1.7.4 Disaggregation, selection and intellectual differentiation:

UNDP recognizes that CSOs are, by their very nature, heterogeneous. This diversity is a valuable development asset that should not be 'homogenized' by

CSO engagement with UNDP. To this end, UNDP adopts the principle of respecting CSO diversity. UNDP is committed to enhancing its own insight and capability to differentiate between CSOs while adopting practices that correspond to and respect their differences.

2.1.7.5 Coherence and consistency:

UNDP acknowledges the importance of the principles of coherence and consistency between engaging with CSOs in its in-country initiatives and in international policy work. It is committed to balanced treatment and investment between CSO engagement at local and macro levels, i.e., in its operations and policy dialogues, within countries, regionally and internationally.

In summary, the principles and commitments as listed in the UNDP Policy Document are based on mutual trust and respect. The primary focuses of the UNDP is to support and build capacity of CSOs to meet their human rights obligations. Engagements with CSOs must be founded on principles of negotiation towards a common interest that recognizes each other's roles and responsibilities. It promotes the acceptance of the diversity of CSOs and calls for the adoption of practices that correspond to and respect their differences. The Policy Document further emphasises the responsibility of the UNDP to support human rights institutions, build capacity for good governance and on the development of rights approaches for sustainable development. The UNDP further compares countries based on a Human Development Index inclusive of the educational levels of the people, their health status and the per capital income or average income. The United Nations formulated Millennium Development Goals (MDG-2000-2015) to build on the holistic development of people.

2.1.8 Millennium Development Goals

In September 2000, countries signed the Millennium Declaration in which they committed to achieving a set of eight measurable goals (United Nations, 2015). These goals included (1) the eradication of poverty and hunger; (2) achieve universal primary education; (3) promote gender equality and empower women; (4) reduce child mortality; (5) improve maternal health; (6) combating HIV/AIDS, malaria and other

diseases; (7) ensure environmental sustainability and (8) develop a global partnership for development.

The MDGs set a timeline for the achievement of the eight goals. These goals were translated into practical steps that would enable people across the world to improve their lives and prospects. Within a period of five years, countries had to focus on the holistic development of all its citizens with specific emphasis on poverty eradication. Ban Ki-Moon, Secretary-General of the United Nations (United Nations, 2015), says that the global mobilization behind the MDGs has produced the most successful anti-poverty movement in history. The landmark commitment entered into by world leaders in the year 2000 was to:

> *"Spare no effort to free our fellow men, women and children from the abject and dehumanizing conditions of extreme poverty" Ban Ki-Moon*

2.1.9 Sustainable Development Goals

Building on the experience of the MDGs, the UN General Assembly Open Working Group (Sustainable Development Goal Fund, 2014) began the negotiation process on the post 2015 development agenda. The process culminated in the subsequent adoption of the 2030 Agenda for sustainable development with seventeen Strategic Development Goals (SDG-2015-2030).

The SDGs include the following: (I) the need to end poverty in all forms; (ii) end hunger and achieve food security; (iii) ensure healthy lives; (iv) ensure inclusive and equitable education and long learning opportunities; (v) achieve gender equality and empower all women and girls; (vi) ensure the availability and sustainable management of water and sanitation; (vii) ensure access to affordable, reliable, sustainable and modern energy; (viii) promote sustainable inclusive economic growth; (ix) build resilient infrastructure; (x) reduce inequality within and among countries; (xi) make cities and human settlements inclusive, safe, resilient and sustainable; (xii) ensure sustainable consumption and production patterns; (xiii) take urgent action to combat climate change; (xiv) conserve and promote sustainable use of the oceans, seas and marine resources; (xv) protect, restore and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification and reverse land degradation; (xvi) promote peaceful inclusive societies for sustainable access to justice for all; (xvii)

strengthen the means of implementation and revitalize the global partnership for sustainable development.

The SDGs aim to realize human rights of all and to achieve gender equality and the empowerment of all women and girls. These goals are integrated and indivisible and balance the three dimensions of sustainable development (United Nations, 2015). These dimensions are economic, social and environmental.

2.1.10 The South African National Development Plan 2030 (NDP)

The NDP (South African NDP, 2030) was established in February 2013, provided a broad strategic framework to guide key choices and actions in the attainment of the SDGs. The NDP identifies poverty and inequality as being the principal challenge in South Africa, and that its actions to redress poverty and inequality successfully depends on all South Africans taking responsibility for the plan which is led by the President and the Cabinet. Active citizenry as described in the NDP refers to community participation to accelerate development in the country. The NDP, however, states that although South Africa has an active and vocal citizenry, an unintended outcome of government actions has been to reduce the incentive for citizens to be direct participants in their own development. As such, the NDP recommends that government must actively seek opportunities for advancement, learning, experience and opportunities that promote participation in development. There is an acknowledgement that the State cannot merely act on behalf of the people.

> *"It has to act with people, working together with other institutions to provide opportunities for the advancement of all communities" (NDP 2030).*

2.1.11 Civil Society Organizations and Health Rights

The term 'civil society' is a blanket term for a group of people and organizations. According to Scott et al (2017), the context and forms of CSOs are so diverse and therefore difficult to define. The authors however state that despite the diversity, CSOs need to interact with each other in a broader sense. This implies that CSOs need to work in partnership with each other and in collaboration with broader stakeholders to address the challenges that societies experience. They echo the WHO's Discussion Paper (2001) on the role of civil society in health: CSOs provide services in response to community needs; they lobby for equity and pro-poor health policies; they act as an

intermediary between communities and government; reach remote areas poorly served by government facilities and provide services that may be less expensive and more efficient. CSOs also provide technical skills on a range of issues from planning to delivery to services. The WHO's paper adds that the CSOs innovate and disseminate information and good practices to other CSOs and contribute to public understanding.

With the development of various international and national human rights instruments, States were obligated to shift their policy approach to that of a human rights-based approach. It aims to promote and protect health and human rights for the community. According to London (2003), there are four ways in which a rights-based approach to health can function: utilization of a human rights framework to develop policy and to hold government accountable, as well as to seek redress and to mobilize communities and vulnerable groups. Cornwell and Nyamu-Musembi (2004) concur that in recent years there have been discussions amongst development actors and agencies about a rights-based approaches to development. They further state it is advantageous as it lends itself to re-politicizing areas of development work such as the efforts to enhance civil society participation in development.

London (2008) explains that a human rights-based approach is critical to address the growing global health inequalities based on the recognition of the inherent dignity and worth of the human person. The prominence of the approach has given civil society a role in raising, advancing and claiming the entitlements of different social groups. In addition, roach gives CSOs a vital role as participants and watchdogs of policy. The author argues that there are three aspects that shape a human rights approach to health. These are the indivisibility of civil and political rights and socio-economic rights; active agency by those vulnerable to human rights violations, and the powerful normative role of human rights in establishing accountability for protections and freedoms as well as facilitating redress for victims of violations of the right to health.

The human rights-based approach frames the social determinants of health as public goods and focuses on the protection of the most disadvantaged individuals and groups (London and Schneider, 2012). Scott *et al.,* (2017) elaborated on the roles of CSOs in the attainment of the right to health. With the shift in focus to a rights-based approach to service delivery, London (2003) and Cornwell and Nyamu-Musembi (2004) concur

that through practices that includes the promotion of health and human rights, CSOs seek to redress, mobilize communities and vulnerable groups. London and Schneider (2012) further emphasize that with using a rights-based approach to development, social determinants of health are integrated into practices.

2.1.12 Benefits of Engagement with Civil Society Organizations

Scott et al (2017) report that there are overarching themes that frame the benefits of civil society engagement. These are empowerment, service delivery, commitment, flexibility, participation in policy, and credibility, as outlined in Table 2.8..

Table 2.8: Benefits of Civil Society Engagement

Benefits of Engagement	
Empowerment	Empowerment is a key benefit of a strong civil society both in general and in the health context. It is strongly correlated with health and wellbeing and its absence, due to poverty, illness or stressful working conditions, is a cause of ill health. In terms of social benefits, empowerment through civil society creates opportunities for people to empower themselves by acting together.
Service Delivery	Delivery of services is a key part of a relationship between health systems and civil society. This means that there are key kinds of relationships to be managed with various consequences. The authors posed questions that could have a negative impact on service delivery. Firstly, what is the nature of the partnership and is it going to be in the form of grants or contracts? Secondly, who will determine the goals and how much oversight will the public sector expect? Thirdly, everybody involved in an international donor/funder relationship must balance multiple political arenas from national to global to the politics of donors, in entirely different countries.
Commitment	The commitment to service delivery is determined by the vision and mission statement of the organization. It demands that the organisation is doing something that its donors and funders believe in, and that their organisational reputation and integrity will be at risk if the service outcome is not desirable for the donors and funders. Commitment further encompasses values of trust, respect and a shared sense of identity.
Flexibility	Civil society is known to be more flexible as it responds to crises and the unexpected needs of the communities. CSOs that are funded by government are more flexible than the public sector, but often less flexible than spontaneous and less institutionalised organizations.

Participation in Policy	One of the key benefits of a strong civil society is that it can bring new information to decision makers whether through research, close contacts or bringing opinions not voiced by government. The benefits to policy-makers of CSOs participation in policy-making are not just better information, but also diversity of ideas.

London (2008) go further and pose the question of whether health and human rights approaches and programs within CSOs can be integrated and implemented in communities, given that the integration of human rights approaches into our health and social policies offers an opportunity to address key health challenges.. This in turn raises the question of motivation for participation within CSOs, one of the objectives of this study, given the impact of external factors such as donor/funder/Governing Board requirements on the type of services delivered by CSOs. Further considerations are the values of commitment, trust, respect and a shared sense of identity amongst CSOs, which are discussed in depth in the following chapter.

My research study explores whether and how a Learning Network (LN) for the Right to Health can provide CSOs with a platform for building their own agency in terms of health and human rights knowledge, and further, whether the knowledge has cascaded to their beneficiaries in order for them to develop agency and participate in the achievement of the right to health. An understanding of the policy context is essential for this analysis. The following section presents an overview of South African human rights laws and policies.

2.2 SOUTH AFRICA HEALTH AND HUMAN RIGHTS

2.2.1 Political Context

Prior to 1994, civil and political rights were not legally entrenched for the majority of South Africans who lived in fear of an oppressive Apartheid State (February, 2006). The author argues that internationally, South Africa remained a pariah state because of the flouting of human rights norms and standards, starting in 1948 when it refused to adopt the Universal Declaration of Human Rights, unlike many other states. According to February (2006), the decision to ignore a policy giving concrete substance to international rights for the first time, was based on the South African (SA) policy of legally institutionalizing Apartheid. Ngwena (2006) concurs with February and

reports that prior to 1994, the most prominent feature of the SA Government before democratization was differential and unequal service provision on the basis of race. While racial inequality in the provision of health services preceded Apartheid, the policy magnified the inequality on a grand scale (Ngwena, 2006). The author further contends that in Apartheid South Africa, the bulk of public health expenditure was used for the provision of health care services to the White population in the country. The Colored and Indian racial groups received less of the budget and the Black population had little access to health care particularly in the rural areas.

Coovadia *et al.* (2009) add that South African history is not only permeated with discrimination based on hierarchies of race, gender and age but note that discriminatory policies had a pronounced effect on health policies and services, and consequently, the health of its people.. They outline the social dynamics and race discrimination, key health challenges, health care resources and health systems in South Africa from 1652-1994. These challenges are tabulated to summarize the impact of Dutch and British colonialism on South Africa (1652-1800), the period of segregation (1910-1948) and the Apartheid years (1948-1994). The period 1994-2008, however, has direct relevance to my research as it summarizes the key health challenges, health care resources and health systems in South Africa in the post-Apartheid era (Table 2.9). It further serves as an introduction to understanding SA Health Laws and Policies.

Table 2.9: Key Health Challenges, Health Care Resources and Health Systems in South Africa (1994-2008)

Key health challenges 1994-2008	Health-care resources	Health system
▪ Quadruple burden of disease recognised: diseases of poverty (perinatal and maternal diseases), non-communicable diseases, HIV/AIDS (communicable diseases), ▪ violence and injury lead the causes of	▪ Stagnation in government funding of health care ▪ Expenditure per head on medical schemes was three times greater than public expenditure in	▪ 1996: free care for children younger than 6 years and pregnant women, and free primary health care for all ▪ 1996: the Choice on Termination of Pregnancy Act legalised abortion, increased access, and led to marginal declines in septic abortions and stabilisation in maternal mortality from septic abortions in recent years ▪ A rights-based approach to youth sexuality: promotion of information and youth-friendly sexual health services,

mortality and healthy years of life lost	1996; this difference had increased to almost six times greater by 2006 ▪ By the end of the 1990s, almost three-quarters of generalist doctors worked in the private sector ▪ Redistribution of government funding between geographic areas	and banning the exclusion of pregnant pupils from schools; teenage pregnancy declined by 56% from 124 births per 1000 women aged 15–19 years in 1987–89 to 54 per 1000 in 2003 ▪ 1999: Tobacco Products Control Amendment Act contributed to substantial reduction in smoking as a result of prohibited smoking in public places, restricted tobacco product promotion, and enhanced taxation ▪ 2000: Firearms Control Act restricted access to firearms; a reduction in gun-related homicides followed ▪ 2001: Free Basic Water Strategy defined water as a social and developmental good and basic human right ▪ 2002: Mental Health Care Act legislates against discrimination against mental health-care users ▪ 2004: National Health Act legislates for a national health system incorporating public and private sectors and the provision of equitable health-care services ▪ provides for fulfilling the rights of children with regards to nutrition and basic services and entrenches the rights of pregnant women and children to free care throughout the public sector if they are not on a medical scheme ▪ legislates for the establishment of the district health system to implement primary health care throughout South Africa

The table shows that funding health care services was the key challenge in the provision of health care in this period. Funding by government stagnated resulting in an underfunding of health care. According to Coovadia *et al*., (2009), the expenditure per capita on medical schemes was three times greater than it was in public sector in 1996. By the year 2006, the gap in the expenditure per capita between the medical

schemes expenditure and that of State was six times greater. Mayosi, et al (2012) building on Coovadia et al (2009), further argue that the extra health burden meant that investment in health systems with effective implementation and management needed to increase at all levels.

As the health system was under pressure, Mayosi et al (2012) proposed that the key health challenges should be prioritized in terms of service delivery. Secondly, the authors recommended that an integrated and effective primary health care service should be implemented with strong management and the capable use of data. Widespread scale-up of successful innovations as well as relevant and rigorous clinical research was viewed as the third priority to upscale the delivery of health services and to achieve the Millennium Development Goals by 2015.

2.2.2: South African Health and Human Rights: Legislation and Policies

Race-based legislation was abolished after 1994. Taking cognisance of the deep social and economic inequalities of the past, the South African Constitutional Assembly included justiciable social and economic rights in the South African Constitution (February, 2006). In addition, the Constitution entrenched civil and political rights such as: freedom and security of the person (Section 12); freedom of religion, belief and opinion (Section 15); freedom of expression (Section 16); the right to assembly, demonstration, picket and petition (Section 18); political rights (the right to citizenship (Section 20); freedom of movement and residence (Section 21).

The first democratically elected President of South Africa, President Nelson Mandela, on behalf of the SAZGovernment, signed the International Covenant of Economic, Social and Cultural Rights (ICESCR) in 1994. The acceptance of the ICESCR showed that the South African government was committed to the promotion and protection of international norms, values and human rights practice, particularly in relation to social and economic entitlements for people in South Africa. South Africa became a signatory to ICESCR and this was an important step for the realization of President Nelson Mandela's revolutionary vision of the promotion of human rights for all citizens, free from discrimination or marginalization.

The SA Government only ratified the ICESCR in 2015, two decades after signing it. The difference between signing and ratification is that by signing the Covenant, a state agrees on the terms that will bind the signatory state and it expresses its intention to comply with the Covenant. However, this expression of intent is not binding. Ratification implies that the State legally binds itself to the International Covenants to implement the Convention and/or Optional Protocol through ensuring its domestic laws and policies are consistent with the Covenant. Table 2.10 summarizes the following South African Laws and Policies:

Table 2.10: South African Health and Human Rights Legislation and Policies

1. The Constitution of the Republic of South Africa (Act No. 108 of 1996)
1.1 The South Africa Bill of Rights (Chapter 2 of the South African Constitution)
1.2 Human Rights Instruments (Chapter 9 of the South African Constitution)
2. The South Africa National Health Act (Act No. 61 of 2003)
3. The Patients' Health Charter (South African Department of Health)

2.2.3 The South African Constitution

The South African Constitution (1996) is regarded as one of the most progressive in the world. It is unique in that it places obligations on the SA Government to promote human rights not present in the ICESCR. The Constitution contains various sections that stipulate that human rights should be progressively realized in order to promote and protect the human rights of its citizens. The Constitution is gender sensitive and includes the civil and political rights and comprehensive socio-economic and cultural rights (Thomas, 2009). It further contains the Bill of Rights (Chapter 2 of the Constitution) and Human Rights Institutions (Chapter 9).

The right to health is provided for in the South African Constitution (1996). Chapter 2 of the SA Constitution contains the Bill of Rights, which is a cornerstone of democracy in South Africa. The Constitution enshrines the rights of all people in our country and affirms the democratic values of human dignity, equality, and freedom. The Right to health is captured in Table 2.11.

2.2.4 The Bill of Rights (Chapter 2 of the South African Constitution)

Table 2.11: The South African Bill of Rights (1996).

1. Everyone has the right to have access to ▪ Health care service, including reproductive health care ▪ Sufficient food and water ▪ Social security, including, if they are unable to support themselves and their dependents, appropriate social assistance.
2. The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights.
3. No one may be refused emergency medical treatment.

The South African Bill of Rights enshrines the rights of all people in South Africa and affirms the democratic values of human dignity, equality and freedom. The state must respect, protect, promote and fulfill the rights in the Bill of Rights. Like ICESCR, the SA Bill of Rights also declares that the government should progressively fulfill the requirements of social and economic rights.

It further establishes a range of health rights that details the specific right of access to health care services and rights related to the underlying conditions needed to be healthy (social determinants of health). The Bill further highlights the rights of vulnerable groups and foundational rights that acknowledge our common humanity and principles of equality (London and Baldwin-Ragaven, 2006).

The following list provides examples of the social determinants of health, which can influence health equity in positive and negative ways (World Health Organization, n.d.):

- Income and social protection
- Education
- Unemployment and job insecurity
- Working life conditions
- Food insecurity
- Housing, basic amenities and the environment

- Early childhood development
- Social inclusion and non-discrimination
- Structural conflict
- Access to affordable health services of decent quality.

Scott *et al*., (2017) state that the shift from the Millennium Development Goals (MDGs) to the 17 new Sustainable Development Goals (SDGs), generated attention to a broader set of social determinants of health. Unlike the MDGs, the SDGs reflected a specific sensitivity to equity which could have a substantial effect on health. They, however, argue that there is a weakness in the broader set of social determinants of health in its approach to community development, civic engagement and intersectoral collaboration. Specifically, it does not recognise the developmental approach to addressing issues relating to social determinants within the health and other sectors.

2.2.5 The Right to Health (Chapter 4 of the South African Constitution)

Chapter 4 of the Constitution stipulates that the right to health is fundamental for the physical and mental well-being of all individuals and is a necessary condition for the exercise of other human rights including the provision of an adequate standard of living. Rights to health closely follow the rights and freedoms protected under the Universal Declaration of Human Rights. Table 2.12 is a summary of the various sections of health rights in the SA Constitution.

Table 2.12: The Right to Health

Category	Provision	Section
1. Health care services	▪ To have access to health care services, including reproductive health care ▪ To emergency health care	Section 27.1(a) Section 27.3
2. Underlying conditions needed for health	▪ To access information needed for health ▪ To an environment that is not harmful to health or well-being ▪ To freedom and security of person, including freedom from all forms of violence from either public or private sources ▪ To freedom of religion, belief	Article 32 Article 24 Article 12 Article 15

	and opinion ▪ To be free from medical experimentation without their informed consent ▪ To have access to adequate housing ▪ To a basic education, including adult basic education; and progressive realization of further education ▪ To have access to sufficient food and water ▪ To have access to social security	Article12.2(c) Article 26 Article 29 Article 27.1 (b) Article 27.1(c)
3. Special populations	▪ Children have the right to basic nutrition, shelter, basic health care services and social services ▪ Prisoners have the right to conditions of detention consistent with human dignity, including the provision of nutrition and medical treatment	Article 28 Article 35
4. Foundational Rights	▪ To dignity ▪ To equality (non-discrimination) ▪ To life ▪ To lawful, reasonable and procedurally fair administrative actions	Article 10 Article 9 Article 11 Article 23

2.2.6 Human Rights Institutions (Chapter 9 of the South African Constitution)

Chapter 9 of the SA Constitution (Section 187) requires the creation of institutions to protect human rights and support constitutional democracy. These include the Public Protector; The South African Human Rights Commission; The Protection of the Rights of Cultural, Religious and Linguistic Communities; The Commission for Gender Equality; The Auditor General and The Electoral Commission.

These institutions are independent and subject only to the Constitution and the law. According to the governing principles of Chapter 9 institutions (South African Government, 1996) they must be impartial and must exercise their powers and perform their functions without fear, favour or prejudice. Organs of state, through legislative and other measures, must assist and protect these institutions to ensure

the independence, impartiality, dignity and effectiveness of these institutions; no person or organ of state may interfere with the functioning of these institutions and these institutions are accountable to the National Assembly and must report on their activities and performance of their functions to the Assembly at least once per year. The roles and responsibilities of the Chapter 9 Institutions are summarized as follows (South African Government, 1996).

2.2.6.1 Office of the Public Protector

The Office of the Public Protector was established to protect the public against matters such as maladministration in connection with the affairs of government and improper conduct by a person performing a public function. The Public Protector has the power as regulated to investigate any conduct in state affairs or in any sphere of governance; must be accessible to all persons and communities and any report issued by the Public Protector must be open to the public unless exceptional circumstances, to be determined in terms of national regulation, require that a report be kept confidential.

2.2.6.2 The South African Human Rights Commission (SAHRC)

The SAHRC is an autonomous agency charged with promoting and monitoring the protection of human rights and is fully empowered to monitor and investigate the State in regard to the realization of socio-economic rights. The mission of the SAHRC as the independent national human rights institution is to support constitutional democracy through promoting, protecting and monitoring the attainment of everyone's human rights in South Africa without fear, favour or prejudice. It further has the authority to hold hearings to inform and investigate the right to access healthcare. Table 2.13 summarizes the mandate of the SAHRC:

Table 2.13: The South African Human Rights Commission

1. Promote the protection, development and attainment of human rights
2. Monitor and assess the observance of human rights
3. Investigate and report in the observance of human rights

4. Take steps and secure appropriate redress where human rights have been violated
5. Carry out research
6. Require relevant organs of state to provide the Commission with information on the measures they have taken towards the realization of the rights as stipulated in the Bill of Rights

2.2.6.3 Commission for the Promotion and Protection of the Cultural, Religious and Linguistic Communities

The function of the Commission is to promote respect for the rights of cultural, religious and linguistic communities; as well as to promote and develop peace, friendship, humanity tolerance and national unity among cultural, religious and linguistic communities, on the basis of equality, non-discrimination and free association. The Commission should further recommend the establishment or recognition, in accordance with national legislation, of a cultural or other council or councils for a community or communities in South Africa.

2.2.6.4 The Commission for Gender Equality

The Commission was established to promote respect for gender and the protection, development and attainment of gender equality. It has the power, as regulated by national legislation, to investigate, research, educate, lobby, advise and report on issues concerning gender equality.

2.2.6.5 The Auditor General

The Auditor General must audit and report on accounts, financial statements and financial management of all national and provincial state departments and administrations; all municipalities and any other institutions or accounting entity required by national or provincial legislation to be audited by the Auditor General.

2.2.6.6 The Electoral Commission

The Electoral Commission must manage elections of national, provincial and municipal legislative bodies in accordance with national legislation; ensure that those elections are free and fair and declare the results of those elections within a period that must be prescribed by national legislation.

2.2.7 The National Health Act (Act 61 of 2003)

The preamble of the National Health Act, states that the Act was promulgated to provide a framework for a structured uniform health system within the Republic of South Africa, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard to health services; and to provide for matters connected therewith. The Act commits the State to subscribe to the basic core obligations and the need to establish a society based on democratic values, social justice, and fundamental human rights. The Act further recognizes the socio-economic injustices, imbalances and inequities of health services of the past. It stipulates that a need exists to heal divisions of the past and to establish a society based on democratic values, social justice and fundamental human rights. It further recognizes that there exists a need to improve the quality of life of all citizens and to free the potential of each person.

Chapter 1 includes the objectives of the Act. These objectives are to regulate national health and to provide uniformity in respect of health services. Chapter 2 covers the rights and duties of users and health care professionals. Chapters 3-7 detail the responsibilities of the National Department of Health, the Provincial Health Services and the District Health System. Chapters 6-7 present Health Establishments and the classifications thereof. It focuses on the planning of human resources and academic complexes. Chapters 8-12 refer to the control of blood, blood products, tissue and gametes in humans. It further covers areas of research and information; health officers and compliance procedures; the regulations of the Act and general provisions.

2.2.8 The Patient's Health Charter

The Patient's Health Charter is an instrument of the SA Department of Health. It proclaims the Charter as a common standard for achieving the realization of the right

of access to health care services. The Charter includes many of the core obligations as found in the International Bill of Human Rights. The SA Government should ensure that every citizen participates in the development of health policies and the right to participate in decision-making on matters affecting people's health. The primary tenets of the Charter are that patients have a right to a healthy and safe environment; patients should participate in decision-making and have access to health care and have a choice of health services. It emphasizes the importance of rights and values in health care delivery and provides a framework that stipulates the principles for how patients and providers should behave towards its other. London, et al (2006) describe the Charter as an intervention aimed at improving health system performance that targets the relationship between the provider and patient. Table 2.14 summarizes the tenants of the Charter.

Table 2.14: The Patient's Health Charter (Extract of the Charter)

1. Have a right to a healthy and safe environment
2. Should participate in decision making
3. Have access to health care
4. Should have knowledge of one's health
5. Have a choice of health services
6. Treated by a named health care provider
7. Should be treated with confidentiality and privacy
8. Have the right to confidentiality and privacy
9. Have the right to be given full and accurate information about the nature of the illness and to make an informed decision about the treatment process
10. Have the right to refuse treatment provided that such refusal does not endanger the lives of others
11. Have the right to a second opinion
12. Have the right to continuity of care
13. Have the right to complain about health care and to have such complaints investigated and to receive a response on such an investigation.

Civil society participation in health decision-making is a key feaure of the National Health Act (2003). Chapters 3-5 of the Act makes provision for the establishment of participatory mechinisms such as the National Health Council whose purpose is to advise the Minister on policy concerning any matter that will protect, promote, improve, and maintain the health of the population. The Act further makes provision for the development of a National Consultative Health Forum. The purpose of the Forum is to promote and facilitate interaction, and the sharing of information on national health issues between representatives of the National Department of Health, National organizations, and Provincial consultative bodies. These Councils and Forums are also constituted at a provincial and district level. At community level, provision is made for the establishment of Clinics and Community Health Centre Committees for community participation in health matters. The following section presents the role that community participation plays in the SA Health System.

2.3 COMMUNITY PARTICIPATION IN THE SOUTH AFRICAN HEALTH SYSTEM

The need to include community participation in the realization of health and human rights is recognized in various International and National instruments, laws and policies. The SA National Health Act recognizes the importance of communities participating in decisions regarding their health care by providing for health committees to be established for every health facility or group of facilities. However, the National Act is silent on the powers and functions of health committees and leaves that matter to provinces to legislate. As a result, no formal structure existed in the Western Cape at the time of the research. Health committees therefore operate in a semi-formal space, contesting power with the health services (Haricharan, 2019).

Civil society has an important role to play in mobilizing communities around the right to health and in involving communities in building equitable health systems (Thomas and London, 2006). The authors assert that CSOs do so by creating awareness of health rights and by providing a voice to marginalized communities seeking health rights.

Chapter 6 of the National Health Act (2003) stipulates three structures through which communities can get involved: Health Committees, Hospital boards and District health

Councils. The Act prescribes that Health Committee should comprise of community representatives, the head of the facility and a local ward councilor. The Act however does not stipulate the role of the Committee.

The White Paper on the Transformation of the Health System in South Africa (1997) stipulates that the Committees should be the link between the health services, health care providers and the communities. The Committees are there to represent the community and to involve the community in decisions to be made by the health officials. In doing so, they build agency within communities as they bring knowledge about local health concerns. Further, having a link between the health facility and the community creates better accountability. In effect, the community has a right to feedback as to how they were treated and can forward complaints and request interventions to improve the delivery of health care.

In addition to the White Paper on the Transformation of the Health System in South Africa, the South African White Paper for Social Welfare (1997) stipulates that the vulnerable and the poor should participate with relevant stakeholders in decisions that impact on their lives.

As much as the role of community participation in the realization of health is emphasized, it is argued that CSOs have an important role to enable the poor, the vulnerable and the excluded in South African society, to secure a better life for themselves (London, 2003, 2004; Ngwena and London, 2004; Thomas and London, 2006).

Aside from community participation, Thomas (2009) contends that evidence to date illustrates the importance of knowing and understanding health rights. This is key to redressing social inequalities on the part of communities who are most vulnerable to the violation of their rights. According to Thomas (2009), translating awareness or knowledge into understanding and translating understanding into practice, is fraught with difficulties and obstacles. She further argues that the lack of education and awareness is a result of health care practitioners being perceived as holders of knowledge and that they play a powerful role in either facilitating or denying access to health care. This might explain why ordinary South Africans still struggle to realize

their health rights, despite the constitutional framework that promotes the right to health.

Muller (2013) concurs that community participation In South Africa is one of the fundamental pillars of the primary healthcare approach. The author reports that primary health care is critical to ensure that every person in South Africa is in the best possible health and should have access to the basic health services needed. Community participation means that people who receive health care should also be involved in decisions about how these facilities are governed. Similarly, London (2018) argues that the South African law regards participation and engagement as integral to the realization of socio-economic rights, and that 'meaningful engagement' is required throughout policy development.

Stuttaford *et al.,* (2014) concur with Thomas and London (2006) that civil society has a crucial role to play in ensuring that the right to health is achieved, particularly in terms of advocacy, developing policies and programs, monitoring state obligations, and addressing violations of the right to health. Mechanisms for participation and accountability are key principles of the right to health and how civil society influences the implementation of the right to health. They assert that non- discrimination is another key principle and that collectives are not passive recipients of human rights but are actors influencing the implementation of the right to health.

Douwes, Stuttaford and London (2018), expand on the role of civil society in the realization of the right to health and acknowledge the power that individuals and collectives have in achieving universal health care. They describe universal health care as a rights-based approach to health that integrates human rights norms in health policies and programs. The rights-based approach embraces the principles of equity, equality and non-discrimination, and is applied to both the determinants of health and health care provision.

2.4 SUMMARY

An overview of legally binding human rights instruments as well as related policies that hold states accountable for the promotion and protection of health and human rights is presented in this chapter.

The SA Constitution, Bill of Rights and Legal instruments promote and protect the human rights of its citizens. The SA National Health Act (2003) particularly acknowledges the value of community participation in peoples' health and provides for structures at community level to effect such participation, but without providing guidance on how such participation should occur.

Despite the range of legislation in South Africa, Thomas and London (2006), emphasized that knowledge and awareness of health rights should be translated into practice to ensure that the community is not only aware of their rights but can access services in order to improve their quality of life. Scott, Greer, and Pastorini (2017) emphasized the role of civil society in the dissemination of health and human rights knowledge and awareness. They called on CSOs to interact with each other and to work in collaboration with broader stakeholders to address the health challenges that communities experience. In addition, they assert that CSOs are closer to the communities and can provide services in response to community needs.

Recognizing the need for communities to obtain more knowledge and awareness of health and human rights, the LN was conceptualized with a specific agenda to build agency amongst CSOs that will equip them to build health and human rights program in their communities.

As referred to in the section on researcher background and positionality, the researcher concurs with the assertion that CSOs need capacity to not only acquire global knowledge about the various legislative instruments, but to be able integrate the knowledge and implement it within their health and human rights programs. It is for this reason that the researcher drew on the global instruments to inform the study, and to understand whether social capital and networks could be used as pathways for learning and implementation of health and human rights programs.

Chapter 3 presents a literature review on social capital and networks, and how social capital through networks can facilitate the realization of the right to health.

CHAPTER 3
LITERATURE REVIEW: SOCIAL CAPITAL AND NETWORKS

3.1 INTRODUCTION

A literature review of social capital and networks was conducted to locate the theories relevant in relation to the research questions: (i) Has the Learning Network for Health and Human Rights provided a platform for knowledge sharing and collaboration amongst the CSO partners? (ii) Has the collaboration developed social capital to build agency for the integration and implementation of health and human rights programs in their organizations?

3.1.1 The organization of this literature review

Social capital and networks are interlinked but each theory has its distinct aspects and purpose, hence, they are presented in two sections in this chapter. Section 3.2 provides an understanding of what social capital is and includes the definitions, aspects, and dimensions of social. The aspects of trust, altruism, reciprocity, cohesion, and power are key for the development of social capital within a network

The section further discusses the relationship between social capital and community engagement and communities of practice. It concludes with a discussion of the role of social capital, civil society, and the realization of the Right to Health.

Section 3.3 provides definitions of networks and describes the various types of networks: (i) Community of practice (Community, Practice and Research-based Networks), (ii) Community-based Research Networks; (iii) Advocacy Networks, (iv) Virtual Networks and (v) Learning Networks. The section further describes drivers of successful networks. The drivers provide indicators and lessons for what a successful network is and how to become a successful network. The section concludes with a discussion on the role of social capital, networks, and the realization of health.

3.1.2 The methods used for the literature review

A narrative review of the literature was selected because of the scope it affords for exploring complex and multidimensional phenomena such as ‘social capital’ and ‘networks’. The following approach was used to conduct the literature review:

a. Keywords: They were not only limited to “social capital” and “networks”. Additional key words included:‘community participation’, ‘civil society’, ‘health and human rights’, ‘right to health’, ‘network types’ and ‘South Africa Legislated Instruments .’ Keyword searches made use of both ‘and’ and ‘or’ in its Boolean search string construct.

b. Data Basis

   - Primo
   - Global Health Observatory (GHO)
   - Online library and publication platform (OAPEN)
   - Full Text - via EBSCOhost
     Google Scholar
   - Humanities International Complete
   - ElseVier (Publisher of Journals)

c. Language of articles: Articles were restricted to English as the researcher was not competent in other languages and did not have resources to do article translation.

d. Additionally, the researcher joined the Institute for Social Capital (Claridge) for access to webinars presented on various aspects of social capital. These webinars alerted the researcher to relevant articles.

.The range of literature on social capital and networks that the researcher read critically and synthesized, is presented in the next two sections of this chapter.

3.2 SOCIAL CAPITAL THEORIES

Before embarking on the discussion of various definitions and aspects of social capital, it must be noted that ‘social capital’ is multi-dimensional and various authors differ in their definitions and aspects.

The growing recognition of the social determinants of health has brought the concept of ‘social capital’ to the attention of international researchers in health (Harpham, Grant and Thomas, 2002). The literature on ‘social capital’ is rooted in in the works of several key authors: Bourdieu, Coleman, Portes, Putnam, Woolcock and Narayan,

Adler and Kwon, Scott and Hoffmeyer, and Fukuyama. They are acknowledged as having brought the social capital debate to its current prominence. They represent early attempts to identify and conceptualize a broad and multidimensional approach to the concept.

3.2.1 Definitions of Social Capital

The following authors define social capital based on their perception of whether social capital has internal or external outcomes.

Bourdieu (1992) was interested in the ways in which the dominant classes retain their position in society. His definition of social capital explains how social capital is accrued for individuals and positions remain constant.

> "*Social capital is the sum of the resources, actual or virtual, that accrue to an individual or a group by virtue of possessing a durable network of more" (Bourdieu, 1992,p.119).*

Coleman (1990) defined social capital in terms of functions, thereby shifting from a focus of individual outcomes to recognising outcomes for groups, organizations, institutions or societies.

> *"Social capital is defined by its functions. It is not a single entity but a variety of different entities having two characteristics in common. They all consist of some aspect of social structures, and they facilitate certain actions of actors whether persons or corporate actors within the structure"* (*Coleman, 1990, p.302)*

Coleman's approach, presents a broader view of social capital where it is not seen only as "stock" held by the powerful elites but also as having structural value for communities, including the powerless and marginalised. The author presents a model in which social capital is one of the potential resources that an actor can use, alongside other resources such as their own skills and expertise (human capital), tools (physical capital), or money (economic capital). Social capital is not 'owned' by the individual but instead it arises as a resource that is available to them.

Portes (1998) stressed the difference between what social capital *is* and what it *does.*

> *"The ability to secure benefits through membership in networks and other social structures" (Portes, 1998, p.6)*

According to this definition, two dimensions are distinguished namely, a relational element residing in the social organizations of which the individual is a member and a

material one that relates to the resources to which that individual has claim by virtue of their membership of the group. Trust between members of a network then becomes critically important as the 'oils and wheels' of social and economic exchange that reduces transactional costs, allowing group members to draw on favours, circulate privileged information and gain better access to opportunities.

Social capital was discussed at length in Putnam's (2000) article on *Bowling Alone: America's Declining Social Capital.* Here, the act of bowling alone, a reference to the disintegration of US after-work bowling leagues, is a metaphor to illustrate the decline of social, political, civic, religious, workplace connections in the United States. He demonstrated this decline by looking at the way Americans play 10-pin bowling, a sport with a big following in the United States. He found that although bowling has never been bigger, Americans are no longer competing against each other in the once-popular local leagues. Instead, they are literally bowling alone. Putnam argued that the decline of the community networks that once led Americans to bowl together represents a loss of social capital.

Putnam differs from Bourdieu, Coleman and Portes and describes social capital as a sociological concept (used in business, economics, organizational behavior, political science, public health, and the social sciences in general), to refer to connections within and among social networks. The core idea is that networks have value. Like physical and human capital, social contacts can increase the productivity of individuals and groups. Putnam explains that social capital is the connection among individuals' networks and the norms of reciprocity and trustworthiness that arise from them. The author defines social capital as:

> *"The features of social organization, such as trust, norms, and networks, that can improve the efficiency of society by facilitating coordinated actions*" (*Putnam, 2000,p.19)*

Fukuyama (1999) expands on the norms and networks to include the aspects of trust in his definition of social capital. The author defines social capital as a capability that arises from the prevalence of trust in a society or in certain parts of it. The aspects of trust, in addition to aspects of altruism, reciprocity, cohesion and inclusion, power, empowerment and agency is further elaborated below in section 3.2.2.

"An informal norm that promotes co-operation between two or more individuals..."It can be embodied in the smallest and most basic social group, the family, as well as the largest of all groups, the nation, and in all the other groups in between" (Fukuyama, 1999,p.1-2).

Woolcock and Narayan (2000) contend that the basic idea of social capital is that a person's family and friends and associates constitute an important asset, one that can be called upon in a crisis. This is also applicable to communities and groups who have a diverse stock of social capital and civic associations. More often, those with the social capital and associations are in a stronger position to confront poverty and vulnerability. Conversely, the absence of social ties can have an equally important negative impact. In summary, they summarize the definition of social capital as follows:

"The norms and networks that enable people to act collectively... It's not what you know, it's who you know" (Woolcock and Narayan,. 2000, p.225)

Adler and Kwong (2002) present additional definitions of social capital. Table 3.1 is an adaption of the table presented by Adler and Kwong. The adaptation combines authors who have an internal perspective of social capital, external perspective or a combination of both perspectives.

Table 3.1: Definitions of Social Capital (Adapted from Adler and Kwon 2002).

Authors	**Definitions of Social Capital**
Internal value of Social Capital	
Baker, 1990:619.	*"A resource that individuals derive from specific social structures and then use to pursue their interests, it is created by changes in the relationship among individuals".*
Belliveau; O'Reilly; Wade 1996:1572.	*"An individual's personal network and elite institutional affiliations".*
Boxman; De Graai; Flap 1991:52	*"The number of people who can be expected to provide support and the resources those people have at their disposal".*
Burt 1997:355	*"Friends, colleagues and more general contacts through which you receive opportunities to use your financial and human capital".*

External Value of Social Capital	
Knoke 1999:18	*"The process by which social individuals create and mobilize their network connections within and between organizations to gain access to other social individuals' resources".*
Brehm; Rahn 1997: 999.	*"The web of cooperative relationships between citizens that facilitate resolution of collective action problems".*
Fukuyama 1995:10. **Fukuyama 1997.**	*"The ability of people to work together for common purposes in groups and organizations".* *"Social capital can be defined simply as the existence of a certain set of informal values or norms shared among members of a group that permit cooperation among them".*
Inglehart 1997:188.	*"A culture of trust and tolerance, in which extensive networks of voluntary associations emerge".*
Portes; Sensenbrenner 1993:323.	*"Those expectations for action within a collectivity that affect the economic goals and goal-seeking behavior of its members, even if these expectations are not oriented toward the economic sphere".*
Internal and External value of Social Capital	
Thomas 1996:11.	*"Those voluntary means and processes developed within civil society which promote development for the collective whole".*
Loury 1992:100.	*"Naturally occurring social relationships among persons which promote or assist the acquisition of skills and traits valued in the marketplace . . . an asset which may be as significant as financial bequests in accounting for the maintenance of inequality in our society".*
Nahapiet; Ghoshal 1998: 243.	*"The sum of the actual and potential resources embedded within, available through, and derived from the network of relationships possessed by an individual or social unit. Social capital thus comprises both the network and the assets that may be mobilized through that network".*

Pennar 1997:154.	*"The web of social relationships that influences individual behavior and thereby affects economic growth".*
Schiff 1992:160.	*"The set of elements of the social structure that affects relations among people..*

Authors who present social capital from an internal perspective are Baker, Belliveau, Boxman and Burt. Those who assume an external perspective are Knoke, Brehm and Rahn, Fukuyama, Inglehart, and Portes.

Authors who combine both the internal and external dimensions of social capital are Thomas, Loury, Nahapiet and Ghosal, Penner and Schiff. In combining internal and external definitions, the latter group emphasizes the importance of networks for the formation of trust and norms amongst the individuals and the shared assets that may be mobilized through the network.

Fukuyama (1995) and Inglehart also emphasize the role of social networks, trust, norms, and sanctions in facilitating collective action. Fukuyama particularly focuses on the role of informal and shared values that give rise to trust. Trust is seen by the author as a key-mediating factor in lowering "transaction costs" in communities and enterprises and enabling people to work together more effectively.

Although the definitions and dimensions of social capital in Table 3.1 vary, there is an agreement that bonding, bridging and linking social capital are key concepts required for the development of trust, altruism, reciprocity, cohesion, power, empowerment and agency.

The table of definitions as presented by Adler and Kwon (2002) covers research between the period 1960-1998. Claridge (2020) reviewed the definitions of Adler and Kwon in 2004 and contends that the definitions as cited by Adler and Kwon continue to be a challenging area for understanding social capital. In 2004, Claridge was interested in ascertaining whether the definitions of social capital as listed by Adler and Kwon, "had faded into obscurity". The author embarked upon research and randomly selected 100 peer-reviewed journal articles with social capital in the title that were published in 2019. Although the research was limited to 100 articles, the author

found that over 70% of the sample still referenced Putnam, Bourdieu, Lin, Nahapiet and Ghoshal, and to a lesser extent, Coleman. Claridge suggests that the definition of social capital is variable, that the differences have not been resolved and if there is a resolution, it is not observed by many authors. Claridge's findings are echoed by Stiglitz, Fitoussi and Durand, (2018) who assert that despite the high level of interest in social capital over the years, there is little agreement about the best way to define it.

Given the various definitions, aspects and dimensions of social capital, the summary by Scrivens and Smith (2013, p.19) of four domains of social capital appears most practical as a means of understanding the complexity of social capital. These domains are: (i) extent of the structure, (iib) density, (iii) resources available in social networks and (iv) trust and co-operation. They inter-relate as follows:

(a) Personal relationships refer to people's networks (i.e. the people they know) and the social behaviours that contribute to establishing and maintaining those networks, such as spending time with others, or exchanging news. This category concerns the extent, structure, density and components of individuals' social networks*. It is confusing to have (a), (b), (c) and (d) above, and then another set of (a), (b), etc … here that do not correspond exactly. I suggest editing it along the lines I have done.*

(b) Social network support is a direct outcome of the nature of people's personal relationships, and refers to the resources – emotional, material, practical, financial, intellectual or professional – that are available to each individual through their personal social networks.

(c) Civic engagement measures activities through which people contribute to civic and community life, such as volunteering, political participation, group membership and different forms of community action. High levels of volunteering and civic action can contribute to institutional performance as well as being a driver of trust and co-operation.

(d) Trust and co-operation: "an individual trusts if he or she voluntarily places resources at the disposal of another party without any legal commitment from

the latter, but with the expectation that the act of trust will pay off" (Scrivens and Smith, 2013:19).

Scrivers and Smith (2013) emphasise that different aspects and interpretations of social capital should not be captured into one overarching framework. Rather, they contend that most work done on social capital in the past two to three decades has been informed by the four interpretations as presented in the following Table 3.2.

Table 3.2: Four interpretations of social capital

	NETWORK STRUCTURE AND ACTIVITIES	**PRODUCTIVE RESOURCES**
INDIVIDUAL	*Personal Relationships*	*Social Network Support*
COLLECTIVE	*Civic Engagement*	*Trust and Cooperative Norms*

Nevertheless, Claridge (2020), argues that clarity and consistency is important when one conducts research on social capital. The definition of social capital must match how you conceptualize and operationalize the concept. With the plethora of literature on the definitions of social capital, the researcher conceptualized her understanding of social capital as being the sum of resources that individuals or groups accrue over time for collective action. These resources are access to skills, knowledge and expertise; shared values that manifests in trust and social cohesion; the bonding and bridging relationships amongst and between individuals and groups and the linkages that benefit the individual or group. The individual or group, however, does not own the resources. Rather, they are resources that are available to the individual or group for the integration of their right to health programs. This research study utilized these concepts as indicators of whether social capital had enabled the participants to form cohesive relationships for the realization of the right to health in communities.

The following section presents the diverse aspects of social capital as listed above.

3.2.2 Aspects of Social Capital

3.2.2.1 Trust:

Fukuyama (1995) defines trust as the expectation that arises within a community of regular, honest, and cooperative behavior, based on commonly shared norms, on the part of other members of that community. Fukuyama emphasizes that informal and shared values give rise to trust between members and as such, members often reciprocate with each other. Trust between members of a network is viewed as being the 'oils and wheels' of social and economic exchange that members draw on favors, circulate privileged information and gain better access to benefits and opportunities (Portes 1998).

Putnam (2000) states that social capital is the connection among individuals, networks and trustworthiness that arise from them. Dudwick, Kuenhnast, Jones and Woolcock (2006) define trust as the degree that people can access support and resources from others. The authors further explain that the definition of trust must be contextualized to the situation as it could reflect a dependency on established contacts or networks.

Different types of trust could be measured within established relationships and networks. Gilson (2007) argues that in the health sector, acceptability and trust also influences patient decision making and experience in ways that shape the benefits derived from health care and are likely further disadvantage socially marginalized groups.

Douwes, Stuttaford and London (2018) define trust as relational aspects that can be instituted from an individual standpoint. According to the authors, a common understanding of trust is "voluntary action based on expectations of how others will behave in the future in relation to yourself" (page number?). This aspect is recognized as enhancing co-operation between individuals and groups. Drawing on Fukuyama's description, they emphasize that trust is important to a strong health care system because it relies on a system of co-operation and shared values within society.

In a recent article by Claridge (2020), trust is framed as essential for the existence of social capital and the argument is made that most authors agree that trust and trustworthiness are at the core of social capital. Trust is often mentioned specifically in definitions of social capital, for example, connections among individual social networks and the norms of reciprocity and trustworthiness that arise from them. Authors equate trust with social capital, vital for any form of social interaction or exchange and trustworthiness 'lubricates social life' (Claridge, 2020).

Applied to South Africa, we see the White Paper for Social Welfare (1997) promoting collaborative efforts in order for CSOs with their limited resources to work in partnership with like-minded organizations. Although CSOs are diverse in their practice they share the objective of building societies that are empowered to access their health and human rights. CSOs have therefore developed relationships with each other involving a greater sense of trust.

The development of trust between the various LN members particularly, that of the development of trust between the CSO members, is an important aspect of social capital as it would enable the formation of a cohesive group and build a common identity amongst the members. Without the development of trust, a network will have loose ties and lack commitment to work as a collective.

3.2.2.2 Altruism:

Fukuyama (1996) defines altruism as the belief that the well-being of others is equally, if not more, important than the well-being or survival of the self. Douwes, Stuttaford and London (2018) similarly, define altruism as a behavior that reflects an unselfish desire to live for others. In essence, altruism comprises a moral obligation to sacrifice oneself or time, energy, or possessions for the collective good. Within the LN, altruism could be an outcome of the development of trust and other aspects of social capital. Dependent on the level of cohesion and common identity within the LN, individual commitment for collective outcomes for civil society is strengthened.

3.2.2.3 Reciprocity:

Compared to altruism that has no assumption of the favour being returned, reciprocity assumes a return of favour in future. Fukuyama (1996) describes reciprocity as a social norm of responding to a positive action with another positive action and rewarding kind actions. According to Molm (2010), the aspect of reciprocity is a defining feature of social capital i.e., the giving of benefits to others in return for benefits received. Douwes, Stuttaford and London (2018) describe reciprocity as a strong determinant of behaviour that contributes to equal relationships. Through the action of giving and receiving, bonding and bridging relationships are formed between members often resulting in cohesion and inclusion.

'Bonding capital' refers to the nature of relationships that are developed between the LN members as a result of the sharing of skills and knowledge. Bridging relationships take place when a member has access to external skills and knowledge that are shared and linked with and between the members. It is a reciprocal relationship that occurs when members link resources with each other for the development of additional agency external to the LN.

3.2.2.4 Cohesion and Inclusion:

According to Dudwick, Kuehnast, Jone and Woolcolk, (2006), the dimension of social cohesion and inclusion focus more specifically on the tenacity of social bonds and their dual potential to include or exclude members of community. Cohesion and inclusion can be demonstrated through community events, such as weddings and funerals, or through activities that increase solidarity, strengthen social cohesion, improve communication, provide learning for coordinated activities, promote civic-mindedness and altruistic behavior, and develop a sense of collective consciousness.

Green and Janmaat (2011): describe social cohesion as being "the glue that holds society together or the property that keeps society from falling apart." According to the authors, social capital is an individual's sacrifices (time, effort, and consumption) made to co-operate with others, whilst social cohesion is an effect of cohesive behaviors on societal norms and support. In these

distinctions the authors state that social cohesion is only possible where there is social capital present or available, in other words, social capital seems to be a prerequisite for social cohesion.

3.2.2.5 Power:

Power is a core concept in the development of social capital. Individual or members of a group or network can utilize their power to influence the objectives and outcomes of a group or network. The various dimensions and levels of power should be explored amongst its members to develop trust, reciprocity and cohesion in the group or network.

Bourdieu's understanding of power is defined by the structure or between different types of capital (Bourdieu 1996). It is also simultaneously a field of struggle for power among the holders of different forms of power.

VeneKlaasen and Miller (2002) define power as the degree of control over material, human, intellectual and financial resources exercised by different sections in communities. Power is ascribed to individuals and groups depending on the social divisions such as gender, age, caste, class, ethnicity, race, north-south, etc. The authors further state that the control of these resources becomes individual or social power which is dynamic and relational. Because power is dynamic, it can cause conflict in the relationships amongst individuals and between groups of people.

Gaventa (2006) argues that although everyone possesses and is affected by power, the meaning of power and how to understand it is diverse. Some people see power as held by certain people, some of whom are powerful while others are relatively powerless. The author further states that some people see power as a 'zero-sum' game which implies that to gain power for one set of actors means that others must give up some power; whilst othersview power as a 'negative' quality, as to hold power is to exercise control over others. Gaventa (2006) asserts that people seldom give up their power thus often resulting in conflict and power struggle.

Kaim (2013) contends that power lies at the centre of social relationships. According to the author, power is complex with multiple interpretations. Lukes

(1994) pointed out that that power affects people's lives in different ways and at different levels, and that not all power is observable as it could be invisible and internalized. Having or exercising power means some people control and have access to information and resources, while others do not. He presents two different aspects of power that has three dimensions and levels: "Power over" and "Power within". The former refers to the ability that powerful have to affect the actions and thoughts of the powerless, compared to the latter, that refers to gaining confidence and awareness. Any relationship whether between individuals, groups or societies is affected by a particular power dynamic that impacts on the deelopment of that relationship (Lukes 1994). Vene Klaasen and Miller (2002) concur, positing that power plays an integral role in either including or excluding role players because it impacts on the relationship amongst the group.

In order to understand and explore the dimensions, levels of power, spaces and forms of power, Gaventa (2006) refers to Lukes "power cube" as a framework for analysing power when seeking to effect social change. The power cube is visibly presented as a cube with each side of the cube representing a dimension or set of relationships. It further refers to the level, spaces and forms of power that must be seen as a continuum or scale. Gaventa (2006), however states that because of the complexity of the power cube, it is not useful to present all the sides at once. Instead, it is important to understand the dimensions of the power cube and then look at the interrelations between them.

People who have the power, utilize the power to influence the outcome of any programme or project. The power must be analysed from various aspects and once understood, could be addressed accordingly. It is further important to analyse whether "power within" had developed agency amongst the CSO members to participate confidently in decision making within the LN.

The LN members consists of CSOs and academic members with varying levels of experience and knowledge of health and human rights. The researcher must take cognisance of the various aspects, levels and dimensions of power when analysing the findings of the research data. For the development of social capital to take place, the LN members should not only identify the source and

level of power, but must empower themselves to address the power imbalance and collectively take ownership of the LN.

3.2.2.6 Empowerment:

Empowerment is understood as increasing the capacity of individuals or groups to make effective development and life choices and to transform these choices into desired actions and outcomes (Krishna, 2015). Perkins (2010), however, states that empowerment has been defined and measured in many ways. The author defines empowerment as an intentional ongoing process centered in the local community. It involves mutual respect, critical reflection, caring and group participation. The process enables people lacking an equal share of resources to gain greater access to and control over those resources, thereby gaining control over their lives. This in turn facilitates their involvement in democratic participation in their community and development of a critical understanding of their environment.

As a process, empowerment is an outcome of the development of strong bonding and bridging relationships within a network. This aspect of social capital in combination with the aspects presented above, is critical for the development of agency amongst the CSO members. Members not only acquire new skills and knowledge but build confidence for the realization of the right to health in communities.

3.2.2.7 Agency:

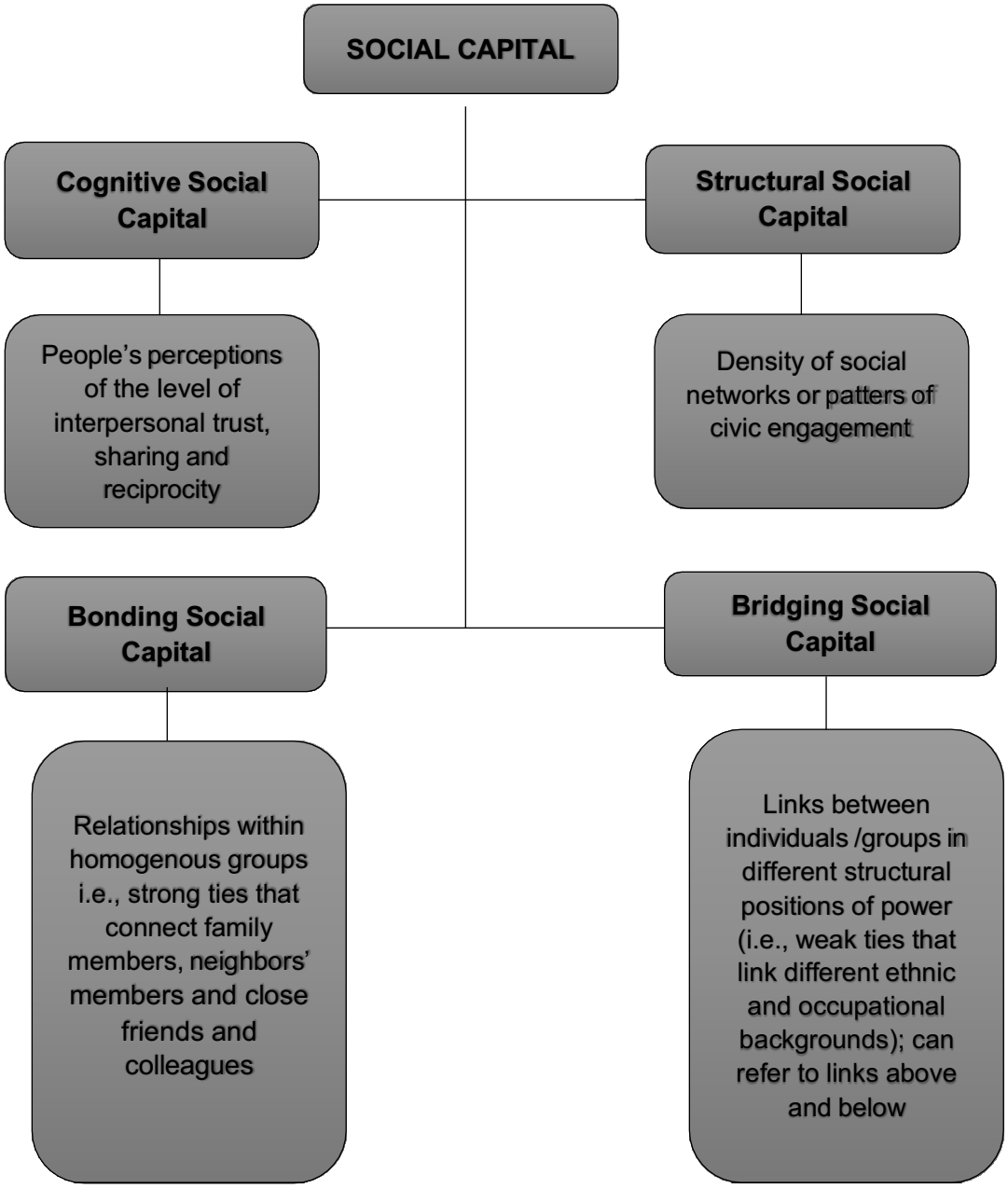
In comparison to empowerment that refers to a process of change, agency refers to an action for change. According to Drydyk (2008), agency either refers to a person's degree of involvement in a course of action, or to the scope of actions that a person could be involved in, in bringing it about. From a human rights perspective, London (2008) contends that the development of agency is critical in a human rights approach to health in order to address conditions that create vulnerability, and to give voice to those who are vulnerable, thereby enabling decision-making scope to change their conditions of vulnerability. In essence, 'voice' refers to the ability that individuals and communities develop

to verbalise their needs and the ability to mobilise actions that aims to bring about change in their circumstances.

Voice and the development of agency is further emphasized in the World Development Report on Gender Equality and Development (World Bank, 2012). It focuses on the inequalities affecting women and defines agency as women having control over resources, the ability to move freely and to take decisions that affect their lives. Specifically, it stipulates that agency is the ability to have a voice in society and influence policy, measured by participation and representation in formal politics and engagement in collective action and associations.

Islam, et al (2006) propose a division of these aspects of social capital into two groups. viz. cognitive and structural arrangements. (Figure 3.1)

Figure 3.1: Conceptual Arrangement of Social Capital



According to Islam et al (2006), the cognitive arrangement consists of the aspects of trust, sharing and reciprocity. These aspects are clustered into what the authors refer to as bonding social capital. Aspects such as the density of the group or network and the pattern of civic engagement are clustered into what the authors term bridging social capital, that is, the external linkages that members develop because of belonging to a group or network.

The aspects of bonding and bridging social capital was first introduced by Putnam (2000) who proposed that bonding and bridging social capital might arise within a particular social group bound together by shared identities and interest. Putnam asserts that bonding social capital is inward looking and tends to reinforce exclusive identities and homogenous groups. On the other hand, bridging capital is outward looking and includes people across diverse backgrounds. In general, bonding social capital occurs when the relationships between people are based on reciprocity and solidarity. This he refers to as "*getting by"* in oppressive situations. Bridging social capital refers to linkages formed with others that enable people to broaden their access to additional resources and services and "getting ahead".

Adler and Kwon (2002), Islam et al (2006), Scott and Hoffmeyer (2007) all agree to a greater or lesser extent that bonding social capital provides a sense of identity, affiliation, shared purpose and support. It further allows people to broker useful resources such as information across a range of networks and for others to leverage new resources from more distant networks into their existing network.

Bridging social capital on the other hand connects different types of people and groups and can be effective for people seeking social and economic gain beyond their immediate society for *getting by in life* (Woolcock and Narayan, 2000). Claridge (2018) claims that the difference between bonding and bridging social capital relates to the nature of the relationships or associations in the social group or community. Bonding social capital is *within* a group or community whereas bridging social capital is *between* social groups, social class, race, religion or other important socio-demographic or socio-economic characteristics. The bonding/bridging distinction can be made in relation to a range of relationship and network characteristics.

Operationalizing a distinction between bonding, bridging and linking social capital is not easy given the multiple and overlapping relationships individuals have with others. According to Woolcock and Narayan (2000), linking social capital may be viewed as an extension of bridging social capital involving networks and ties with individuals, groups or corporate actors represented in public agencies, schools, business interests, legal institutions and religious/political groups. Linking social capital further refer to ties and networks within a hierarchy based on differences in social position or power. An example of linking social capital is the resources and networks that are

embodied in the relationship of communities to the state or other agencies. Further examples of linking social capital are found in networks when individual network members have linkages to resources outside of the network and introduce and link the network members to the resource. In general, linking social capital is a sharing of resources to advance an individual, group or community.

Claridge (2018) concurs with Woolcock and Narayan (2000), but reports that although the aspects are not always called the same thing, the distinction between bridging and bonding and linking social capital is common in the literature. The author further states that while Islam et al (2006) refer to the conceptual arrangements of social capital as being structural and cognitive, other authors often describe these conceptual arrangements as 'dimensions.'

3.2.3 Dimensions of Social Capital

According to Claridge (2020), due to social capital being multi-dimensional, different authors present various dimensions of the concept, based on the different contexts and levels.

The dimensions that are presented in the section include:

- Communitarian
- Network
- External Dimensions
- Macro
- Micro
- Structural
- Cognitive
- Relational

Woolcock (1998) and Narayan (2000) identified the communitarian, network, and external dimensions of social capital. According to the authors, the communitarian dimension equates social capital with local organizations such as clubs and associations. It looks at the number and density of these groups in communities and holds that social capital is inherently good, and that more is better as well as it always

having a positive effect on the community. The communitarian dimension further stresses the importance of vertical as well horizontal associations between people and relations within and among organizational entities such as community groups.

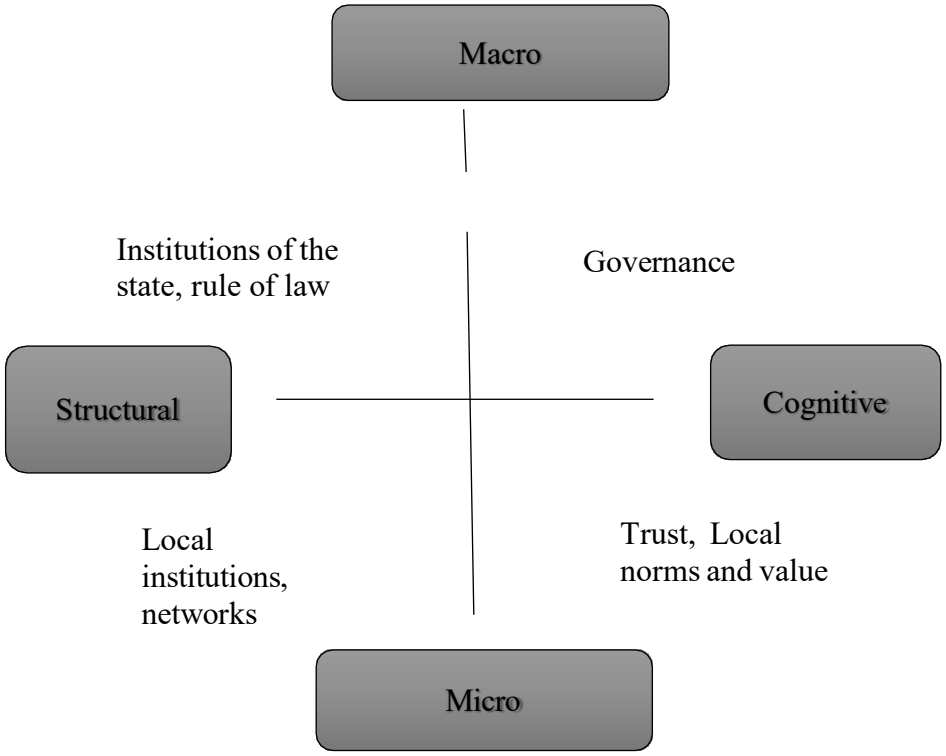
The network dimension recognizes that strong intra-community ties provide members with a sense of identity and common purpose. The external dimension views community networks and civil society as a product of the political, legal, and institutional environment. Where the communitarian and networks perspectives largely treat social capital as an independent variable giving rise to various outcomes, the external dimension views social capital as a dependent variable. This perspective argues that the very capacity of social groups to act in the collective interest depends on the quality of the formal institution under which they reside (Woolcock andNarayan, 2000).

Social capital can further be grouped according to macro and micro dimensions, alternately external and internal dimensions (Woolcock and Narayan 2000; Grootaert and van Bastelaer, 2002). The terms are used interchangeably. The macro-level refers to the institutional context in which organizations operate including governance arrangements, state institutions and the rule of law, while the micro level refers to the potential contribution that horizontal organizations and networks make to development as well as the values, norms and trust involved.

At a micro level, Grootaert and van Bastelaer (2002) refer to embeddedness as dense intra-community ties or the extent to which individual members are integrated into their networks. Autonomy refers to an individual's community ties or the freedom they have to interact with others outside the immediate group. Lin (2005) concurs with them and states that embeddedness refers to society connections or the extent to which there is synergy between various external actors.

Figure 3.2. presents the dimensions of social capital as conceptualised by Grootaert and van Bastelaer (2002).

Figure 3.2: Dimensions of Social Capital



Claridge (2020) is the most recent and relevant (to this study) proponent of social capital theory and organizations, and builds on the work of previous authors. Claridge's description of structural, cognitive and relational dimensions is outlined below. The relational dimension is additional to those described by Islam et al (2006).

Claridge describes the structural dimension as consisting of roles, rules, procedures and precedents. Roles are an important aspect of structural dimensions as they facilitate collective action. They further not only allow people to work together efficiently, but are important for making decisions, mobilizing resources, communicating efficiently, coordinating activities, and resolving conflicts. The way the various roles are assigned creates patterns of interaction and it may motivate members to interact and cooperate for a common purpose. Cognitive dimensions refer to shared goals, purpose, and vision. Shared goals are the collective aspirations of actors and the sense of a shared destiny with others. Goals hold people together and allow for people to work together for mutual benefit. The use of a shared language is also mentioned as an element of cognitive dimension of social capital. Using shared language, members of a group/network identify with each other and develop a sense

of belonging. Having a shared identity based on trust means that the members recognize and commits themselves to the commitment to the common good.

Claridge defines the development of commitment and trust, as relational dimensions. Various authors also define trust as aspects of social capital. Trust and a shared identity become relational dimensions when trust is built amongst similar minded individuals, and they act collectively for common objectives. Claridge however cautions that relational dimensions can have negative outcomes where close-knit groups create a tendency for conformity and 'group think'. This can limit creativity and innovation and ultimately constrain actions. In the analysis of the findings of my research study, this dimension was important to explore to ascertain if a shared identity was developed amongst the members. Trust is an important aspect of social capital and lends itself to collective activities and programs. The researcher draws on Claridge's definition of commitment and trust as relational dimensions. One of the objectives of the research study is to explore these dimensions and to ascertain whether a sense of identity was fostered within the members of the LN.

Social capital is complex and multi-dimensional and once developed within a group or community it presents opportunities for community engagement and community empowerment. The following section discusses whether and how social capital can promote community engagement and empowerment.

3.2.4 Social Capital Community Engagement and Empowerment

Community engagement and empowerment are distinct concepts. Engagement implies a process whereas empowerment is a resource that communities use to achieve collective outcomes. Eriksson (2010) is specific about the definition of engagement as a methodology that ensures that communities develop agency and are empowered to take decisions and manage resources.

Arnstein (1969) writes about citizen engagement that describes various levels of power ranging from high to low. He presents a model called a "ladder of citizen participation" to assess the power in decision making. The ladder consists of 8 rungs of citizen participation, in descending order of participation level:(viii) manipulation;
(vii) therapy; (vi) information; (v) consultation; (iv) placation; (iii) partnership; (ii) delegation and (i) citizen control.

Partnership, delegation and citizen control are rated high on the ladder while levels of power such as manipulation, therapy, information, consultation and placation are rated low.

Wilcox (1994) reports that there are different levels of power in communities that need to be understood together with the level of engagement. Eriksson (2010) concurs in that community engagement builds trust and access to new resources. Through improved communication and collaboration, the overall health conditions of the community can be improved.

Gaventa (2006) elaborates on the understanding of power and state with the following four components of definitions: *power 'over'; power 'to'; power 'within' and power 'with'.* The *power 'to'* is important for the capacity to act, to exercise agency and to realize the potential of rights, citizenship, or voice. *Power 'within'* often refers to gaining the sense of self-identity, confidence and awareness that is a precondition for action. *Power 'with'* refers to the synergy that can emerge through partnerships and collaboration with others, or through processes of collective action and alliance building.

Gaventa (2006) explained that his work on power was based on the 'three dimensions' of power developed by Lukes (1994), which must be understood in relation to how spaces for engagement are created, and the levels of power (from local to global), in which they occur. Understanding each of these spaces, levels, and forms of power as separate but interrelated dimensions could be visually linked together into a 'power cube', with each side of the cube as a dimension or set of relationships, not as a fixed or static set of categories, as previously described. Any of the sides may be used as the first point of analysis, but each dimension is linked to the other.

In contrast to Gaventa (2006), Greer et al (2017), provide a more critical view of community empowerment. They define community empowerment as a process of enabling communities to increase control over their lives. It is more than the involvement, participation or engagement of communities as it implies community ownership and action that explicitly aims for social and political change; it is a process of re-negotiating power to gain more control. Consequently, if some people are going

to be empowered, then others will be sharing their existing power and giving some of it up.

In the context of health, the absence of an empowered community, whether due to poverty, illness or stressful working conditions, is a cause of ill health. Addressing disempowerment is therefore important for the realization of the right to health.

The members of the LN are representatives of various CSOs and have different levels of power and knowledge. This could be viewed as a challenge for the development of synergy in the LN. Gaventa (2021), however, purport that despite the different levels of power, synergy can emerge through partnerships and collaboration with others, or through processes of collective action and alliance building. The study further draws on Gaventa (2006) who broadened the aspects of social capital by explaining that empowerment is a process that leads to ownership and enables communities to increase control over their lives. The purpose of the LN is to equip members with knowledge and skills in order for them to integrate the knowledge for the empowerment of the communities.

3.2.5 Social Capital, Civil Society and the Realization of the Right to Health

With the adoption of a human rights-based approach to development, CSOs use human rights to develop agency amongst the most vulnerable groups (London, 2003). Eriksson (2010) reinforces the notion that when communities can access resources through networks, they develop agency and are empowered to make effective decisions for the realization of the right to health. Agency, as an aspect of social capital, serves to connect the individual and community to hierarchies of power to build their capacity to participate in health systems (Ling and Dale 2013).

CSOs have become important actors and a resource for health systems and peoples' health and well-being. Vega-Romero and Tovar (2007) explain that CSOs can influence processes of radical social transformation, health systems design, public policy, delivery of health care services, accountability, and responsiveness. Furthermore, it has been acknowledged that civil society has the capacity to challenge fundamental societal issues such as social inequality and exclusion as well asthe unequal distribution of power and wealth. This is, however, dependent on whether CSOs have the capacity and resources to act as change agents. In addition to the

influential role that CSOs play in the process of radical transformation, Krishna (2015) adds that CSOs are catalysts in mobilizing social capital. Through the development of social capital in communities, resources are accrued and can help resolve multiple problems through collective action.

Research on social capital continues to demonstrate that higher social capital is associated with improved health conditions (d'Hombres, Rocco, Suhrcke and McKee 2007; Scott and Hoffmeyer, 2007, and Eriksson, 2010). They all agree that a variety of mechanisms have been proposed to explain the observed relationship between social capital and health. These mechanisms include formal and informal networks in which membership is a means to access health care and that the members can further draw upon a collective body of knowledge that will facilitate access to scare resources including information that will enhance the ability to make healthy choices.

Eriksson (2010) supports the notion that there is growing evidence that individual social capital accrued through networks can influence health and health behaviors in a positive way. The improvement and maintenance of health is dependent not only on individual's behavior, but also on the behaviors of significant others and the ability for positive communication in networks.

Despite the value of social capital in the promotion of the right to health, Story (2013) argues that while there is growing evidence on the linkage between social capital and health in recent years from research in high income countries, there is a lack of research from poor resourced countries. However, it is precisely in resource poor settings that social capital is an important factor for improving health. Story (2013) recommends that future research on social capital and health in the developing world should focus on applying appropriate theoretical conceptualizations of social capital in the developing country context. Lau (2014) supports the notion that various factors can impact on the development of social capital and the improvement of health.

Cloete (2014) argues that within South Africa as a developing country, South Africa's policy theme on social capital and the role that it plays in building a cohesive society is questionable. Cloete poses questions about whether the development of social capital and social cohesion could be developed, given high levels of inequality,

unemployment and poverty; and whether the voices in the lowest socio-economic strata will be heard and valued.

> *"Does equality of people across these boundaries have the same vision and needs in order to participate in networks together and build social capital and so improve or form social cohesion? Are they on equal ground in order that all participants' contributions are valued and taken seriously? Is the South African context not more conducive for negative networking, that is, against each other?*". *Cloete (2014-3)*

Within the LN, the CSO members initially perceived a devide between themelves and the academic members. They perceived themselves to be unequal in terms of of the levels of qualification, knowledge in health and human rights, academic language, and position in society. Their voices were not heard until interventions took pkace in the Review and Reflect meetings where they could comfortably assert themselves. and develop agency in the process.

Having explored social capital in detail, the next section turns to an examination of the literature on social networks, a concept closely tied to Social Capital and one essential for understanding learning networks.

3.3 SOCIAL NETWORK THEORIES

There is growing evidence that individual social capital accrued through networks can influence health and health behaviors in a positive way Eriksson (2010). The improvement and maintenance of health is dependent not only on individual's behavior, but also on the behaviors of significant others and the ability for positive communication in networks. An understanding of network theories is essential for understanding how social capital is developed within networks. While social capital is contingent on networks, they are neither equivalent nor interchangeable terms (Lin 2005).

Networks provide the necessary condition for access to and use of embedded resources. Lin says that without networks, it would be impossible to capture and measure the embedded resources. Networks and network features by themselves are not identical with resources; rather, variations in networks or network features may increase or decrease the likelihood of having a certain quantity or quality of resources.

Lin (2005) concurs that the various dimensions and combinations of social capital lead up to different outcomes for different people. This is to be expected as social capital emerges and is maintained between actors. The author argues that each of the definitions implies that networks are at the core of social capital.

Globalization and technological advances in recent years have led to an increase of networks at community, regional, national and global levels (Liebler and Ferri, 2004). According to the authors, networks involve member collaboration through engagement in mutual or joint initiatives. In most cases the purpose of a network is to build capacity amongst its members and as such, members must be confident enough in their work that they are willing to share with others. Further, in order to contribute towards the network goals, members must be committed. Strong commitment is fostered when members of the network match the network's priorities to that of their own and when they see the network as adding value to their work. They further state that networks should possess the *generative capacities* which include the ability to work across traditional boundaries, learn how to learn, lead new ways, develop a systems view, create the future, balance autonomy with interdependence, manage co-operation and competition as well as align organizational form with purpose.

Keijzer, Ornemark and Engel (2006) describe networks as being more than a dialogue between people. It encompasses action-orientated elements such as policy influence, advocacy, negotiations and a search for common positions and social change. According to the authors, networks provide a platform for creativity and critical thinking through dialogue and exchange. Networks further enable civil society actors to collectively search for new ways of understanding complex matters and to build agency to participate and influence policy making.

Networks can further be used to describe many kinds of relationships between various levels of actors and entities. Lieber and Ferri (2004) contend that the term *network* is expansive and encompasses a wide variety of sub-categories. Because of the expansiveness of the term, it is essential to understand the contextual environment in which networks operate. Thomson (2005) asserts that the notion of networks can be informal, volunteer-based, dynamic, and operating in an open system that is flexible, fluid, and adaptable. According to the author, networks should be open to the development of trust, innovations, new ideas and the sharing of information.

3.3.1 Definitions and Nature of Networks

According to Scott and Hoffmeyer (2007), a network approach is based on the understanding of social structure as patterns of relations between social units or actors such as individuals, organizations, and countries. Skye Bender-de Moll (2008) defines networks within a broader framework. According to the author, the term network has both technical and common-use meanings in multiple fields. Networks allow representation of *one-to-many and many-to-many* relationships between the actors. This makes networks a useful way to share information about complex issues such as human rights. In a human rights context, the author asserts that networks usually refer to groups of individuals or organizations having some form of common interest and relationships with each other. These relationships may include linkages, ties, associations, knowledge sharing and contracts between entities. Knowledge sharing is a key driver for organization success. Through personal and information networks, organizations become more responsive to planning, implementing and correcting courses of actions (Nonaka and Nishiguchi, 2001).

Networks have the sense of not only naming a set of entities with a common vision but also specifying the relationship between them so that patterns and structures can be revealed or utilized. Additional key features about networks are (i) the vertical and horizontal dimensions; (ii) network closure; (iii); density; (iv) range and (v) centrality. According to network theories, cognizance must be taken of the importance of vertical as well as horizontal associations in community groups and organizational entities. These intra-relationships strengthen community ties and give families, communities and groups, a sense of identity and purpose (Skye Bender-de Moll, 2008). Scott and Hoffmeyer (2007) elaborate on the importance of vertical and horizontal associations and claim that the social network approach is based on the understanding of social structures as patterns of relations between individuals, communities or organizations. The authors further purport that an underlying assumption is that social structures influence actions of individuals just as the actions of individuals can influence social structures.

The concept of network closure has been described as a network in which everyone is connected; hence no one can escape the notice of others (Coleman, 1988, 1990, Fukuyama, 1997, Woolcock, 1998, Putnam, 2000). Densely knit networks have direct

communication among all members. In contrast, Garton, Haythornwaite and Wellman (1997) state that sparsely knit networks provide people with room to act autonomously and to switch between relations. Larger networks have more homogeneity in the social characteristic of network members and more complexity in the structure of these networks. Small homogenous networks in contrast are characteristic of traditional work groups that are good for conserving existing resources.

They further state that it is important to examine who is central or isolated in networks i.e., who are the key information brokers / coordinators in the network. In examining networks, centrality can be used to identify network members who have connections to others (high degree) or those whose departures would cause the network to fall apart (cut-points).

Thomson (2005) discusses the importance of the shape of networks and argues that the shape helps to determine its usefulness to members. Smaller tighter networks (closed networks) can be less useful to their members than networks with loose connection (open networks) to individuals outside the network. Open networks with weak ties and social connections are more likely to introduce new ideas and opportunities to their members than closed networks. Thomson explains that a greater degree of diversity enables dynamism and innovation. A group of individuals with connections to other social worlds is likely to have access to a wider range of information. Thomson further elucidates on factors that drive the interest of successful networks. Table 3.3 lists the drivers of networks.

Table 3.3: Drivers of Successful Networks

Drivers	
Information and communication technology	The emergence of information and communication technology (ICT) in the 1980's and 1990's made (global) networking easier.
Urgency	A sense of urgency to solve issues such HIV/Aids, environmental degradation and poverty. The growing complexity and interrelatedness of major social, economic and environmental problems, and the failure to solve issues, makes multi-stakeholder learning unavoidable and relevant.

Frustration	A sense of frustration among public and academic actors because of the marginalization of many research endeavors and the failure of research in recent times to have a much-needed impact on public policy.
Knowledge management	Private sector experiments with knowledge management and its impact on the private sector have aroused the interest of public sector and civil society organizations in networks.
Collective action:	Civil society actors want to improve their performance by means of collective action, when their work is hampered by a perceived lack of access to knowledge. Networks fortify creativity and critical thinking through dialogue and exchange.
Upshifting impact:	Civil society want to upshift their impact, to take the focus of their activities to a higher policy level, enabling them to participate in public and/or governments debates on development, and also to influence policymaking.

According to Thomson (2005), successful networks respond urgently to matters of social and economic concerns. It further minimizes frustration among various actors who have the need to input and impact on public policy. Network members further utilize new knowledge to participate in collective outputs and to improve the impact of their efforts in bringing about collective change.

In order to ensure the success of the network, Ashman (2003) argues that project goals must be appropriate for the needs of the members. It must further address the issues that members perceive to be important. As such, the network needs to be reassessed or even re-negotiated among members on an on-going basis. The more a network is successfully able to demonstrate and communicate its value as a space for learning, innovation, and advocacy, the more successful it will be in continually renovating and revitalizing itself.

The drivers that are explored within my PhD research study are knowledge management, collective action, and upshifting impact. The tagline of the LN is *Learning by doing and doing by learning* and the question that I pose is whether and

how the LN served to fulfill the objective of being a network of knowledge transference and the application of the knowledge into practice. Collective action is required to improve performance and program outputs. Social cohesion within a network is dependent on the development of trust and identity amongst the members. My research study explores whether strong social cohesion and relational dimensions of social capital has resulted in collective outcomes. Through empowerment and the development of agency, network members can use their collective power to enable impact at higher levels involving institutions of state as well as participation in decision-making structures that pertain to the health of the community and influencing policy.

Thomson (2005) further states that there are indicators and lessons that could be used to assess if networks are successful. This PhD study utilized the following indicators proposed by Thompson (Table 3.4) to explore and analyze whether the LN was successful in building an inclusive network through its vision, mission statements and objectives.

Table 3.4: Indicators of Successful Networks.

	Indicators
1	Achieve a position of centrality.
2	Have a clear mission statement and rules of engagement.
3	Be inclusive and ensure all agencies and individuals gain ownership.
4	Developing network cohesion. Strategies for network cohesion are important to avoid network fragmentation.
5	Ownership may be facilitated by formal contracts or agreements. However, over-regulation of hierarchical networks should be avoided.

6	Avoid network capture, for example, by dominant professional elite or organisational culture.
7	Respond to the needs of network members in such a way that the network remains relevant and worthwhile.
8	A network will survive as long as members perceive that involvement is valuable.
9	Professionals in the network must allow members to manage and govern their activities.

3.3.2 Types of Networks

In addition to typologies related to the extent of openness (open versus closed network) or sparseness (densely versus sparsely knit), networks can differ in terms of their purpose and structure, according to Keijzer and Ornmark) (2006). . They can provide learning opportunities, information exchange, advocacy or advancing interests and positions, and network management. In addition, virtual networks are becoming more prominent for the purpose of information sharing (Kazienko and Musiał, 2001).

Given the objectives of this study, the review focuses on networks that promote information exchange, community practice, research, advocacy, and collective action. They have distinct features, and an understanding of the nature and characteristics of each was essential for analysing how capacity and agency was developed within the Learning Network for Health and Human Rights.

3.3.2.1 Community of Practice

A community of practice consists of a tightly knit group of members engaged in a shared practice who know each other, work together, typically meet face-to-face, continually negotiate, communicate, and coordinate with each other directly. Jjoint decision-making and problem solving enhances the formation of strong interpersonal ties and creates norms of direct reciprocity within a small

community (Lave and Wenger 1991). An elaboration of communities of practice as a group that coheres through sustained mutual engagement on an indigenous enterprise, creating a common repertoire, and the co-operative relationships providing platforms for collective action is provided by Cox (2005) and Westfall et al (2006).

Wenger-Trayner (2015), explains that communities of practice are formed by people who engage in a process of collective learning in a shared domain of human endeavor e.g., a group of engineers working on similar problems, a network of surgeons exploring novel techniques, a gathering of first-time managers helping each other cope. The author identified three characteristics of a community of practice: (i) domain, (ii) community and (iii) practice.

(i) Domain:

Community members have a shared domain of interest, competence and commitment that distinguishes them from others. This shared domain creates common ground, inspires members to participate, guides their learning, and gives meaning to their actions. Membership implies that the group is committed to the domain and therefore possesses a shared competence that distinguishes members from other people.

(ii) Community**:**

Members who join the domain are interested in joint activities, discussions, problem-solving opportunities, information sharing and relationship building. The notion of a community creates the social fabric for enabling collective learning. Wenger (2015) asserts that a strong community fosters interaction and encourages a willingness to share ideas. They build relationships that enable them to learn from each other; they care about their standing with each other.

(iii) Practice:

Community members are actual practitioners in this domain of interest, and build a shared repertoire of resources and ideas that they take back to their

practice. While the domain provides the general area of interest for the community, the practice is the specific focus around which the community develops, shares and maintains its core of collective knowledge.

The Loka Institute (2003) describes a practice-based network as a network of grassroots organizations with the purpose of conducting community and practice-based research for social change. For example, the Loka Institute formed a community-based network in the mid 1990's with a vision to:

> *"Kindle a vibrant popular movement for community driven policies in research, science and technology that will advance democracy, social justice and ecological sustainability at every level- from neighborhoods to nations" 2003:1)*

Loka's mission of a community-based network is to create a system through which grassroots, workers, public interest organizations and local government can find solutions to social and environmental problems and participate more effectively in public policy (Loka 2003).

Within the LN of this study, each CSO member operates within various geographical clusters, providing services deemed necessary for the particular community. A description of the LN members is provided in Chapter 4.

Community members who have common interests and concerns in the area where they live, provides the common ground for people to work collectively for the common good of that community. Community of practice not only includes the community members but also practitioners rendering services in those communities. Through their conjoint involvement in a particular project, the community members and practitioners share knowledge and resources. The sharing of knowledge builds agency for action.

Community of practice further provides a platform for community members to work with practitioners in research projects within their communities, and become active members of the research teams. They are part of the research process and collectively participate in the interpretation of results, dissemination and implementation of the findings. Ownership, participation and

collective action through the development of close relationships are aspects of the development of social capital within communities.

3.3.2.2 Virtual Social Networks

Kazienko and Musiał (2001) describe a virtual social network as consisting of millions of people who are in a mutual relationship and that each participant can add and receive value from belonging to the network and therefore stimulate social capital. They state that when the network expands and become more persistent, the community as a whole and each individual that belongs to the network, will benefit if the social capital of the members grows. However, the definition of an online social network is not widely accepted and the development of social capital in that context has not been established due to limited research. They further recommend that research should be done to evaluate if the various aspects and dimensions of social capital are evident to establish whether online social networks can build social capital with close-knit ties, bonding and bridging relationships. It would also have to include whether trust, altruism, cohesion and power are evident, given that.the development of social capital is contingent on their existence..

Milgram, (cited in Musial and Kazienko, 2013) conducted a study called the small world experiment in the United States. He concluded that the evolution of a social network depends on the mutual experience, knowledge, relative interpersonal interests, and trust of human beings. Additionally, the classification of social networks can be based not only on the type of the relations that occur in the network, but also on the type of the communication, which is pertinent to information via the internet.

In searching for additional information on virtual social networks, the researcher came across a case study on the benefits of internet in the promotion of access to information:

> *Hlokomelo Mabogale, a South African chicken farmer and digital activist, wrote about the disadvantages rural youth experience by lack of access*

to quality education, computers, and the Internet. Being from a rural area himself. Mamaila is in the country's northernmost Limpopo province.

It was an issue he knew all too well. Remembering his own lack of digital skills as a young person, Mabogale signed off with a plea, "These days, Internet is life."

Mamaila is "a deep-rooted rural area," says Dr. Peter Mamaila, secretary of the Mamaila Royal council and Bishop of Moratabatho Missionary Church International. But, he adds, "it is a rural area, it is not an island. It is still connected to South Africa. So much as the other parts of South Africa advanced technologically, we ought to be part." Like many of his fellow residents, he feels that the connectivity gap holds back the youth, especially in terms of education, employment opportunities, access to information, and the chance to innovate. Hlokomelo Mabogale tries to help as best he can. He lets young people in his neighbourhood use his home Internet connection for free, so they can research school projects or apply for jobs online. In so doing, the Mamaila Community Network was formed

3.3.2.3 Learning Networks

Networks that build capacity and agency are known as learning networks. Engel, Keijzer and Ornemark (2006) differentiate learning networks from other networks with the following features: they promote improved performance through processes of collaborative action, appraisal and analysis of activities, innovation with interventions and participation in policy development. They focus on learning as an outcome of the interactions between individuals and support the establishment of a community of interests through learning platforms.

Scott and Hoffmeyer (2007) support the notion of collaboration through networks and state that civil society must be encouraged to work in partnership as well as build interdisciplinary teams. They observe that an underlying assumption is that social structures such as networks influence the actions of individuals and that, collectively, networks have the capacity to challenge fundamental societal issues.

Skye Bender-Moll (2008) supports the view of collaboration through networks as it has benefits for organizations and individuals. They include an improved diffusion of information, facilitation of creativity and learning as well as new initiatives and research for knowledge sharing and resources that improve effectiveness and mobilization. He asserts that researchers find it useful to think of knowledge, relationships, access, privileges and rights of individuals and organizations as some form of capital. Once accrued, it can be then employed to facilitate collective action through a network. According to the author, each interest group brings different information, values, capacities, perspectives, methods of learning, and historical experience to any problem situation. In essence, learning is the integration of these diverse knowledge bases in ways that advance the collective decision-making capability of all. The premise is that working together through collaborative partnerships is a powerful way to improve our communities and environment. These alliances can be used to improve the health of a community in the widest sense of the term.

Aside from the indicators of successful networks, a learning network has distinct indicators that differentiate it from other networks (Table 3.4).

3.3.3 Success indicators of Learning Networks

Engel, Keijzer and Ornemark Engel (2006) identify factors that enhance the success of learning networks as being pertinence, added value, specialization and focus, optimum diversity of learners and facilitated learning networks.

Table 3.5: Learning Networks Success Indicators

Indicators	
Pertinence	Different actors and networks place very different interpretations on the pertinence of networking efforts, i.e., the adequacy and relevance of what the network does within a particular socio-political context. Since the members have many interests and backgrounds, there is a need to search for a 'strategic fit'. The project goals must address needs and issues perceived to be significant by all the important members of the network. Pertinence is closely related to the changing needs of members and the

	sectors in which they work. As such, it needs to be reassessed or even renegotiated among members on an on-going basis. The more a network is successfully able to demonstrate and communicate its value as a space for learning, innovation, and advocacy, the more successful it will be in continually renovating and revitalizing itself.
Added value, specialisation and focus	At the same time as networks continually change and adapt to the socio-political context and the needs of their members, they also need to focus on specialist fields in order to be of added value. Many networks do not stick to their priorities well enough but branch out into other topics and thematic areas. Those networks that do focus, whether they concentrate on a limited number of well-defined themes or limit themselves to a well-defined sphere of social and political interaction, generally achieve more tangible results. In other words, while networks need to be open to a diversity of views and ideas among their members, they also need to stay focused on their defined field of interaction.
Optimum diversity of learners	An important issue to consider is how diverse and inclusive a network should be. This may depend on the network's set goals, its main activities and the types of learning through which the members try to attain these goals. If the focus of the group is on retrospective learning (i.e., making sense of past actions and detailing lessons that can shape future actions), a wide diversity of learners can potentially provide a rich common understanding of contexts, trends, opportunities and constraints. For action-oriented learning, on the other hand, a wide diversity of learners may make it more difficult to agree on what information is needed and how it should be collected. It may also be more difficult to agree on priorities, either due to differences in priorities (for example, different information needs among policymakers and development practitioners) or to funding considerations (i.e., who should pay for these activities?).
Facilitated Learning	Networks need to pay systematic attention to designing and facilitating learning processes among their members, widely sharing knowledge and experiences, and making proposals based on these. They need to be open to a wide range of ideas, experiences and knowledge. Learning will remain limited if the interpretation of evidence is restricted to a very narrow 'like-minded' group without sufficient local or on-the-ground representation. This is not to say that members of very homogeneous networks cannot learn from each other about specific topics. However, in terms of more crosscutting development issues, the participation of grassroots organizations and other local development actors are essential. The level of openness to other communities of practice and ideas is demonstrated by the ways in which the network validates and disseminates experiences, as

	well as by its readiness to develop strategic alliances with other actors and networks.

3.4 SUMMARY

The researcher discussed her professional experience in the section on 'researcher background', that the networks that she was part of did not develop the bonding and bridging relations required for collective outcomes. It is the authors experience that those networks consisted of individuals who accrued value for their own initiatives. In this research study, the researcher provides new knowledge as to how to build agency.

The literature review presents a range of authors who define social capital either from an individualistic or a collective perspective. Most authors combine the perspectives. While some authors express concern about the paucity of research from low- to middle-income countries (Story, 2013), others question whether social capital and networks can contribute towards an improved quality of health and human rights in South Africa (Cloete, 2014).

The purpose of the study is to explore whether the development of social capital within a learning network can result in CSOs integrating new knowledge of health and human rights in their communities The study aims to contribute towards a new body of knowledge about how health and human rights can be realized in lower- and middle-income communities in Cape Town, South Africa. My study is a case study of a learning network that promotes knowledge sharing and participation in co-activities and co-research.

The following Chapter 4 describes the Learning Network as the unit for the case study in my research study.

CHAPTER 4
CASE STUDY: THE LEARNING NETWORK FOR HEALTH AND HUMAN RIGHTS

4.1 INTRODUCTION

The Learning Network emerged as a research study for conceptualizing the role of human rights approaches in promoting health equity (Thomas 2009). The study focused on 3 Civil Society Organizations (CSOs) in Cape Town, South Africa, and found that there was a need for practical support to CSO groupings to equip them to use human rights approaches to advance health objectives more effectively.

One of the recommendations emerging from the study was the need to establish a learning space in which CSOs could share experiences both positive and negative. In addition, the study found that to be effective, CSOs needed to be linked to other CSOs who share a vision and values that were required for the realization of the right to health. The Learning Network (LN) for Health and Human Rights, bringing together academic members, researchers and CSOs, was a response to the recommendation (Thomas, 2009).

London (2008) argues that while charters and commissions are important, it is the collective action of civil society that translates human rights into practice. He asserts that civil society has played a crucial role in ensuring that the right to health is achieved, particularly in terms of advocacy, developing policies and programs, monitoring government's obligations and addressing violations of the right to health.

Translating the right to health into practice, and to research how this is done, requires an understanding that the CSOs knowledge about health and human rights may be incomplete and they may require additional knowledge in the area (Stuttaford, London and Glattstein-Young, 2012)., Furthermore, a need exists to develop new ways of 'learning' if agency is to be fostered amongst the CSOs to translate the right to health into practice (London, Tram and Stuttaford, 2012).

It is for this purpose that the LN for the right to Health 'Learning by Doing and Doing by Learning: A Civil Society Network to Realize the Right to Health' was established in 2009. It had an explicit agenda to build member organizations' capacity to be agents

for the realization of community's rights to health. It also sought to share lessons generated from this process and organizations beyond the LN (London, Tram and Stuttaford, 2012).

Based on previous research that realized the importance civil society in achieving the right to health (London, Tram and Stuttaford, 2012), the University of Cape Town, Health and Human Rights Division, School of Public Health and Family Medicine conducted a pilot study in 2006 with three civil society organizations in Cape Town for the conceptualization of the role of human rights approaches in promoting health equity (Thomas and London 2006). The researchers found that there was a need for practical support to civil society groupings to equip them to use human rights approaches. In addition, the research study found that to be effective, CSOs needed to be linked with other like-minded organizations and departments across the spheres of government, business and labour, and that this was critical to realizing health rights. The report was post on the LN Website.

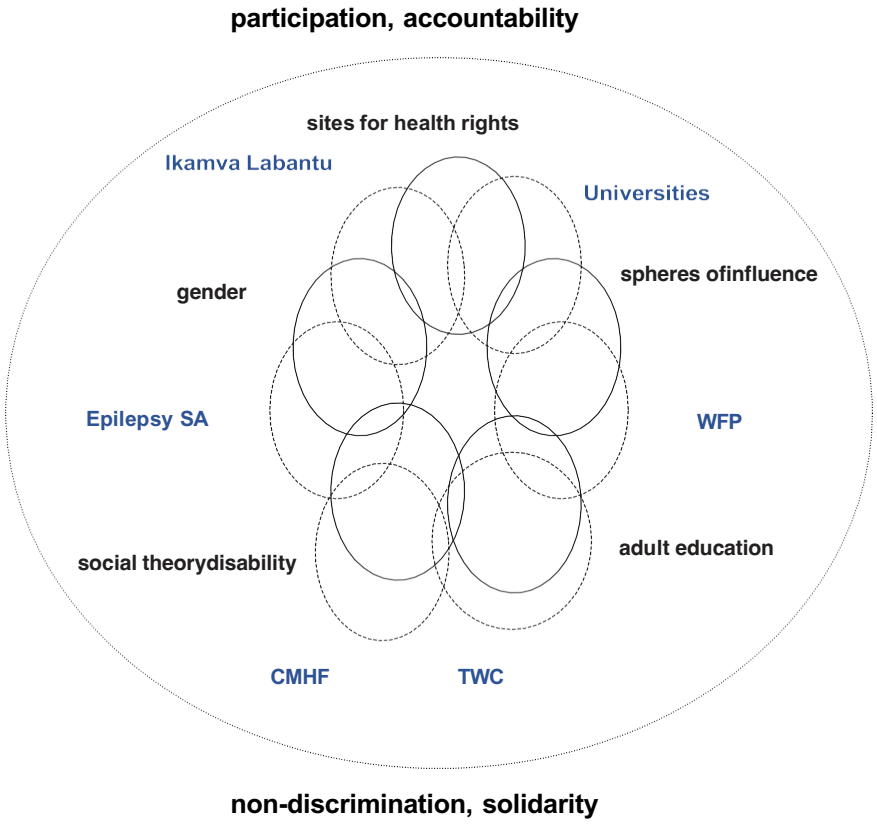
One of the recommendations emerging from the pilot study undertaken by the researchers (Thomas and London 2006) was to establish a space in which CSOs could share experiences to learn from each other and to identify strategies that work best to realize health rights.

London, Heap and Baldwin-Ragaven (2009) state that to realize the right to health in communities, it is important to recognize that building agency amongst civil society organizations and communities is required. Eriksson (2010) reinforces the notion that when communities can access resources through networks, they develop agency and are empowered to make effective decisions for the realization of the right to health. As an aspect of social capital, agency serves to connect the individual and community to hierarchies of power to build their capacity to participate in health systems (Dale, 2014).

Figure 4.1 Illustrates the conceptual framework of the LN as found in Stuttaford et al, (2012). The conceptualization of the LN includes the principles and value of participation, accountability, non-discrimination, and solidarity. It further shows the sites for health rights and the roles that the sites can play in advocacy programs,

redressing health and human rights violations and monitoring the implementation of government policies.

Figure 4.1 Conceptualization of the Right to Health in the Learning Network



4.2 CASE STUDY: THE LEARNING NETWORK FOR HEALTH AND HUMAN RIGHTS

4.2.1 Conceptualization

For the purposes of this study, the LN ais a case study to explore the role that social capital and social networks play in the integration and implementation of health and human rights programs. The research study assessed whether the Learning Network for Health and Human rights had enabled the development of social capital amongst CSOs for the realization of health and human rights. Figure 4.2 portrays the following lines of inquiry:

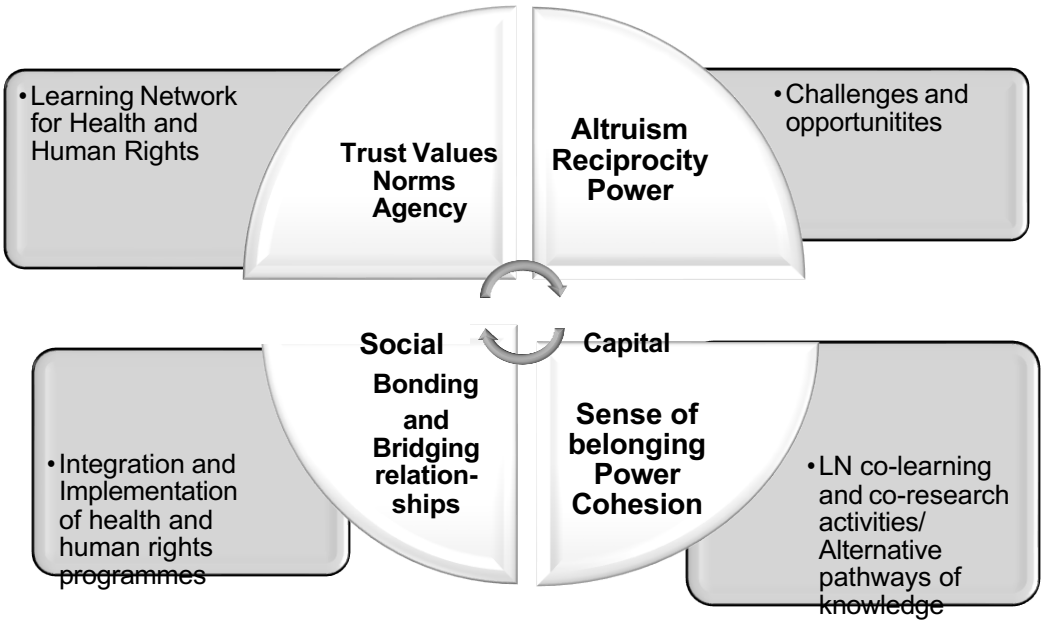
4.2.1.1 Whether and how the LN provided a platform for the development of social capital amongst its members.

4.2.1.2 Whether there were challenges and opportunities that impacted on or enhanced the development of social capital.

4.2.1.3 Whether the LN co-learning and co-research programmes resulted in capacity building and the integration and implementation of health and human rights programmes in communities. Whether there were alternative pathways of knowledge and skills acquisition in terms of health and human rights.

4.2.1.4 Whether the human rights programmes were achieved as a result of social capital.

Figure 4.2: Conceptualisation of the Research Study



4.3 RESEARCH CONTEXT

The following section lists and describes the diverse CSOs and academic members who participated in the LN

Table 4.1: Description of the Members of the Learning Network

Organization	Description of organizations
Cape Metro Health Forum (CMHF) (Health)	The Cape Metropolitan Health Forum is a coordinating structure for health committees in the Cape Metro District. It facilitates community participation in health with multiple districts and community health committees. Health committees act as the interface between communities and health care service
Epilepsy South Africa (ESA) (Disability)	Epilepsy South Africa is a non-profit organization that renders developmental services to persons with epilepsy and other disabilities. The mission is to create an equal society through its integrated approach to development. The organization aims to build agency through individual and family counseling, disability sensitization, public education and awareness, accredited training on disability and human rights and economic empowerment.
Ikamva Labantu (Ikamva) (Community Development)	Ikamva Labantu provides services to the residents of South Africa's township communities through all spheres of life. Its mission is to build community capacity that is self-reliant and sustainable through programs driven by community needs focusing on children, adults and seniors. The main focus areas are: education and skills development, food security, health at primary care level and building community infrastructure through securing land and buildings. The primary means of delivering services is through strategically located community based multi-purpose Centre's that are hubs where community members can access a vast array of support services.
Women on Farms Project (WFP) (Rural Women's Empowerment)	The Women on Farms Project is a rural feminist NGO working to strengthen the capacity of women who live and work on farms to claim their human rights by taking both individual and collective action. This is done through socio-economic rights based and gender education, advocacy and lobbying, case work and support for building the social movements of farm women.
The Women's Circle (TWC) (Women's Empowerment)	The Women's Circle is an organisation of grassroots women working together to promote a culture of equity and women's rights around a program of action that aims to encourage respect for women's rights and for women amongst all members of society; expose woman of all ages to a wide range of opportunities; showcase innovative women led projects and programs; and celebrate women's achievements through on-going collaboration.
Maastricht Centre for Human Rights, Faculty of	The Centre hosts research activities in the field of human rights. It consists of members of staff in the Maastricht University Faculty of Law, and adopts an integrated approach to economic, social and

Law, Maastricht University, Netherlands	cultural rights. Their research has contributed to clarification of the normative content of social and economic rights, such as the right to food, health and education.
University of the Western Cape (UWC)	The School of Nursing at the UWC aims to contribute to health care delivery and research nationally and internationally. It trains nurses and midwives to work on sexual and reproductive health rights.
University of Cape Town (UCT)	The School of Public Health and Family medicine has a diverse involvement in human rights teaching, research and advocacy. Currently the Health and Human Rights program is involved in collaborations with NGO's and other research and training institutions to explore how collective action and reflection can identify best practice with regard to using human rights to advance health.
Warwick University	During the period 2010-2013, the Health and Human Rights Research Group, within the Institute of Health, supported the development of multi-disciplinary research in the field of health and human rights.

As stated, the CSOs are diverse and have different focus areas. They represent disability, rural development, women's empowerment, community development and community health forums. The academic members represented 2 South African universities and 2 international universities. The CSO and academic members consisted of 3 white females, 2 black females and 3 colored females. The researcher explains in the Case Study that one international academic could not be contacted for an interview. This member is not included in the total number of members above.

The commonality is that all CSOs embarked upon programs that addressed the social determinants of health. The academic members initially conceptualized the LN and provided knowledge, direction and value to the activities of the LN. Research was undertaken in collaboration with the CSOs and academic papers were published.

The following sections describe the LN methodology, vision, mission and activities as conceptualized by LN members.

4.4 THE LEARNING NETWORK METHODOLOGY

The LN utilized reflective participatory action research (PAR) methodology to review and evaluate the co-learning and co-research activities amongst its members. According to Moon (1999), 'review and reflect' is a dimension of participatory and

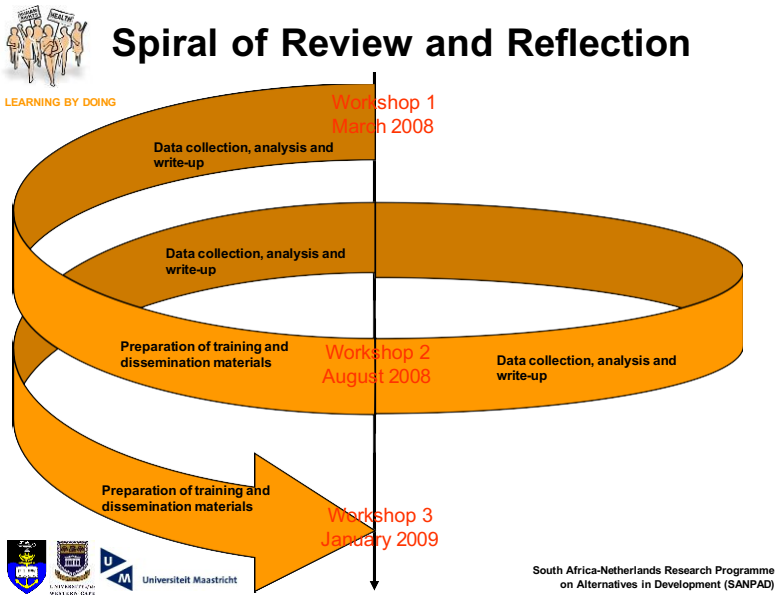
qualitative research methodology. It provides methods and techniques that help individuals and groups reflect on their experiences. Moon holds that the Review and Reflect practice can help the individual members to understand their own intentions, values, and visions in a challenging field where ethics and morals may be tested, and where power relations may be decidedly unequal.

> *"Reflection is part of learning and thinking. We reflect in order to learn something, or we learn as a result of reflecting, and the term 'reflective learning' emphasises the intention to learn from current or prior experience" (Moon 2004).*

Utilizing the PAR methodology, a spiral of dialogue was developed amongst its members during the period 2008 and 2009 (Sttutaford, London and Glattstein-Young, 2012). The conceptual framework used by the LN was designed to develop, sustain and grow the LN. According to London (2007), the framework is not presented as a generalized framework for the right to health, but to identify learning potentially applicable for other contexts.

Stuttaford et al (2012) assert that reflection and dialogue enable a PAR process where multiple experiences and knowledge can be shared, discussed, and used to progress to the implementation of the right to health. The processes are integrated, and each phase starts with the review and reflection of the previous phase and the planning of the next phase. The phases are (i) participation in gathering data; (ii) data collection, analysis and write up; (iii) participate in data dissemination; assessing processes to-date; participate in self-identified training; (iv) generating new ideas and learning goals; preparation of the training materials; dissemination of materials e.g., pamphlets, policy briefs, articles, and presentations; (v) and planning of the next phase. See Diagram 4.1 (LN Network: Minutes of the LN Review and Reflection Meetings, 2009)

Diagram 4.1: Learning Network Spiral of Review and Reflect



"*Information moves in a circular process of learning, action and reflection" (Stuttaford, London and Glattstein-Young , 2012).*

The LN project life can be envisaged as a spiral of intersections that mark milestones when network members come together. Through coming together and working collaboratively, the members have the opportunity to build strong ties with each other (Stuttaford, *et al*., 2014).

Through a PAR process the LN members identified a need for the development of a vision and mission statement. Objectives were further identified to provide the direction of and the type of activities the LN members would embark upon. Principles and roles were agreed upon to develop a collective sense of purpose amongst its members. The vision, mission, objectives, principles and roles of the LN are listed in Table 4.2.

Table 4.2: Vision, Mission, Objectives, Principles and Roles

Vision	*"Empowered communities able to enjoy healthy lives".*
Mission	*"To empower Learning Network members to realize communities' rights to health."*

Objectives:	1. *To establish a network of civil society organizations that share knowledge of and develop best practices for community engagements with health facilities on the right to health.* 2. *To build the capacity of civil society organizations participating in the Learning Network to work more effectively with health care providers and health authorities on accessing the right to health.* 3. *To strengthen community participation in health by supporting and strengthening the function of Community Health Centres' and clinic committees.*
Principles:	*The Learning Network:* 1. *Believes that empowerment means knowledge, assertiveness, critical engagement and collective action.* 2. *Believes that health is a state of wellbeing, determined by access to health care and healthy social conditions.* 3. *Is based on a partnership of mutual respect, benefit and equality.*
Roles:	*In addition to the principles, four roles of the LN have been identified to support the delivery of the objectives:* 1. *A research role documenting and analyzing best practices in realizing the right to health.* 2. *An informational role to ensure communities are better informed about rights to health.* 3. *A capacity-building role to promote access to learning opportunities for member organizations;* 4. *An action role to use the learning gained by member organizations to support services and advocacy around health.*

The LN governance structures evolved over a period of time. The purpose of formalizing the governance structure was to ensure inclusive participation and transparency. An Executive Committee (Exco) was constituted in February 2010. The Exco consisted of a representative from each member organization and each academic partner. The Exco was responsible for decision-making, identifying projects

and research opportunities. Exco meetings were held monthly and the Exco members were responsible for the cascading of the decisions and discussions to their organizations. Quarterly meetings took place with the LN members and representatives of their CSOs.

4.5 LEARNING NETWORK ACTIVITIES

The following is a summary of learning activities and research(LN Website):

4.5.1 Learning Network Activities

4.5.1.1 Civil Society and the Right to Health

4.5.1.2 Knowledge Production for the Right to Health and Social Solidarity

4.5.1.3. Community Systems Strengthening (CSS) for Health (2016-2019)

4.5.1.4 The Right to Enjoy the Benefits of Scientific progress (2016-2018)

4.5.1.5 Health Care Committees as a vehicle for social participation in health systems in East and Southern Africa (2016- 2018)

4.5.1.6 Civil Society Agency and the Right to Health (ongoing)

4.5.1.7 Health Care Users' Experiences (2012-2018)

4.5.1.8 Health System Governance: Community Participation as a key strategy for realizing the Right to Health (2012-2015)

4.5.1.9 Photo voice (2012-2015)

4.5.1.10 Project Reports

Aside from the activities and research undertaken by the CSO members and academic members, the LN published academic papers, contributed towards book chapters, policy submissions, posters, presentations and student theses Students attached to the Health and Human Rights Division of the School of Public Health and Family Medicine (UCT) participated in a range of research topics for their Masters, Doctoral and Post-Doctoral Theses.

4.6 SUMMARY

The researcher presented and described the LN as a case study for the research study. The focus of the study was to research and analyze the role that social capital amongst the CSO members had played, or not, in building agency for implementing health and human rights programs. The researcher was a member of many forums and networks in her practice and her experience was that the nature of the forums and networks did not result in collective outcomes. The study provided the researcher with new knowledge about the inter-relationship between social capital and networks. While social capital is contingent on networks, they are neither equivalent nor interchangeable terms (Lin 2005).

The following chapter 5 presents the research methodology. The researcher chose to utilize the qualitative research methodology as it is best suited to explore the complexity of the research question. Dudwick, Kuehnast, Jones and Woolcolk (2006) suggest that as a topic, social capital complexity lends itself to a mixed method research approach. Employing both qualitative and quantitative methods allows researchers to uncover the links between the different dimensions of social capital, as well as to construct a more comprehensive picture of the structures and perceptions of social capital.

CHAPTER 5
METHODOLOGY

5.1 INTRODUCTION

This chapter describes the methods used. It further includes a description of the various stages of the research, i.e., the selection of participants, the data collection process and data analysis. It concludes with a discussion on the dissemination of the findings and the ethical considerations. Should this not be in the Conclusion?

5.2 RESEARCH METHODOLOGY

5.2.1 Qualitative Research Methodology

Research methodologies are decided up when the researcher conceptualises the research question in a manner that the questions could be answered as effectively and efficiently as possible (Babbie and Mouton, 2001). They list the following requirements for the selection of qualitative research design:

- *The research purpose of the study*
- *The insider perspective*
- *The ideographic, contextual research strategy that was followed for the study*
- *A discussion of each of above aspects.*

The research purpose was to analyse whether and how social capital could be developed amongst a group of network members. Social capital is a complex concept with various aspects and dimensions, hence the choice of a qualitative exploratory research design. The researcher further explored different types of networks and to analyse what type of network has learning as an outcome.

As the researcher was a member of the LN when the research data was collected for her PhD study, the insider perspective had to be considered. Chapter 1: Researcher Background and Positionality provides a background of the researcher's interest in the

research topic and also the potential bias that could arise due to the researcher's "insider/outsider" position. There the researcher detailed how she managed the situation with the participants, and her withdrawal from activities in the LN.

Babbie and Mouton (2021) explain that an ideographic contextual research strategy emphasises that a phenomenon should be understood in terms of the specific context in which it took place, and is not concerned with generalisation of the data. All the CSO participants in the research study came from different backgrounds. The academic members represented various universities but all had knowledge and practice of health and human rights in common. During the data collection process and the analysis of the data regarding the development of social capital within a network, the researcher was cognisant of the varying contexts and that differing individual perceptions or understanding of social capital must be interpreted within the participant's context.

The researcher selected qualitative methodology as it enables exploration of a wide array of dimensions of the social world. A combination of various qualitative approaches produces rounded and contextual understandings based on rich nuanced and detailed data (Hudson and Ozanne,1988; Mason, 2002; and Mouton, 2001). Dudwick, Kuenhnast, Jones and Woolcock (2006) suggest that the strength of qualitative research is its ability to identify intangible factors such as social norms, values and belief systems of the participants, core to understanding social capital and networks. Anderson (2010) concurs and adds the advantage of flexibility, that is, it allows greater spontaneity and adaptation of the interaction between the researcher and the participants.

The qualitative case study methodology was utilized as it provides tools for studying complex phenomena within their contexts, and allows for an in-depth, detailed study of an individual or a small group of individuals (Baxter and Jack 2008). In addition, it enables the exploration of the contextual conditions which may be considered highly pertinent to the research study, according to Yin (2014).

When the approach is applied correctly, it becomes a valuable method for health science research to develop theory, evaluate programs and develop interventions.

Researching social capital requires the researcher to utilize a methodology that will uncover patterns of engagement, interaction and collaboration with and or between members of the LN. It further requires the probing of relationships and common interests between the CSOs and the academic members and whether these relationships have developed a shared sense of identity and collaborative action between members. Therefore, a combination of exploratory and descriptive case study methodology was applied to my research study.

Exploratory case studies generate rich subjective data and bring to light the variable relationships and processes that merit further investigation (Burns, 1994). Babbie and Mouton (2001) describe the use of exploratory case study methodology for researching relatively unknown phenomena, which reveals new information for the development of new subject theory. Additionally, exploratory case study methodology enables an insider perspective of the participants and their practices as participants are more open with the researcher (Breen, 2007; Buckle, 2009 and Dwyer and Buckle, 2009). This openness and acceptance of the researcher could produce data that will have greater depth and breadth to the data collected

Zainal (2007) concurs with the previous authors, as he defines the participatory case study method as "an empirical inquiry that investigates a contemporary phenomenon within its real-life context; *when boundaries between phenomenon and contexts are not clearly evident and in which multiple sources of evidence is used*'. Baxter and Jack (2008) agree with Zainal, and state that the triangulation of data ensures that the research is not explored through one lens, but rather a variety of lenses that allows for multiple facets of the phenomenon to be revealed and understood.

Zainal further notes that the case study approach in social science studies is relevant when exploring the depth of the research matter. It is further considered by the author to be a robust research method particularly when a holistic and in-depth investigation is required. As a tool in social science studies, explorative case study enquiry becomes more prominent when issues regarding education, sociology and community-based problems. The author concludes that with the application of the exploratory case study method, a researcher can go far beyond the quantitative statistical results and understand the behavioral conditions through the actor's perspective.

The methods of data collection between 2010 and 2017, the duration of the study, will be discussed in the next section. The Researcher did not purposely elect to collect data over time, but the protracted research however provided the researcher with an opportunity to conduct interviews during various phases of the LN's development. (Engel, Keijzer and Ornmark, 2006; Scott and Hoffmeyer, 2007 and Sky-Bender-Moll, 2008), concur that collaborative efforts and the development of social capital amongst a group of people can best be assessed over time. The DA provided the researcher with additional data to triangulate the findings.

5.2.2 Qualitative Methods of Data Collection 5.2.2.1 Semi-Structured Interviews (SSI)

Data collection for the research study included two rounds of Semi-Structured Interviews (SSI) with representatives of 5 CSOs and 3 academic members. The first round of SSIs with the CSOs and the academic members took place between 2010- 2011..

The LN is a closed network and when two of the CSO members exited the LN during the study period, they were replaced by alternative CSO representatives. The researcher chose to interview all 5 CSOs members (including the 2 new representatives) due to the change in CSO representatives. The purpose was to explore whether there were any changes in the nature of the relationships amongst the founder members and the new representatives.,

Exploration further included whether the change had impacted on the nature of relationships amongst the members. Garten, Haythornwaite and Wellman (1997) state that when change occurs in network members, it is important to examine the impact of this change and whether this change would impact on the relationships amongst the network The interviews with the new members provided them with an opportunity to reflect on their understanding of the purpose of the LN and on their participation in the various LN activities. They further shared their observations of whether and how their organizations had benefited from participation since the inception of the LN.

A second set of SSIs took place in 2017 with the 5 CSOs, thus 10 interviews were conducted.

5.2.2.2 Focus Group Discussions (FGDs)

A focus group discussion (FGD) is described by De Vos (1998) as a purposive discussion of a specific topic or related topics taking place between individuals with a similar background and common interests who are brought together in a group. The group interaction consists of both verbal and non-verbal communication and interplay of perceptions and opinions that will stimulate discussions without necessarily changing or modifying the ideas of the other participants. Dudwick, Kuehnast, Jone and Wookcolk (2006) elaborated on the use of focus groups when researching social capital. According to the authors, it allows the researcher to explore the views of homogenous as well as diverse groups of people and it enables the researcher to unpack differing perspectives within a group. Because social capital is relational, it exists between people and by asking a group of people to respond together to certain questions and hypothetical situations, a researcher may elicit information that is more nuanced than data collected through a questionnaire. FGDs provide the researcher with an opportunity to observe the social capital aspects such as trust; a shared identity, empowerment, agency, and collective action are observable during the focus group discussions.

The FGDs with the beneficiaries of the CSO members on the LN were held to explore whether their representative on the LN had cascaded information and knowledge to the beneficiaries and whether and how the information and knowledge had been integrated into the CSOs health and human rights programs. Three FGDs took place in 2017. The first group consisted of 10 participants and the second, 8 participants. In total 28 participants participated. Table 5.1 presents the number of SSIs and FGDs.

Table 5.1: Number of participants included in the study

In-Depth Interviews		**Number**
2010- 2011	Number of SS Interviews	**8**

In-Depth Interviews		
2017	Number of SS Interviews	**5**
Focus Group Discussions: 3 FGDs		
2017	Number of participants	**28**
Total number of participants		**41**

Two of the five CSOs could not participate in FGDs as their beneficiaries lived in various communities and the beneficiaries experienced financial constraints. The researcher attempted on numerous occasions to convene these focus groups without success despite offers to overcome the challenges experienced by the CSO beneficiaries.

The questions in the discussion schedule were similar to that of the SSIs. The purpose of exploring similar themes was to triangulate the data, probe and add depth to the data collected during the SSIs. Furthermore, exploring similar questions with a group of like-minded people with broadly similar goals could help the researcher to surface relational issues in a way that individual interviews may not.

The FGDs further explored whether and how they developed relationships with each other and whether they developed a sense of a shared identity with the other members (bonding relationships) and the LN, and whether they had collaborated with the members outside of the LN (bridging relationships).

5.2.2.3 Documentary Analysis (DA)

Documentary analysis (DA) is research that involves searching for and extracting information and evidence from original archives. Archives are historical, non-current documents, records and other sources relating to the activities and claims of individuals, entities or both. They exist both to preserve historic material of value and to make it available for future use. DA provides information of interest to research professionals across a wide range of fields. Given the vast sea of archived documents available, it is typically more complex and time-consuming than your average online search, but it often yields more reliable results.

According to Ventresca and Mohr (2001), documentary research methods include a broad range of activities applied to facilitate the investigation of documents and textual materials produced by and about organizations. In documentary research, researchers analyse data sourced from existing records and serve to help develop understandings of the research context, rather than to inform the development of concepts and theories. Documentary research comprises of a wide array of empirical materials created by individuals for individual use or on behalf of an organization (e.g., diaries, letters, photographs, reports, research, minutes and any other documents collected by a second party). Further, they claim that virtually every researcher who has collected data from interviews, focus groups and documentary data offers quotes from interviews or field notes when reporting research findings and developing theoretical contributions.

The purpose of utilizing LN documents was to provide the researcher with substantive information about the activities since its inception in 2008 and for the duration of the study period, up to 2017. The documents reviewed included LN strategic planning reports, quarterly Review and Reflect meetings, executive and general meeting minutes. In addition, the researcher utilized data from published academic articles on the LN as well as presentations delivered by the LN members. The DA was conducted in 2018 and 2019 with the purpose of adding depth to the data. Utilizing three sources of data enabled the researcher to triangulate the data. In doing so, De Vos (1998) observes that the use of various data sources ensures that a theory is tested in more than one way.

The LN records were filed in an office allocated to the LN by UCT. The researcher had physical access to the files and sourced additional records through the UCT Vula website. It is an intranet site accessible only to persons with the password, and was used for internal communication amongst network members. In addition, documents were sourced from the LN website, which is an externally-facing open access site (LN Website). The documents were easy to access as most reports were uploaded on the websites. The documentary data and analysis are presented further in this chapter.

5.3 SELECTION AND DESCRIPTION OF PARTICIPANTS

Participants were purposively selected for this case study. Purposive selection refers to the method used by qualitative researchers to select participants that can provide in-depth and detailed information about the phenomenon under investigation. The participants consisted of 5 CSOs and 3 academic members. FGD participants were selected by the CSO members of the LN. These participants were beneficiaries of the member CSOs and not directly involved in the LN activities. The purpose of selecting the beneficiaries was to ascertain their understanding of the LN and the benefit that they receive through their CSO representative on the LN.

5.4 RESEARCH PROCESS

5.3.1 Data Collection

Both primary and secondary data sources were utilized in the data collection process. Semi structured Interview schedules and a focus group interview schedule (Annexures 3-4) were designed to guide the researcher in exploring the objectives of the study. The primary data sources included SSIs and FGSs with the CSO members and academic members of the LN. The secondary data included a DAs of the LN data. The documents were sourced electronically[37] and physically through utilizing hard copies of documents.

A Researcher Background document and Consent Form (Annexure 1 and 2) were designed and explained prior to the onset of the interviews. Consent was received from the respondents of the SSIs. Before consent was received from the participants of the FGSs, the researcher discussed the language diversity in the groups. The groups agreed that members who wished to speak in their African mother tongue (isiXhosa) or Afrikaans could do so and that those members who spoke English offered to summarize and translate the information.

The researcher informed the members that they had the right to withdraw at any stage of the interview process, that the data would be recorded electronically, and that their

[37] The LN website: https://salearningnetwork.weebly.com/papers-briefs--other-reports.html /
UCT Vula site https://vula.uct.ac.za/portal

anonymity and information shared would be confidential and that the participants may access copies of the interviews. This information was translated into isiXhosa to ensure that members understood the research process. Written consent was received after the participants indicated that they accepted the process and that they were

anonymity and information shared would be confidential and that the participants may access copies of the interviews. This information was translated into isiXhosa to ensure that members understood the research process. Written consent was received after the participants indicated that they accepted the process and that they were willing to participate.

5.3.2 Data Analysis

Dudwick et al and Yazan (2015) draws on 'Yinian' (Yin, 1994) perspectives which state that case study research should rest upon multiple sources evidence with data needing to converge through triangulation. Multiple sources of data collection were used to explore social capital within a network and the impact that it had on the realization of health and human rights programs amongst CSO members.

Thematic analysis was used with lower and higher order categories, and a combination of inductive and deductive analysis was used as the researcher had a clear understanding of the dimensions of social capital for which she was looking. The higher order is referred to as themes and the lower order as sub themes.

The researcher analyzed the data according to the various themes and sub themes that emerged from the data. The documentary analysis of the LN data provided a context of the LN and the documents such as minutes of meetings, Review and Reflect ion reports, strategic planning reports enabled the researcher to systematically track the activities of the LN and members' participation in the various activities.

Analyzing social capital data depends on the definition of social capital and the framework within which the definition is conceptualized (Social Capital Workshop, 2003). As presented in Chapter 3 of the research study, the researcher's understanding of social capital was drawn from the literature review of various definitions, aspects, and dimensions of social capital. In summary the researcher understands social capital to be the sum of resources and power and a sense of

identity that individuals and groups accrue through interaction and collective actions. The process of the development of social capital within the LN was analyzed according to theoretical frameworks presented. The predetermined aspects and dimensions were used as a guide to identify themes emerging from the data. The theory on networks presents a description of various networks, drivers and indicators for successful networks. The theories provided a framework for the analysis of the social network data and whether and how the nature of the LN provided the CSOs with a platform for mutual learning and knowledge sharing.

Denzin and Lincoln (1970) report that the various dimensions of social capital could be analysed according to themes (thematic analysis). Themes are abstract and often fuzzy constructs that researchers identify before, during and after data collection. The researcher drew on a model of thematic analysis as designed by Attridge-Sterling (2001, p.391), who defines thematic network analysis as a way of organizing qualitative data that seeks to identify the themes salient to the text at different levels. Thematic network analysis facilitates the structuring and depiction of these themes and the process of deriving these themes from textual data. It further draws on core features that are common to most approaches in qualitative analysis. Due to the complex and multi-dimensional nature of social capital and networks, my research study utilized three qualitative methods: SSIs, FGDs and DA to extract data for the study. Table 5.2 presents the two stages in the thematic network analysis process.

Table 5.2: Stages in Thematic Network Analysis

Stage A: Reduction or breakdown of text	
Step 1. **Code the material**	1. Devise a coding framework 2. Dissect text into text segments using the coding framework
Step 2. **Identify themes**	▪ Abstract themes from coded text segments ▪ Refine themes
Step 3. **Arrange themes**	▪ Rearrange into organizing themes ▪ Deduce global themes ▪ Illustrate themes ▪ Verify and refine themes
Stage B. Exploration of the text	
Step 1. Identify themes	
Step 2. Select basic themes	
Step 3. Select the organizing themes	
Step 4. Describe and explore global themes	
Step 5: Summarize the themes	
Step 6. Interpret patterns	

The table illustrates that once all the text was coded, themes are abstracted from the coded text segments. In stage B of the model, the text is explored and refined to arrange them into coherent groupings. These grouped themes are known as basic themes. Through further arrangement of the basic themes, they are grouped into organizing themes. The organizing themes are the grouped into global themes.

The results of thematic analysis are presented in Chapter 6 as Findings.

5.5 TRIANGULATION AND VERIFICATION

Triangulation addresses the issue of internal validity by using various methods of data collection to answer a research question of importance (Barbour, 2001). According to the author, the production of similar findings from different methods such as interviews and FGDs provides corroboration or reassurance. The absence of similar findings does not however provide grounds for refutation as different methods used in qualitative research afford only a partial view of the whole picture. describes Triangulation is a combination of at least two or more theoretical perspectives, methodological approaches, data sources, investigators, or data analysis methods (Denzin, 1970; Kimchi, Polivka and Stevenson, 1991). Thurmond (2001) supports this view and adds that the intent of using triangulation is to decrease, negate or counterbalance the deficiency of a single strategy thereby increasing the ability to interpret the findings. The benefits of triangulation can include increasing confidence in research data, creating innovative ways of understanding a phenomenon, revealing unique findings, challenging or integrating theories and providing a clearer understanding of the problem. The data of the two sets of SSIs, the FGDs and DA were used to triangulate the findings.

5.6 DISSEMINATION OF INFORMATION

A paper was presented at the International Conference in Brighton, England entitled “Social protection for Social Justice” (Centre for Social Protection, 2011). The researcher further contributed towards a book Chapter as found in Stuttaford, *et al*., (2014).

The knowledge of social capital and networks that was generated through the research study, has enabled the researcher to share her the knowledge with other forums and networks that the researcher belonged to.

The finding of the research study will be shared with the participants. Academic papers on health and human rights practices in communities will be presented at conferences. Through knowledge sharing, the researcher aims to broaden practices for the realization of the right to health.

5.7 ETHICAL CONSIDERATIONS

Researchers are ethically obliged to ensure that they are competent and adequately skilled to undertake the proposed investigation (de Vos, 1998). The researcher has a Masters qualification in Social Welfare Policy and Development and has developed research skills during her studies. As a social worker, the researcher is obligated to practice according to a Code of Ethics developed by the South Africa Council for Social Services Professions and has to keep herself abreast of new knowledge through the acquisition of accredited training. The UCT Research Ethics Committee initially approved my study for 2011 (REF: 207/2010). As a result of the protracted time line, the researcher re-applied for ethics approval in March 2021. During 2022, the researcher submitted her thesis for examination.

According to Mouton (2001), ethical issues arise from our interaction with other people and the environment, especially at the point where there is potential or actual conflict of interest. As the researcher was a member of the LN, the researcher disclosed her positionality at the onset of the study.

In the research study, the researcher approached members of the Learning Network for voluntary participation in the study. The aims and objectives, the methodology and research process were explained to the participants. The consent form guaranteed anonymity and respect of the confidentiality of information. As the researcher is a director of one of the participating organizations, I utilized the services of a co-researcher to interview a staff member of the organization. The purpose of using a co-researcher was to decrease the potential bias in analyzing the data.

All data was anonymized. Questionnaires and transcripts from interviews and focus groups were transcribed and the electronic and hard copies of data were secured. Feedback will be given to the participants utilizing the Learning Network's structures and the structures of the participants. Transcripts of the interviews were offered on request from the participants. The completed research findings will be shared with all participants in the study in the form of a meeting.

5.8 RIGOUR AND TRUSTWORTHINESS OF THE DATA

The study methods required attention to strategies for achieving reliable and trustworthy data for analysis. This is different to the ideas of validity and reliability used in quantitative research. Because of the researcher's long standing relationship with the participants, there was prolonged engagement which would enhance the trustworthiness and credibility of the data (Flick, 2009). Secondly, trust was established between the researcher as an insider to a network which also aided the quality and veracity of the data obtained. Triangulation also assisted in enhancing the veracity of the findings.

5.9 SUMMARY

This chapter presents the research methodology and study design. Diagram 5.1 illustrates the process of how the research outcomes were reached. These outcomes are whether and how social capital within a network contributed towards the realization of health and human rights. The complexity of social capital having varying definitions, multiple aspects and dimensions necessitated the adoption of multiple qualitative methods to uncover patterns of engagement, interaction, and collaboration between members of the LN.

The LN was utilized as a descriptive and participatory case study and the use of the qualitative research methodology by the researcher was justified. The use of a combination of SSIs, FGSs and DAs of the LN data, provided depth and richness to the findings. It enabled the researcher to validate the data through triangulation. The use of a Thematic Network Research Analysis (TNA) model was utilized to code and analyze organizing and global themes. (Primary and secondary data). The analysis was done manually using various tools to ensure that themes could be identified.

Two of the member representatives changed during the period of research. Change of membership of a close-knit network could result in a change in the development of cognitive social capital. Cognitive social capital refers to aspects of trust, respect, inclusion and cohesion. The researcher found it imperative to examine whether there were any changes in relationships amongst the LN members and whether the experiences and responses of the founder members and newer members correlated or differed amongst them.

The findings of the study are presented in two chapters: benefits of participation and co-learning in the LN in Chapter 6; and the development of social capital and networks in Chapter 7.

CHAPTER 6
FINDINGS:
BENEFITS, CO-LEARNING AND CO-RESEARCH

6.1 INTRODUCTION

The findings are presented in two chapters given the complexity of the study and volume of data, sourced from Semi-Structred Interviews (SSIs), Focus Group Discussions (FGDs) and a Documentary Analysis (DA) of the Learning Network (LN) documents. The researcher drew on a model of thematic analysis as designed by Attridge-Sterling (2001:391) which is a way of organizing qualitative data that seeks to identify the themes salient to the text at different levels.

The primary findings that emerged fell into two broad categories: (i) benefits of participation, co-learning and co-research in the LN and (ii) the development of social capital and networks. The first category is presented in this chapter, and the second in Chapter 7.

For the purpose of anonymity, CSO members are referred to as CS1, CS2, CS3, CS4, CS5, and the focus groups as FG1, FG2 and FG3. The academic members are referred to as A1, A2 and A3. The quotations that are verbatim are placed in parenthesis "…". The data from the DA are also anonymized where individuals are associated with data.

The themes and sub- themes are presented as follows:

6.1.1 Themes

1. Benefits and opportunities of participation in the LN

2. Development of Social Capital

3. Challenges within the LN

4. Implementation and integration of health and human rights programs in communities

5. Dominant knowledge and alternative pathways of knowledge acquisition.

	Co- learning Activities from the Documentary Analysis done in 2018-2019.
Training	Training in health and human rights
	Training on submissions to Parliament on health rights matters
	Training of the roles and responsibilities of health committees
	Co-learning with fellow LN members
	Disability rights training programs
	HIV/Aids training programs
	Nutritional training programs
	Epilepsy training programs
	Training in SA Health Act and health rights legislative instruments
	Development of an understanding of the dominant knowledge of health and human rights amongst CSOs
	Development of an understanding of the experience and expertise of CSOs
Benefits/ opportunities	Opportunities for LN members to obtain diplomas, and post graduate degrees
	Opportunities to travel and participate in national and international programs
	Presentations of papers and posters at conferences
	The formation of youth and disability forums in Delft and Khayelitsha

	Sixteen days of activism against gender-based violence programs
	Community strengthening programs

The findings in this chapter are presented in tables and text. The purpose is to corroborate and ensure that the findings of the SSIs, FGDs and DA are consistent. Table 6.1 documents the benefits, co-learning activities in which the participants engaged. These findings were sourced from the DA.

Table 6.1: Benefits, Co-Learning Activities undertaken within the LN between the periods 2008-2011 (London et al 2012)

Training area	**Co- learning Activities. (Adapted by the researcher from London et al 2012). Information sourced from the DA.**
The right to health	*General information on what is meant by the right to health and how to hold government accountable* *Development of a toolkit on the right to health* *Development of pamphlets on the right to health* *Disability and the right to health rights advocacy* *Community participation as key to the right to health*
Engaging State service	*Accessing basic services- advocacy with provincial and municipal authorities*
Community development tools	*Participatory community mapping as an action research method* *Alternative methods for community decision-making in social structures* *Training*
Re-theorizing the right to health based on our experience	*What do African theories and philosophies say about human rights, individual and collective rights, and the right to health?* *Culture as an obstacle and opportunity*
Writing skills	*Building capacity of LN members*

The CSO members are from diverse CSOs. The respondents verbalized the benefits, as they perceived it to be applicable to their organizations (findings of SSIs and FGDs). All the members agreed that through collaboration with other CSOs and the academic members, their knowledge about health and human rights was enhanced as a result of training received. Reference was particularly made to the development of the tool-kit on health rights; the health rights pamphlets and the training on the roles and responsibilities of health committees (LN website). The theme of learning and co-learning as a benefit recurred throughout the analysis of the findings. The themes of shared learning between the CSO members and academics, the training and understanding of the right to health, building capacity amongst members for them to improve not only the individual members confidence, but also their health and human rights programs. The members further benefitted through participation in various research and programme activities and also the reflective practice of 'learning by doing and doing by learning':

> *"… we learn from each other …they could assist you in saying that this might be the route to go, this is what you could try because we had the same challenges and that worked for us… As an organization, we thought that it would deepen the members understanding about health issues… we also need to build capacity of the people we serve". CS1*

> *"I definitely benefit in terms of growth and understanding around the right to health…and then gradually as the process unfolds, I think the way in which the action and reflection and the way the spiral process worked…it allowed us to learn together…I have definitely learnt in terms of understanding human rights and understanding how organizations and academic institutions can work together collaboratively in creating best practice approaches…" CS2*

> *"What motivated me was the idea of learning and learning from other and actioning the learning…it was an opportunity to learn and for my organization to progress… So, for us, a network must have a purpose, it must have clear goals, and there must be a good fit in terms of what our ideologies are". (CS3)*

> *"… so, attending the LN for me was an advantage because then I have other NGOs that I can engage with…. they got training, I mean, it's an opportunity, they wouldn't have had if they were not part of the Learning Network. And then also the exposure to other countries within Africa". (CS4)*

The following members' comments capture the essence of the aspects of co-learning and capacity building. The members not only expressed the value of participation in the LN because it brought people of different experiences together, but also

highlighted the principles of co-learning where members should be valued and acknowledged for their own expertise and experiences. In the context of the interview, the member expressed that a network should not be unidirectional where members are passive recipients of knowledge acquisition, but that it should be interactive, and members should be able to 'take away' experiences from other members of the network and to integrate the experiences into their own health promoting programs:

> *"…we like the linkage with that academic institutions and other community-based organizations, and we felt that working together with our knowledge on the ground and expertise and best practice, we could equally share knowledge between us". CS2*

> *"…I tend to seek benefits and opportunities where I can share my expertise, so to me the learning network is important because it brings people together from different avenues. And also, what's the value you can add, what are the experiences that you can share and also what you can take away". (CS5)*

Additional opportunities for individual members were afforded through funding for diplomas in adult education, Master's and PhD studies. Additional benefits and opportunities were travel to Uganda to participate in health rights training, health rights training in two provinces in South Africa, presentation of an academic poster in East London in the Eastern Cape and attendance of a conference in Kampala Uganda.

> *"Yes, they opened the door. I'm in my second year and it is not only myself… two other members… are doing a diploma in adult education: it's our second year now… "Yes, last year we received bursaries… but then there were other learnerships that were made available through the LN which was then circulated into the wider communities". CS1*

> *"The LN will provide benefits and opportunities for engagements with outside stakeholders… and I do think that if our proposal (poster presentation on disability, health and human rights) be accepted that it will be definitely beneficial for the organization externally in terms of the research we've conducted and through that process, the linkages that we've' made with networks outside…" Once I presented the poster… in East London, we are taking the process further in terms of disabilities and human rights". CS2*

> *"I think 2009 was the Equinet South-Eastern regional conference in Kampala, and that was a very good experience in terms of learning specifically more about health rights". CS3*

The participants of FG1 reported that they were trained by their LN representative to be health change agents in their communities. Change agents are people who have developed agency through training and knowledge and who are committed to work

with the communities and stakeholders to bring about changes in the lives of community members.

> *"So, we learnt a lot, not only for the people we are working with, but to me it is empowering me to work …it made me happier to tell people how they must treat themselves at home… people are poor". FG1*

> *"The training makes us very close …we work together and share our problems…I was so raw when I was elected. I did not have anyone to direct me… so we had to find our way... And it was through… and the LN, that I learnt about the right to health…I do not have skills … but while I was here meeting the LN, they provided us with training so that I know exactly what I am here for and how can I save my community as a member of the health forum".FG2*

> *"The LN has created an opportunity to train our health committees". FG2*

The FGs participants (beneficiaries of each CSO) spoke about the benefits of training that they received from their LN representative and from other members of the LN. The trainings sessions included information on the right to health, health education, how to create awareness about the prevention of these conditions, how to impart information about the management thereof and treatment options that are available at the local health structures. As a result of the agency that was developed through training, the members were able to network with health stakeholders to report on the health conditions of the community and to work in collaboration with them. The members further cascaded the information and knowledge to their district health committee members through training on the right to health and on the role of health committees.

The CSO members received training from the academic members on the governance of committees and the roles and responsibilities. The participants reported that the LN not only provided them with new knowledge, but also that the training process created an enabling support network for them to work together and to learn and share experiences.

A LN academic member conducted research into the functioning of health committees. As an outcome of the research, the CSO members received training from the academic members on the governance of committees and the roles and responsibilities. The participants of FG3 reported that the LN not only provided them with new knowledge, but also that the training process created an enabling support

network for them to work together and to learn and share experiences. The participants received training on the South African National Health Act that legislates community participation, and which makes provision for the establishment of participatory mechanisms such as health committees. In terms of the Act, the purpose of these structures is to promote and facilitate interaction and to share information on health issues with the representatives of the Provincial Health Department.

> *"I do not have skills… but while I was here in the meeting, the LN provided us with skills so that I must know exactly what I am here for and how I can save my community as a member of the health committee". FG3*

> *"I am being equipped in understanding the community at the same time knowing the rights of patients and at the same time understanding Government's plan around health". FG3*

The participants further reported that because of the knowledge gained in terms of South African legislation, they could confidently make submissions directly to Parliament regarding health-related matters. The confidence expressed by the members was as a result of the development of agency and empowerment amongst the members.

> *"It was interesting… there is this visit to parliament… and learnt a lot from the LN… "The LN created a space where the health committees were mentored about the bill, the Acts, make them understand how parliament works… the LN has created an opportunity for the health committees to present submissions to Government". FG3*

As with the CSOs, the academic members had different experiences, expertise and knowledge of health and human rights. One CSO member reported that the benefit for academic members is that the academic members can collaborate with civil society for the attainment of health and human rights programs. This statement was confirmed by a member who reflected on the reasons for the conceptualization of the LN and the benefits that could be accrued through learning from the community and by adopting a collective approach for the realization of the right to health. The collective approach emphasized that the realization of the right to health required the action of many other social and economic sectors in addition to the health sector. Co-learning is about CSOs learning from academics and academics learning from communities.,

One member saw the value of her participation in the LN as an opportunity to network with other international academics about the work done by the LN. An additional benefit was being acknowledged for her publications of research articles on the LN.

> *"…and just the people that I meet at other conferences and they say, oh, well, there's this group in SA they are doing this…there's that kind of academic networking that takes place" …being involved in an international research project is very good for my (career). When a mentor or potential employer looks at my (work done in the LN) they are more than willing to engage with me…so that does have an impact because it opens doors for me". A1*

A2 acknowledged the benefit that the LN afforded her was through her intellectual contributions in shaping health practice methodologies. An additional benefit was the value of data collected by a student who researched an aspect of the LN. The data was found to be beneficial for her and her academic institution.

> *"In the LN… for its intellectual contribution which is in terms of shaping and the methodology and the objectives". A2*

Another member shared the benefit through her active participation in the co-ordination of the LN. It provided her with an opportunity to gain more practical experience in the realization of the right to health.

> *"In my undergraduate, I was extensively involved in different organizations, NGOs around human rights… (By being part of the LN) it was more of a practical experience in grounding… policy… legislation... rather than sort of the theoretical grounding of human rights... the LN was interesting as it tried to bring together academics and civil society and that that provided her an opportunity to become involved with a research project for knowledge creation". A3*

> *"Without the initial knowledge received in the LN, I would not have known so much about health and human rights and how to integrate disability rights into our programs". A2*

The findings clearly demonstrate that the CSO and academic members both commented on the unique co-learning opportunities . The members developed agency that enabled them to advocate for the promotion of health and human rights. Through advocacy action, CSOs were equipped to implement health and human rights programs. Table 6.2 presents the various programs in which the LN members participated.

Table 6.2 Health and Human Rights Programmes (Source SSIs and FGDs)

	Findings
Awareness about health and human rights	*"We were thinking about how are we actually going to kick-start a program in our communities and the relevance of those programs as it relates to things that would improve what is happening in communities. And a decision was made - use Women's Day as a platform to kick start things around health and socio-economic rights and to raise awareness about Reclaiming your Rights". CS1*
Building Agency	"*And the way forward from here; we will be running programmes within our circles inviting other members and our themes would be (around health matters) ... we offer nutrition plans and we are busy developing a little recipe booklet, healthy but cheap recipes" … we are running programmes outside our circles because we can build their capacity". CS1*
Promotion of Disability Rights	*"…we are ready to start running our programmes in communities…ja (yes) definitely…we are obviously in the infancy in terms of incorporating what we're starting to develop in terms of disability and human rights, but the commitment is there with the team members and we can see that through how we've already started incorporating it into our language, into our everyday programmes- so we have a disability sensitization program which incorporates disability rights into it… so there is a consciousness".CS2*
Advocacy for Health and Human Rights	*"There has been some paradigm shift specifically around human rights…it is something we can own … we are not health providers; we are human rights-based organizations where we advocate for health and human rights". CS3*
Agency and the Promotion of Health and Human Rights	*"We take action in meetings, we take positions in meetings, and if you take a decision, you must be able to walk your position to wherever it needs to go. I could work with the documents with the women- you make them understand the social determinants of health…it is your right to water and sanitation and environment and nutrition…we use to talk about human rights, but now we're using the tools, pamphlets". CS5*
Capacity Building	*"Health and nutrition are a new position here…so they want health and nutrition to evolve in the organization…but it is from attending meetings and*

	I see they focusing on health and human rights. They want to impart skills to communities in terms of how they must be assertive in terms of first of all knowing what their rights are, and also complaining if they do have violations… it was an opportunity so the club members got training… they wouldn't have it if they were not part of the LN".CS4
Advocacy and Agency to deal with violations.	*"…when they (community members) go to the day hospitals, family planning, they are forced to take an HIV test. And then one of them had a STI and she was told she's not going to be treated until she tests for HIV or bring her partner…these violations were reported to (LN)… we were trained to deal with the violations. So now they were saying …every month we should have a feedback meeting".CS5*
Monitoring Health Services and reporting health violations	*"So, we have agreed that we would pilot the complaints and complements process in one facility and look at how we can take it forward. And then also the whole maternal health issue- that is where we also would like to focus on the complaints that there's been women giving birth in ambulances or on the streets or wherever- and that is a violation of a women's right. So, the next phase would be is to take it to the Health structure". CS5*

During the second set of data collection in 2017, three of the original members reported that they continued to benefit from the activities and learning opportunities presented by the LN during their years of participation. The LN members continued to participate in a range of co-learning activities. The activities ranged from the development of the right to heath pamphlets; the development of the toolkit on human rights and participation in the photo-voice project. One member presented an academic poster on her organization's health and human rights programs. Members were further involved in a research initiative in Uganda, which included training of health care providers at their community health facilities. The research activities were monitored and evaluated.

> *"This process of developing the pamphlets was particularly useful … because people had the opportunity to reflect on their situation in terms of health… That was useful because it gave the people benefits and opportunities to learn about their rights and their responsibilities towards that right. So, it gave people the opportunity again to look into their communities to see what was happening; to reflect on how it is happening, the impact on the community and their personal situation and the relationship between all of those". CS1*

Another member reported that the health and disability rights programs continued within their organization, and that the benefit that was received was to integrate the right to health with disability rights health and disability rights remained embedded in all the programs. The training programs enabled the member to map the organization's programs and to cascade her knowledge to her colleagues. Regarding collective programs with members of the LN, the member reported that they started working with the health structures and they launched a Disability Forum with all the key stakeholders in the community. Partnerships were also formed with the other members in joint programs such as Sixteen Days of Activism against Women and Children and Women's Day activities. Training in disability rights was also done with member organizations.

A member who had joined the LN after her predecessor left, reported that when she joined the LN she had limited knowledge of health and human rights and how it could be integrated into their current human rights programs. The member also reported that she had no prior contact with the LN members but through getting to know the members, bonding relationships with the other LN members were formed and bridging relationships were formed with the academic members in terms of training and research activities. The member further reported that joint events took place with other LN members.

> *"It can help building and increasing people's activism… We attended seminars, health colloquiums, trainings and building activism on the right to health... Yes, we have built a relationship with the academic institutions with regardto-. participation in the community project also with the health structures". CS5*

Partnerships and collective activities with other LN members were further reported to be of benefit as it brought the members together and the resources amongst the members could be shared. Collective activities were also reported to be beneficial to the communities.

> *"It showed great potential for communities to collaborate on issues of people's right to health. I found the partnerships to be great with the other members- sixteen days of activism- women's day and also the training in disability… I am proud that we can work together as a LN and impact on the communities". (CS6)*

In order to ensure that co-learning activities were meeting the needs of the members, the LN utilized a reflective participatory action research methodology that promoted

the inclusion of members in decision making in all of the LN activities. London, Fick, Tram and Sttutaford (2012) list the activities that took place during 2008-2011.

The data show that the members embarked upon co-learning activities that provided them with specific knowledge on the right to health. A significant achievement of the LN was the development of six pamphlets and a toolkit on the Right to Health. The pamphlets were developed to enable the LN members to access information about the right to health (Thomas and London, 2006). The topics in the pamphlets include the right to health; community involvement and the patient's rights charter.

The development of the toolkit on human rights and pamphlets on the right to health, widened the CSOs understanding of the right to health to include the social determinants of health (Strecker, Stuttaford, and London, 2014). According to the authors, the pamphlets deepened CSOs understanding of the right to health by providing information on how to address health rights violations. It further had a positive impact on community and individual awareness and played a role in strengthening CSOs participation in the right to health.

CSO participation in the development of the materials ensured that the language used in the materials was not academic in nature and that it was user friendly and understood by communities. Because of the diversity in language used by various communities in South Africa, the LN had the pamphlets translated into English, Afrikaans and isiXhosa (languages of the Western Cape). The following section presents that findings of participation in co-research activities.

6.2 CO-RESEARCH ACTIVITIES AS SOURCED FROM THE DOCUMENTARY ANALYSIS

The participation of the CSO members in the co-research activities developed critical research skills that the members used in their research activities within their organizations. According to Stuttaford *et al.,* (2014), the purpose of the inclusion of the CSOs in the research activities was to enhance their knowledge about research and for the implementation of the right to health.

The researcher sourced the following findings that support then notion that CSOs knowledge about research can be enhanced. DA:

1. Co-research Activities

2. Development of Materials

3. Use learnings to promote advocacy

4. Integration and Implementation of health and human rights programmes research skills

5. Documenting Best Practices in Realizing the Right to Health (Organizational research skills)

6. Promote access to research opportunities for member organisations.

The members who participated in the range of co-research activities reported that they developed skills that they would not have developed if they were not part of the LN. They further reported that the skills enabled them to conduct research studies within their own organization thus adding value to their organizations.

The aim was to build agency amongst the beneficiaries to participate in the realization of health rights in communities. Alternative methods for community decision-making in social structures were explored as communities are not homogenous and different strategies are required. A research project known as the photo-voice project was implemented in one community and the methodology required that community members participate in the project through taking photographs of what they perceive to be causative factors that leads to ill health in communities (Source: SSIs, FGDs with CSOs and DAs).

The following section was extracted from the DA. CSO participation in the following research activities not only built agency but strengthened the relationships between the CSO and academic member as they had to work together. Particularly, the members felt valued as their lived experience in communities was acknowledged. The following Table 6.3 lists the type of co-research activities as extracted from the DAs.

Table 6.3 Description of Co-Research Activities (Source London et al (2012) and DAs).

Activity	**Co-Research activities**

Questionnaire development	organizational profiles - Basic demographic information on all LN organizations. Questionnaire: Knowledge and Practices - LN organisations at baseline knowledge of health and human rights. organizational profiles - Basic demographic information on all LN organizations. Knowledge and Practices - LN organisations at baseline knowledge of health and human rights.
Qualitative Research	Mixed methods exploring organizations learning for health and human rights - Impact of LN participation amongst LN members. Mixed methods evaluation: Community participation through Health Committees - Health Committees as vehicles for community participation in advancing the right to health. Ethnographic study of women's development within the LN - Experiences and development of women participants in the LN. Qualitative evaluation of the LN pamphlets - Assessment of coverage and effectiveness. Audit of Health Committees - Study of the capacity and building needs of Health Committees and barriers to participation. Documentation of Health Team development - Following the development of a Health Team in a rural farming region. Qualitative study on disability and human rights - Understanding of human rights by people with disabilities. Mixed methods research to explore the process of knowledge generation through rights- based research processes - Power and trust in the context of University and CSO engagement. Case Studies - SSIs regarding health violations; used for training and advocacy.
Photo-voice design	Photo-Voice - CSO members taking photos about health and human rights which are used as a basis for FGSs and SSIs.

Development of a Toolkit	Toolkit on the right to health - Development and piloting of a toolkit as a training and advocacy tool; monitoring and evaluation of roll out; adapting for use in Southern and East Africa.
Document review	Document review and key informant interview - Qualitative study on disability and human rights. Documentation of Health Team development - Following the development of a Health Team in a rural farming region.
Qualitative reflection	Qualitative reflection on the process of co-learning and knowledge creation – Reflections on how the LN undertakes research.
Literature review	Literature review exploring the contribution of African philosophy to conceptualize the right to health - An anecdotal bibliography; theoretical analysis of the traditional value of 'Ubuntu' as expressed in the rights aspects of dignity, rights explored as collective entitlements.

6.3 DEVELOPMENT OF MATERIALS

The development of the toolkit on human rights and pamphlets on the right to health widened the CSOs understanding of the right to health to include the social determinants of health (Strecker, Stuttaford, London, 2014). According to the authors, the pamphlets deepened CSOs understanding of the right to health by providing information on how to address health rights violations. It further had a positive impact on community and individual awareness as well as playing a role in strengthening CSOs participation in the right to health.

CSO participation in the development of the materials ensured that the language used in the materials was not academic in nature and that it was user friendly and understood by communities. As previously mentioned, the diversity in language used by various communities in South Africa, necessitated that the LN had the pamphlets translated into English, Afrikaans and isiXhosa (languages of the Western Cape).

The following Table 6.4 demonstrates how the CSO members used their learnings to participate in events and to promote advocacy.

Table 6.4 Learnings to Promote Advocacy (Source SSIs)

Member	Learnings to Promote Advocacy
CS1	*"Participated in the auto-photography project and a member was asked to document the photographs as a case study for the use in promoting the work of the CSO and in their campaigns for a healthy environment".*
CS2	*"Attended a Regional Meeting in Uganda on sharing best practice on health and human rights programs within the organization".* *"Utilized the knowledge to train staff at a hospital about the Batho Pele principles (SA Government, 2014)* *"Presented a seminar on epilepsy with medical practitioners. The LN members requested of the CSO to present the seminar for health forum and committees".* *"Invited LN members to join the FGDs on health and disability rights."* *"Facilitated a seminar at an academic institution on disability sensitization."*
CS3	*"The creation of a policy brief for advocacy on health issues faced by women."* *"Training of home-based carers and to link the training of health care workers with another organization."* *"Hosting a workshop on mapping and PAR process for LN members."* *"Participated in the development of a policy brief on health issues in collaboration with public health students assigned to the LN."* *"Presented a workshop on adult education for members of the LN."*
CS4	*"The representative attended an advocacy workshop and was asked to do the closing remarks. The representative believed that the CMHF were invited because of its work with the LN."* *"The CSO requested a workshop on mentoring and mapping process from another CSO."*

The LN members verbalized that they were provided with new knowledge about research into various aspects of health and human rights and that they valued the knowledge sharing that they received not only from the academics but also from other

CSO members. An analysis from both the SSIs and DA show that new knowledge and research skills enabled them to cascade the knowledge to their beneficiaries and communities.

The new knowledge further enabled the members to implement their health and human rights programs. This is in keeping with the definition of networks offered by Lieber and Ferri (2004) in that networks should possess generative capacities such as the ability to work across traditional boundaries, learn new ways, develop a systems-view, create the future, balance autonomy with interdependence, manage co-operation and competition as well as align organizational form with purpose.

The development of agency, capacity building and advocacy are key aspects of a human rights-based approach. According to London and Schneider (2012), a human rights-based approach focuses on the recognition of the inherent dignity a human being. To, Community members should have the knowledge and a voice to advocate for the promotion and protection of rights in order realize health and human rights programs in communities. The Monitoring of health and human rights was further found to be imperative to ensure that the services are sustained. The findings support the assertion that new knowledge enabled the participants to integrate and implement health and human rights programs. Table 6.5 lists the programs that were integrated and implemented in communities.

Table 6.5 Integration and Implementation of Health and Human Rights Programmes (Source SSIs)

Integration and Implementation of Health and Human Rights Programmes	
CS1	*"Implementation of the auto-photography project in their communities."* *"A cleaning and recycling project was initiated as an outcome of training the community members on the right to health (R2H). Some of the items recycled was used in a children's drama. The drama was intended to inform/educate others in the community about a health environment."* *"One thousand pamphlets were distributed at a women's day even." CS1*

CS2	*"Used 237 pamphlets on community health centers at libraries, clinics, places where social workers were working on disability and human rights (HR) campaign."* *"Extended the right to health and disability rights training to the northern suburbs."* *"Utilization of posters for information sharing."*
CS3	*"The CSO held a Women's Health fair and spoke about the right to health (R2H) with approximately 300 women at one venue."*
CS5	*"Creating own materials profiling the health forum and the work that they do. Busy with a collage of activities for the past three years."*

6.4 PROMOTE ACCESS TO LEARNING OPPORTUNITIES FOR MEMBER ORGANISATIONS

These findings presents evidence that all the CSO members had integrated and implemented the knowledge gained through co-activities and co-research The CSO members not only implemented programs to address health and human rights but also developed capacity amongst their beneficiaries to participate in the programs.

Through the analysis of the DA, it became evident that not only does the data support the above findings but also documents the commitment of the CSO members to continue with the implementation of health and human programs. The following table 6.5 documents the programs that were integrated in Health and Human rights programs.

Table 6.7 How Learning led to the Integration of Health and Human rights programmes. (Source SSIs)

How Learnings led to the Integration of Health and Human Rights in Organisational Programmes	
Awareness about health and human rights	*"We were thinking about how are we actually going to kick-start a program in our communities and the relevance of those programs as it relates to things that would improve what is happening in communities. And a decision was made - use Women's Day as a platform to kick start*

	things around health and socio-economic rights and to raise awareness about Reclaiming your Rights." CS1
Building Agency	*"And the way forward from here; we will be running programmes within our circles inviting other members and our themes would be (around health matters) ... we offer nutrition plans and we are busy developing a little recipe booklet, healthy but cheap recipes" … we are running programmes outside our circles because we can build their capacity." CS1*
Promotion of Disability Rights	*"…we are ready to start running our programmes in communities…ja (yes) definitely…we are obviously in the infancy in terms of incorporating what we're starting to develop in terms of disability and human rights, but the commitment is there with the team members and we can see that through how we've already started incorporating it into our language, into our everyday programmes- so we have a disability sensitization program which incorporates disability rights into it… so there is a consciousness."CS2*
Advocacy for Health and Human Rights	*"There has been some paradigm shift specifically around human rights…it is something we can own … we are not health providers; we are human rights-based organizations where we advocate for health and human rights." CS3*
Agency and the Promotion of Health and Human Rights	*"We take action in meetings, we take positions in meetings, and if you take a decision, you must be able to walk your position to wherever it needs to go. I could work with the documents with the women- you make them understand the social determinants of health…it is your right to water and sanitation and environment and nutrition…we use to talk about human rights, but now we're using the tools, pamphlets." CS5*
Capacity Building	*"Health and nutrition are a new position here…so they want health and nutrition to evolve in the organization…but it is from attending meetings and I see they focusing on health and human rights. They want to impart skills to communities in terms of how they must be assertive in terms of first of all knowing what their rights are, and also complaining if they do have violations… it was an opportunity so the club members got training… they wouldn't have it if they were not part of the LN."CS4*

Advocacy and Agency to deal with violations	*"…when they (community members) go to the day hospitals, family planning, they are forced to take an HIV test. And then one of them had a STI and she was told she's not going to be treated until she tests for HIV or bring her partner…these violations were reported to (LN)… we were trained to deal with the violations. So now they were saying …every month we should have a feedback meeting."CS5*
Monitoring Health Services and reporting health violations	*"So, we have agreed that we would pilot the complaints and compliments process in one facility and look at how we can take it forward. And then also the whole maternal health issue- that is where we also would like to focus on the complaints that there's been women giving birth in ambulances or on the streets or wherever- and that is a violation of a women's right. So, the next phase would be is to take it to the Health structure." CS5*

6. 5 SUMMARY

This chapter's findings show that CSOs were capacitated with new knowledge to implement health and human rights programmes in impoverished communities. Referring to the literature on the state of health in poor countries, research suggests that people in communities are not only unaware of their rights but also struggle to access information about health services in their communities (Thomas and London 2006). In order to ensure that people become aware of their health and human rights, Wilson, Lavis and Guta (2012) state that CSOs who work directly with the community should be the catalyst for the promotion of health and human rights. CSOs provide numerous valued programmes and services to their members of their communities, particularly to the most marginalized, disadvantaged and/or stigmatized members of the community. In order to be a catalyst for change, knowledge about health and human rights needs to be integrated into their community programs.

The findings of the chapter show that, through shared knowledge, co-learning and co-research activities, agency was built amongst the LN members to integrate and implement health and human rights programs. The findings further support the notion that through collaborative activities, CSOs were able to address critical health and human rights matters in their communities.

Through these activities such as co-research, development of materials, use learnings to support advocacy, integration and Implementation of health and human rights programs and documenting best practice, positioned the LN members to impact on and effect change in communities and to become a “catalyst for change.”

Working collaboratively in a network such as the LN lends itself to the development of strong, close-knit relationships. Social Capital that is developed through bonding, bridging and linking relationships is described as being “glue that holds society together.”

The findings of the next Chapter 7 therefore focuses on the development of social capital and networks, and addresses whether and how social capital was fostered within the member organisations, as well as how social capital contributed to the integration and implementation of health and human rights programs.

CHAPTER 7

FINDINGS: THE DEVELOPMENT OF SOCIAL CAPITAL AND NETWORKS

"It is not my process. It is our process, it is not my project, it is ours; it's not my decision, we must decide".

7.1 INTRODUCTION

Social capital has both structural and relational or cognitive dimensions and these were lenses through which data from the SSIs, FGDs and DA were analysed. Relational dimensions refer to trust, altruism, cohesion and power. The structural dimensions refer to roles, rules and procedures. These dimensions allow people to work together and are important for making decisions, co-oordinating activites and resolving any conflict within the group or network. Referring to the goals of the LN as described in chapter 4, shared goals creates a sense of identity and allows prople to work together. In this chapter the various dimesions are presented and they are used interchangeably. Trust for example can be an aspect of inclusion, cohesion and the development of agency. This chapter will address the study objective related to exploring these dimensions, and to ascertain whether social capital has developed amongst a network of CSOs and academic members.

7.1.1 The Development of Social Capital: Bonding, Bridging and Linking

The LN members referred to various aspects of social capital, for example, the provision of a comfortable space in which to develop relationships and get to know each other; open lines of communication which in turn refers to the development of trust, acceptance and reciprocity. Through collaboration with CSOs members, bonding relationships were formed and they accessed resources such as knowledge or information sharing from each other.

.

The findings show that all the CSO members of the LN had developed various forms of bonding and bridging relationships with each other over time. This was evidenced in Table 6.1 wher the LN members participated in the development of a toolkit on the right to health; development of pamphlets on the right to health and disability and the right to health rights advocacy training.

"It's a space where you know that if you need something, let's take for example- If I need something which is … field of expertise, I could then contact the organization and say – this is what we are planning to do, how can you assist and support… the members of the LN share information... so that means that that there is a relationship and it's a relationship of sharing information." CS4

"The training makes us very close … we work together and share our problems." FG2

"Yes… So that meant that there is a relationship… I think that the group has bonded, really bonded to a point where people are quite comfortable in the space." CS1

"The LN members planned a workshop on mapping of services and offered to host the event." CS2

"In terms of collaboration with other member CBOs, CSOs, definitely we saw relationships developing with CS5, relationships developing with CS3, shared learning, shared seminars … so definitely I would find strong bonds have been formed"… CS2

"…and I think all the other CBOs, CSOs, we do great work together… I think that as the LN, we are all there because we believe in the individuals that are there and it is the individuals that make the collective. I believe in the integrity of the people that use to be on the Exco level; it is changing now." CS3

"Participated in the development of a policy brief on health issues in collaboration with public health students assigned to the LN."CS3

"…so, attending the LNfor me was an advantage because then I have other NGOs that I can engage with, you see, besides now attending anything external." CS4.

"I think that between me and the partner organizations there's a better understanding of the person … And I think also the value that gets added … there's an opportunity to work together." CS5

"…through the LN … partnering with Knowledge and Partnership Development … they are offering skills sharing … or they might be able to offer us IT support or something that will benefit the organization. The LN will provide benefits and opportunities for engagement with outside stakeholders … we've definitely had increased resources with more access, new networks outside of the LN." CS2

"*And one of the things that we're going to do is to bring the health teams with the health committees because that is what we think really would build each other, because it's*

my understanding that I bring to the health teams but if these people speak directly to each- other I think we will be able to achieve a whole lot more … yes, I see opportunities going forward … I think that the EQUINET regional conference in Kampala was a good experience in terms of learning specifically more about participatory research because that is something that we do quite extensively in the organization" CS3

"…I mean, it's an opportunity they wouldn't have had if they were not part of the LN. And then also the exposure to other countries in Africa … so. It is the sharing of information both locally and internationally. So, I think it is a nice touch." CS4

Tables 6.2.; 6.3; and 6.4 in Chapter 6 (DA) corroborates the findings of the SSIs and FGDs.

"Co-learning is possible when we have built trusting relationships between organizations (only then are organizations willing to share resources." (DA)

All members were involved in co-learning and co-research activities that not only built agency but strengthened the relationships between the CSO and academic members as they had to work together.

The academic members were involved in the LN activities and served to provide knowledge, mentorship and training required by the CSOs. Some of the academics were directly involved in the CSOs health programmes and close-knit ties were developed as a result of the shared research and activities, for example, the photo-voice project.

The following co-activities and co-research between the academic members and CSOswere extracted from the DA:

- General information on what is meant by the right to health and how to hold government accountable
- Development of a toolkit on the right to health
- Development of pamphlets on the right to health
- Disability and the right to health rights advocacy
- Community participation as key to the right to health

The participants of the FGDs reported that their representative on the LN linked them with members of other health structures and CSO members on the LN. The

participants verbalized that through their training and capacity building programs around health and human rights, they not only bonded with each other but were able to form bridging relationships with other community committees in either providing training or receiving training from other community stakeholders.

> *"It can help building and increasing people's activism … We attended seminars, health colloquiums, trainings and building activism on the right to health … Yes, we have built a relationship with the academic institutions with .regard to participation in the community project, also with the health structures." CS6 (DA)*

> *"I think that with (academic member), initiated a relationship … for me to use the students associated with the LN was utilized for doing a situation analysis ... And as a result, I get students to do practicals." CS4(DA)*

> *"…the engagements will be about attending the event or participation in an event, or about information … we are having this event, would you be able to speak on it? … So, meaning now I've been added as part of their pool of resources," CS2*

> *"It was difficult because I think that people do things when they see a value in it for their organizations … otherwise it always sort of felt like we as the research officers were forcing something that might not actually be natural … I didn't know them outside of workshops … so it was formal." CS3*

> *"We had a young lady joining the structure not so long ago … Painfully shy, wouldn't talk to nobody … and she came to me and she, 'Aunty Martha' … and she is talking to me and I am saying 'what happened to the shy girl?' … She says, no, I am not shy any longer." FG2*

> *"I think seeing the people here, and I mean the welcoming into here and in other committees … it's just to see that how not everybody yet, but how some of them just blossomed." FG3*

> *"As a group we're working lovely together because if I don't understand something, I can phone … we are like family so we work hand in hand … By working together, it gives you strength." FG2*

> *"It showed great potential for communities to collaborate on issues of people's right to health. I found the partnerships to be great with the other members- sixteen days of activism- women's day and also the training in disability … I am proud that we can work together as a LN and impact on the communities." (CS6)*

7.1.2 Trust, Respect and Reciprocity

Trust between members of a network is viewed as being the 'oils and wheels' of social and economic exchange that enables members to draw on favours, circulate privileged information and gain better access to benefits and opportunities (Portes, 1998). However, trust can only be built when members in a group or community respect each other and share similar values to advance the right to health and human rights; it must be mutual, earned by both sides, hence the multidimensionality of social capital.

The challenges and milestones of the LN.

Tables 7.2 and 7.3 in the later section were sourced from the DA. The data refers to trust, value, inclusion, agency, power and decision making. These tables will be referenced in each of the following sections as it corroborates with the findings of the SSIs and FGDs:

> *"… there is trust … you can say there is a vibe and also just feeling comfortable with them in the group … I think that it is informative and also people are friendly, you know … and people listen." CS4*

> *"I'd think that there's a trust relationship amongst us … openness plays a very important role. If you are not open to certain things then it raises a concern that what is it you actually hiding? And you then ask the question of if you are not open, how can we trust you?" CS5*

Respect for each other was built over time and members felt valued because of the expertise and knowledge that they brought to the LN. Information shared within the LN was found to be beneficial for each of the members. Members further received acknowledgement for their programs, which is a key element for the development of trust, which in in turn, creates the formation of a shared identity. CS3 reported that she encouraged the shift of community practice from an individualist approach to that of a collective approach for mutual gain. The member was successful in changing the mindset from 'my' to 'us'.

> *"It is not my process. It is our process, it is not my project, it is ours; it is not my project, it is ours; it's not my decision, we must decide". I think that has been something that I've been pushing quite hard in the LN … I am always willing to share." CS3*

Respect is an important dimension for the growth of a shared identity and social cohesion. Trust amongst the members ensures the growth and sustainability of the LN. Trust is the "glue" that holds networks together.

> *"I think that respect is an important thing … is one of the things I like within the LN … is that there is respect for other organizations and for the work we do … Initially there is apprehension and then when you get to know each other, you look at the value of shared collaborations … and this is a slow process because trust is a major factor in any network. I would understand that it would be built over time." CS2*

> *"I think just anecdotally from what I've heard there is respect for myself and the way I do things, and there is also respect for the work being done by the organization and it is respect I think based on the level of equality … So I think that I do bring some value to the Network and I have a whole lot of experience that I'm willing to share … this is how we do it." CS3*

> *"It's a space where you know that if you need something, let's take for example- If I need something which is … field of expertise, I could then contact the organization and say – this is what we are planning to do, how can you assist and support … the members of the LN share information ... so that means that that there is a relationship and it's a relationship of sharing information." CS4*

The responses of the academic members to the questions about trust were different to that of the CSOs. The academic members perceived a lack of trust between themselves and the CSO members.

> *"In this kind of network, you need to build relationships, and I think that we have been less good at doing that because we're not out there all the time … that remains a stumbling block for us … I just think that in terms of building trust, I think that if we were out there engaged more regularly and more visible, it would be easier to build trust … I feel like I'm a – I try not to be a research tourist and I think I'm very conscious that there is a danger that I do that … I feel like I parachute in, cause a lot of chaos and then leave … I think that in terms of building trust, I think that if we were out there more engaged more regularly and more visible, it would be much easier to build trust." A1*

> *"It always felt sort of felt like we were the research officers, we are forcing something that might not be natural for the CSOs." A2*

> *"I think definitely (distrust). And I think that it's understandable that people would question what's in it for them … Research goals did not drive dialogue with communities." A3*

The CSOs however ascribed the lack of trust as being part of the 'academic divide' between the academics and the CSO members.

"And then for me, the objective (of the LN) does bring in members of civil society groups and health care providers together to discuss and explore models for realizing rights to generate opportunities … building trust between service providers, community members and building trust in health services … to our organization." CS1

"I think that respect is an important thing … is one of the things I like within the LN … is that there is respect for other organizations and for the work we do … Initially there is apprehension and then when you get to know each other, you look at the value of shared collaborations … and this is a slow process because trust is a major factor in

7.1.3 Value

The theme of value emerged when the respondents were asked about the importance of the LN for their organization. This theme differs from the theme of 'shared values' as emerged in the first set of interviews.

Members CS1 and CS2 reflected on the value and sustainability of the LN. They strongly emphasized reciprocity in adding value, that is, each member ensuring that they add value to the LN, and not only the LN adding value to them and their organization. The members believed that each LN member should continue to share knowledge and information and to integrate the knowledge into their practice. The members should also work more collectively with each other, build agency amongst each other and not wait for the LN to do so.

"This shared values has benefitted the organization to a point where we have a good understanding of the practices … Two years ago, I would have told you a different story; I would have told you that I don't know why I'm going to the LN; I don't see the value of the LN. But quite frankly, now if you are part of network to build capacity to implement health programs … that is what the LN has done to our organization." CS1

"And I would like to say, I think we should also realize that it is us that makes the Network and if the network is failing, all of us are failing in some way because all of us are accountable and we blame the Network it is then as if we are blaming something else." CS1

"I believe that the Network has value, but I also think that it has to be relevant. But then again, also reflecting on that each of us makes up the Network so we have a role to play in ensuring the life of the network." CS3

7.1.4 Inclusion and Voice

Inclusion as a concept of social capital focuses on the strength and close-knit ties amongst members in a community or networks. It further develops a sense of collective consciousness amongst members of a network. The CSO members of some LN members referred to their insecurity regarding their lack of knowledge and skills about health and human rights and therefore felt excluded from the process. As quoted below, members over time and via self-examination became more empowered to raise their voice and to be heard and acknowledged.

> *"Maybe we are just sitting there and we are thinking that I'd like to start (a project) how do I go about it? Am I going to sound silly or be seen as silly if I'm sitting here and I'm going to ask all these educated people or actually admit that I don't know? But personally, I believe that if you can admit that you don't know, you have a voice." CS1*

> *"When the LN started listening to us; we actually had to say that the language that is being used there, and whatever is done should actually be something that speaks to us … I remember sitting around the table and had no idea what these people were talking about … And when they started shifting and shaping, and I promise you … what a difference in terms of language, in terms of interaction, in terms of no silent voices around the table." CS2*

> *"I think being able to say that you do not understand, can you please explain it to me in simple terms … the language that they use and the ways things are presented … Even the materials that they send out now is not so academic anymore … I can send community members (to the meetings) and they are doing quite fine there. And that for me is a network … they feel that they own the space, because they are comfortable in that space, because they are given a voice … and their voices are heard." CS3*

CS3 reported that she observed that certain voices were not heard in the LN and reiterated the importance of developing women's voices for inclusion in the LN and to grow their self-esteem. In order to ensure that the women's voices were heard in the LN meetings, the member encouraged the women to attend reflective meetings and to be confident about their practice. The member utilized the LN reflective meetings to mobilize for the acceptance of women's' voices despite the differences in language and rural experiences.

> *"…the woman lives on a farm, she speaks from her heart when she speaks, and she speaks from her own reality … the women speak for themselves with their own voices*

and I think also with the women to come to the Review and Reflection, and I would be bringing the health team and they will come share their experiences. And I think that it did a lot for the self-esteem of those women because very often what they do is, they do not value it themselves … it means that an acknowledgement of what they had done, it's their own intervention … Let's not make them guinea pigs, let's make them part of the process." CS3

The CSO members of the LN emphasized the importance of being heard and also being heard in a language with which the community is familiar.Challenges in the use of academic language and 'mother tongue' language isolated the members, and it was only after the member discussed this concern that the academic members of the LN gained an understanding that the language should be at a level that the community members could understand and apply to their practice. As a result, the members felt included and valued.

"I think that whenever there's a separate event that not inclusive, I think that does bring about elements of misgivings or mistrust- what is happening in that particular meeting that we can't be privy to? And that reinforces people's feelings that it's just a research-based project … I think that might bring up feelings of mistrust and power sharing issues." CS2

CS1 concurred with CS3 and expressed her frustration about the challenges in the LN, particularly around members' voices still not being heard in the LN. People from the communities could not engage because their voices were not heard when they raised issues that were of concern to them in the communities. The 2 new representatives that joined the LN later felt most strongly about this.

"…but putting people into a space where thy cannot engage with the topic, I think is really detrimental to the person and the process … it undermines participants … if you are speaking about voice, you can only voice when you have the knowledge … And I find that is a weakness in the LN". CS1

In addition, there were tensions relating to non-participation in projects. According to a CSO member, t the concern was as a result of the decision that the academic members made to employ an external actor and to exclude CSO members in the projects. The member elaborated on the process of exclusion of the CSO members and attributed it to the perceived notion that the LN CSO members lacked the

academic qualifications. The member also highlighted the lack of transparency in the selection of the trainers who were to participate in the projects.

> *"I wasn't aware of the trainers; I can't recall that it was advertised. I can recall for the coordinator … I don't have a university degree, so where does that put me with my experience, because we do look at lifelong learning, would be the other question … I had a discussion with another LN member and the member commented that her people will not be able to apply for the position (because of a lack of qualifications)."CS1*

CS4 stated that initially she could not participate in the discussions that took place in the LN. She attended LN meetings and it was only when she acquired knowledge of the aim, objectives and activities of the LN, that she started engaging in discussions.

> *"I use to be quiet because I could not engage, I didn't have the knowledge and the capacity to engage. But now I can challenge, and I can engage because my capacity has been built." CS4*

The member was a replacement representative and was not part of the inception of the LN. It therefore took her a while to understand how the governance structure worked. The member reported that because she was new to the Exco, she was silent during the meetings because she was not part of previous decision-making processes and program planning. The member however reported that as she gained confidence, she began contributing freely.

> *"My voice was silent during the Exco meetings but when I gained an understanding of how the LN works, I felt confident to contribute towards decision making and participation in the LN Review and Reflection meetings". (CS4)*

7.1.5 Agency and Empowerment

The objective of the LN is to impart knowledge and skills about human rights in order for members to cascade information to communities. The CSO members of the LN participated in community activities through community engagement. The development of pamphlets and training tools within the LN further empowered the members to cascade the information and knowledge to community members through their programs. Some members implemented the Train-the-Trainer program to ensure that their community beneficiaries become engaged in community development programs.

The development of agency further included the development of research and writing skills that enabled the members to document their best practices in the realization of the right to health. The LN PAR methodology and the Review and Reflect activities provided the members with opportunities to document and share their programs. The practice of *"learning by doing and doing by learning"* enabled CSOs to translate their knowledge into practice. Examples on how members promoted access to learning opportunities for member organizations and the use of learning to support advocacy included the presentation of the auto-photography project to LN members; a presentation of epilepsy with medical practitioners and a seminar at an academic institution on disability sensitization; the development of a policy brief in collaboration with health students; a workshop on adult education for members of the LN; using knowledge to monitor rights violations and complaints and using the NGO week to set up a dialogue on the right to health and to lobby the government's Portfolio Committees and Standing Committees on health. Two Uganda exchange visit by members of the LN occurred with the aim to assess health programs in the country and to train health workers on the right to health. An exhibition on the Photo-voice project further took place and one member's organization developed a disability toolkit on the right to health. The organization utilized the toolkit to train various sectors and traditional healers in the right to health for persons with disabilities.

Table 7.3 in a later section presents the milestones achieved in the LN. The information was sourced from the DA. As previously indicated, it is referenced here for corroboration of the findings of the SSIs and FGDs:

> *"Our involvement in the LN (through participation in meetings, discussions, access to info) has enhanced individual and organisational capacity and knowledge on health rights." DA*

> *"Participation in the Learning Network has increased individual and organisational knowledge and capacity on health rights".DA*

The CSOs were positive about the activities and research in which they participated as it enabled them to share the information within their community.

> *"We were really involved and that was good … and then came the toolkit and the workshops around it. And that then started getting you thinking of the different things that could be done to make people more aware, but also to have*

them participate and understand … and from there on with the research with the photos …" CS1

"The nice thing about the LN is that we want to see outputs … generating information for the pamphlets, developing toolkits, together with the member organizations …" CS2

As a result of the training on health and human rights, the members shared information with the communities through the distribution of pamphlets and health talks. Other members became involved in research projects such as the photo-voice project and gained a new 'lens' on their understanding of health rights. The photo-voice project aimed to assess LN members understanding of the right to health and to identify their perception of health rights violations. This was done through taking photographs in communities of what they perceived to be a violation. This experience provided the members with an opportunity to talk about and share their experiences and through their participation, members gained a broader understanding of the social determinants of health and that these determinants should be addressed holistically.

The members further commented on the LN methodology of Review and Reflect and how shared learning among the members had developed through this process. The Review and Reflect process further empowered members to learn best practice and to integrate and implement it into their practice.

"Being involved in research … Review and Reflect meetings which is always a positive experience … and to cascade the information to our beneficiaries … and for community engagements." CS2

"And we also take women along (to the meetings) … I always look for benefits and opportunities for farm women to come to meetings or for farm women to engage in meetings, so that again it is up-skilling those women, and our goal is to see farm women taking positions, taking leadership positions, but we have to coach the women into those positions." CS3

"Like my people, we've trained different community health workers with the information … because people are now more assertive, I think in terms of voicing their rights when they go to a health facility … they can use the information to make communities a better place to be in." CS4

The members of the FGDs spoke passionately about the benefits and opportunities they received from the LN in terms of research activities and training in health and human rights. The members reported that the training enabled them to engage more meaningfully within the community. They further observed that to bring about change,

commitment to social development is required. As argued by Lieber and Ferri (2004), members must be confident enough to not only share with others but must be committed to the goals of the network. Strong commitment is developed when members of the network match the network's priorities to that of their own and they see the network adding value to their work.

> *"…You know, you work in the community, not just with health… Because when you with the health, you tackle everything, health, welfare, social and everything." FG1*

> *"And it helps a lot (the training) because people are suffering, and they don't know even if they are sick … So, we just come to them and make them feel free and we talk to them nicely and we train them. We do activities, exercises, we do our programs … So, these trainings help us a lot." FG2*

> *"We have a very good policy on human rights in health. But the public don't always understand it … we did a survey, we went to house and what we found out was that the poorer the person, the less they knew about rights." FG3*

7.1.6 Community Participation and Engagement

The responses below from the participants of FGD3 attest to the fact that if knowledge is not shared, the vulnerable and poor struggle to realize their health rights.

> *"I also think that the less resources you have, the less caring you will receive at the end of the day because you are subjected to your poor position and therefore you are not interested … especially with regards to information at the clinic … So, for the wealthier, one is much more fortunate … and they can go and read that information at the clinic."*

> *"A good leader to me is the leader who is really caring and committed to serve the community, it does not help if you are a leader with all the knowledge and skills but you are not committed- so you will take disadvantage the community".*

Regarding community engagement, the following comments support the notion that CSOs play a critical role in the realization of the right to health.

> *"I think that we have a little bit of engagement because sometimes the Department of Health invites some of the members of this group to their Annual Performance Plans or to their annual budget or projected plan." FG1*

> *"We are fortunate to have all the role players such as the Department of Health present in the very same meeting, so we can pose our concerns and our questions, our challenges direct to them." FG3*

"There is a connectivity to me and the LN and academic members because the two institutions play a very meaningful role, a vital role in our community so to make sure that our community gets educated and our community gets the necessary skills." CS4

"In my club, I am networking with a clinic sister – she helped me a lot with the health of the seniors." FG2

"The Bill of the Health Committees that was proposed, we contributed towards the workshop from the LN and even when the Act was passed, we know so, the skills that we got sharpening our minds … he gets passion, he wants to assist and that mentality that you get in the health committee to help the community." FG3

Arnstein (1969) identifies different levels of participation and presents them in a 'ladder of citizen participation'. The level of participation in the community is also dependent on levels of power that the individuals within a group or community have, which in turn is based on the position that the individual has in that group and community.

The data from the SSIs and FGDs show that with the development of agency, the LN members became more actively involved in health rights programs in communities. Prior to the members joining the LN, the CSOs shared that they had community-based programs; however, the agency that was developed relates to the training and sharing of health and human rights knowledge from within the LN. Partnerships, which is rated high on the Arnstein's Ladder of Participation, were formed amongst LN member organizations through the development of bonding and relationships. The CSO members further formed bridging relationships with resources within and outside of the LN thus empowering the CSOs with knowledge and resources to implement their health and human rights programmes.

In general, Eriksson (2011) states that the goals of community engagement are to build trust, enlist new resources and allies, create better communication, and improve overall health outcomes as successful projects evolve into lasting collaborations.

7.1.7 Power and Decision-making

Power and inequality have effects on the development of social capital. Inequality arises when those with more resources to invest, are more easily invited into powerful networks. This links with the literature on power where the various dimensions and levels of power should be explored amongst its members to develop trust, reciprocity

and cohesion in the group or network. One of the academics reflected on the process of decision-making in the LN and explained that the exclusionary approach on the side of the academics had entrenched the sense of distrust amongst the CSOs and as a result thereof, the relationships with the academics were estranged. It was only after the Executive of the LN was formed where CSOs became part of decision making and that the CSOs were willing to engage with the academics.

> *"Before the Exco [was formed], decisions were made by the research team because there wasn't a shared process to make decisions, and for that reason there wasn't ownership of the network because things happened and CSOs weren't involved … but now they are part of the Exco … it also impacted on the type of exchanges that took place." A3*

CSO members perceived the academics as having power by virtue of their knowledge and practice as well as academic status. They commented on power not being shared and that decision making was unilateral.

> *"Initially I don't think people understood what was going on. I think there was definitely a sense of academics versus the community-based organizations and there wasn't this shared power... " CS1*

> *"At the beginning I think everyone's a little grumpy but I think that's with anything and with change, with a new idea, people need to get accustomed to it." CS2*

> *"Well from the top down, I serve on the Exco so I have a fairly good sense of the activities and the funding." CS3*

> *"I think that you know people take it for granted that they can do things and questions will not be asked." CS4*

During the second round of interviews, CS1 and CS5 continued to experience challenges regarding power and decision making within the LN. The member ascribed the lack of problem solving to the power imbalance between the academic member and herself.

CS5 reflected on her experiences as being a member of the Exco and how decisions were taken. The member stated that this decision was not taken at the Exco and that it impacted on the other members of the LN, as they felt excluded from the program.

The member further reflected on the bias of the academic members towards certain health committees. Some of the committees were included and the member was

concerned that the participating committees were exploited because the funding was research-focused and that the outcome was to publish an academic paper on the roles and responsibilities of the health committees.

The member further saw power as playing a detrimental role in the development of the Exco and the LN. The member stated that for the first three years as a member of the Exco, she did not have the capacity or power to challenge decisions taken at the meetings. The member reported that she felt "powerless", and that the academic members held all the power.

> *"Do we play a particular role in the LN… there is a sort of separation in between the member organization and the LN… There is a sort a miss". CS5*

The findings of the SSIs with CS1 and CS5 show that they experienced a strong sense of dissatisfaction about power imbalances and decision-making between the CSO members and academic members. These two members have prior experience in community development programs and worked with various academic institutions. They further had experience in working with other networks and as such, were empowered through their knowledge and experience to challenge the academic members at various meetings particularly the Reflect and Review Planning Meetings.

7.1.8. Nationality and Language

The concepts of nationality, a lack of understanding of the African experience and indigenous language were further reported to be a barrier in the establishment of trust between the CSOs and the academic members.

> *"The fact that I am not South African I was sort of the – well, I guess (a foreigner) and people start assuming that you are quite transient- so what is the point of getting to know somebody that they are just going to leave anyway … the reason for trusting me was sort of grew over time …" A1*

> *"It took a long time to actually get acceptance to do the research … maybe it is my background (a foreigner) … a member was skeptical and critical of my role … and it was a barrier. So, nobody said anything to me but I think obviously we need to be conscious of what we potentially present to other people … I had many meetings before they allowed me to do the research … I suppose in that process some level of trust was gained." A1*

"So, I think I took a lot of time in that initial space – talk and just talking to people … I think that another issue that I experienced during my research was particularly in isiXhosa speaking community, I had to use an interpreter … I had to use a translator … I think that the translator creates maybe a sense of familiarity … I think that its important because people should be allowed to express themselves in a language that they were comfortable with". A1

"I mean, who is this person with a funny accent and coming from this university … a member of a health structure thought that I was from the department of health and was skeptical and critical." A4

Not all the members could understand foreign and local languages and consequently, had to use interpreters to interface with the researcher and the members of CSOs and their beneficiaries.

Members of a FGD confirmed that language plays a critical role in the understanding of the training because it is more effective when the training is done in the members' mother language.

"The people who teach us is the people who speak our language, so sometimes maybe it's difficult from English, so we turn to our language so that's why maybe we took some things more-easy." FG2

7.2 IMPLEMENTATION AND INTEGRATION OF HEALTH AND HUMAN RIGHTS KNOWLEDGE

The LN members verbalized that they were provided with new knowledge about health and human rights and that they valued the knowledge-sharing that they received not only from the academics, but also from other CSO members. They further reported that the new knowledge and skills enabled them to cascade the knowledge to their beneficiaries and communities.

"Like we used to talk about health as a human right, but now we have the pamphlets … that makes it possible for us to say, here's your take-away health and human rights tool … so I asked if she wants to come and do a workshop on the right to health … Thanks, but I can do it, I have my pamphlets, I can facilitate my own workshop'. So, for me it is there's also now independence and I think that it is as a direct result of the LN and the materials." CS4

The new knowledge further enabled members to implement their health and human rights programs. This is in keeping with the definition of networks offered by Lieber and Ferri (2004) in that networks should possess generative capacities such as the

ability to work across traditional boundaries, learn new ways, develop a systems-view, create the future, balance autonomy with interdependence, manage co-operation and competition and align organizational form with purpose.

The development of agency, capacity building and advocacy are key aspects of a human rights-based approach. According to London and Schneider (2012), a human rights-based approach focuses on the recognition of the inherent dignity a human being. In order to realize health and human rights programs in communities, community members should have the knowledge and a voice to advocate for the promotion and protection of rights. The Monitoring of health and human rights was further found to be imperative to ensure that the services are sustained.

The findings that support the assertion that new knowledge enabled the participants to integrate and implement health and human rights programs in their communities is presented in Table 7.1.

Table 7.1: Implementation and Integration of Health and Human Rights

Programmes	Quotations
Awareness about health and human rights	*"We were thinking about how are we actually going to kick-start a program in our communities and the relevance of those programmes as it relates to things that would improve what is happening in communities. And a decision was made - use Women's Day as a platform to kick start things around health and socio-economic rights and to raise awareness about Reclaiming your Rights." CS1*
Building Agency	*"And the way forward from here; we will be running programmes within our circles inviting other members and our themes would be (around health matters) ... we offer nutrition plans and we are busy developing a little recipe booklet, healthy but cheap recipes" … we are running programmes outside our circles because we can build their capacity." CS1*
Promotion of Disability Rights	*"… we are ready to start running our programmes in communities…ja (yes) definitely … we are obviously in the infancy in terms of incorporating what we're starting to develop in terms of disability and human rights, but the commitment is there with the team members and we can see that through how we've already started incorporating it into our language, into our*

	everyday programmes- so we have a disability sensitization program which incorporates disability rights into it … so there is a consciousness."CS2
Advocacy for Health and Human Rights	*"There has been some paradigm shift specifically around human rights … it is something we can own … we are not health providers; we are human rights-based organizations where we advocate for health and human rights." CS3*
Agency and the Promotion of Health and Human Rights	*"We take action in meetings, we take positions in meetings, and if you take a decision you must be able to walk your position to wherever it needs to go. I could work with the documents with the women- you make them understand the social determinants of health … it is your right to water and sanitation and environment and nutrition … we used to talk about human rights, but now we're using the tools, pamphlets." CS5*
Capacity Building	*"Health and nutrition is a new position here … so they want health and nutrition to evolve in the organization … but it is from attending meetings and I see they focusing on health and human rights. They want to impart skills to communities in terms of how they must be assertive in terms of first of all knowing what their rights are, and also complaining if they do have violations … it was an opportunity so the club members got training… they wouldn't have it if they were not part of the LN."CS4*
Advocacy and Agency to deal with violations.	***"…**when they (community members) go to the day hospitals, family planning, they are forced to take an HIV test. And then one of them had a STI and she was told she's not going to be treated until she tests for HIV or bring her partner…these violations were reported to (LN)… we were trained to deal with the violations. So now they were saying … every month we should have a feedback meeting."CS5*
Monitoring Health Services and reporting health violations	*"So, we have agreed that we would pilot the complaints and compliments process in one facility and look at how we can take it forward. And then also the whole maternal health issue- that is where we also would like to focus on the complaints that there's been women giving birth in ambulances or on the streets or wherever- and that is a violation of a women's right. So, the next phase would be is to take it to the Health structure." A1*

7.3 DOMINANT KNOWLEDGE AND ALTERNATIVE PATHWAYS OF KNOWLEDGE ACQUISITION

The following section presents the findings on whether alternative pathways of knowledge, skills and values acquisition contributed to the integration and implementation of health and human rights.

Three CSO members reported during the SSIs that they were involved in human rights structures before becoming members of the LN. These structures included the People's Health Movement (PHM), the South African Non-Governmental Organizations Coalition (SANGOCO), Cape Metro Health Forum, Academic institutions and Disability Networks. One organization is a feminist organization and their focus is promoting and protecting the human rights of women, particularly women in rural areas.

Despite the prior knowledge of human rights, all the CSO members however stated that they acquired their primary knowledge of health rights through their participation in the LN.

> *"In terms of a human rights-based approach, my understanding of a human rights-based approach has increased or improved through seminars and discussions. I have a better understanding of the approach and also different perspectives on it- for instance Ubuntu." CS1*

> *"Working with disability, it's a lot more complex … and you really need to take the information we are getting in terms of disability rights and look at how we're going to impart that into our beneficiaries and make them realize that their disability rights and their health rights are intertwined." CS2*

> *"For me, I have government background and I am familiar with government institutions, so when it comes to NGO's I am totally lost … so attending the LN was an advantage because then I have other NGO's that I can engage with and also learn about health and human rights." CS4*

> *"The health structure has a very long in existence, but I think we struggled with our own objectives … and here you become a part of a network that some of the objectives are similar to yours … and I think that we took what was relevant to us, like community participation, the health professionals … As the strategic planning unfolded, there was a clear fit for us, in fact that human rights are addressed as well as service delivery issues." CS5*

The responses from the FGDs to the theme of dominant knowledge and alternate pathways of knowledge acquisition echoed the data emerging from the SSIs: participants had dominant knowledge of community development, however, they acquired new knowledge of health and human rights through the training that the LN provided. The FGD members belong to structures and CSOs in the community. As communities of practice each FGD found it easier to engage in collective learning in a common domain. Wenger-Trayner (2015), argue that collective learning is more effective in communities of practice as they have common objectives. Cox (2005) explains that collective learning takes place in a group that coheres through sustained mutual engagement.

> *"This nutrition training also helped me a lot because before I could start this training, I thought maybe it has something to do with food and stuff, but I didn't think that I will learn about rights … so now we are attending this training for nine weeks. We're learning about human rights, as my colleagues just said that we didn't know that in nutrition you could learn about rights as well. So, it was very good. It helps us a lot because now we understand." FG*

In addition to the training on health and human rights, new knowledge provided members with an understanding of the social determinants of health. FG1 particularly shared their understanding of how poverty can impact various aspects of peoples' health. Poor self-esteem, unemployment, drug abuse and the impact thereof on the family, lack of access to the health facility and lack of access to information.

> *"Because we did a survey, we went to houses and what we found out was that the poorer the person the less they understood rights. And the more affluent people, they understood." FG1*

The members explained that poorer community members were pre-occupied with so many social challenges. These challenges include poverty because they do not have money to travel to the health facility and consequently, they do not have access to information on health rights. The members referred to the LN health and human rights pamphlets and the Patients Charter that is found at health facilities.

> "…*It is about bread and butter on the table." FG1*

> *"And I also think the less resources you have, the less caring you will have … because you are subjected to your poor position and therefore you are not interested especially with regards to information at clinics, like posters and stuff like that." FG1*

The group explained the juxtaposition of the poorer communities who do not know their rights and have limited access to health care versus the more affluent who can attend the health facility and read about health rights. The group further referred to the impact of poverty and the lack of access to information about their rights. Without being informed of your rights, the communities often do not have the ability to express themselves. Poor self-esteem has developed because they are too scared to ask questions about their health when they are at the health facility.

> *"I think that the self-worth is so low … they are scared to talk, too scared to actually say 'listen here, this is what is wrong with me'… because they are too scared because of the reaction of what they going to get…" FG1*

FG3 shared that the LN provided additional learning opportunities and this is reflected in the different co-learning opportunities emerging from the DA (Table 6.3). For example, they gained knowledge about the South African legislation particularly the Bill of Rights and how Parliament works and were further mentored on how submissions to Parliament should be done.

> *"The Learning Network created a space where health committees were mentored about the Bill … the LN has created an opportunity to be mentored in submissions to Parliament … he has never been to parliament before …" FG3*

> *"… At that time, I was working for an 'action group' as a leader… the LN would provide leadership training workshops for the leaders that are within the 'action group'. Monthly training on different topics was provided to equip the leaders … That's how he was given an opportunity to serve on the health committee. That training created a space for him to understand when to speak and for him to know how to run the facility working hand in hand with the facility manager." FG3*

The focus group aligned the acquisition of new knowledge with building confidence to engage other professionals.

> *"Remembering that they are not qualified but with training it was putting them to a level of understanding … created an opportunity … now we can interact with the manager and they can sit in a meeting with Dr's and advise the Dr's and pharmacist or any-one else in the facility that might need their contribution can come with confidence." FG3*

The above discussion is mirrored in the DA, in particular, the documents setting out (a) challenges and achievements of the LN; (b) LN Milestones and (c) a process of Outcome Mapping employed as part of Strategic Planning. They confirm the emerging sub-themes related to the development of Social Capital.

7.4 CHALLENGES AND ACHIEVEMENTS

The Review and Reflect meetings provided a platform for discussion and reflection on the nature of relationships between the members. At a Review and Reflect meeting dated 29 June 2010, the LN members reflected on the challenges, acheivements, milestones and lessons learnt for the period 2008 to 2010. Table 7.2 lists the challenges and achievements as experienced by the LN members. The information was sourced from DAs

Table 7.2: Challenges and Achievements

Challenges	Achievements
▪ Relationships are still nodal in the sense that they are primarily from UCT towards each CSO ▪ Relationships have not been "spontaneously" formed between the members; NGO's do not spontaneously (outside of network meetings) arrange such interventions. ▪ The idea of co-learning has been slow to take off	▪ This is changing slightly and we see more interest for exchanges across-LN CSOs. ▪ The relationship between organisations has improved and we are able to utilise each other's skills, information and knowledge in order to provide a more holistic service to our beneficiaries ▪ Organisational representatives seem to be building more trust and knowledge of each other's organisations ▪ Willingness to assist capacity building within each other's' organisations ▪ The relationships have however provided members with an opportunity to get to know about each other's programs. ▪ Starting to identify how members can be supportive of each other; learning about each other and from each other
▪ Sometimes not enough collaboration ▪ Lack of proper funding – no coordinator formally appointed	▪ There is a lot of potential for greater exchanges in the future. ▪ We share similar goals (advancing health rights)

▪ In 2009 there was quite a bit of sharing of best practice; there has been less of that in this year	
▪ Power issues still not easy – University can lapse into taking decisions for people ▪ Participation is not always even; some organisations are often not represented (sometimes because of the demands of core work); ▪ Ownership or control of the information remains in the hands of the academic institutions	▪ Power issue more easily discussed, challenged, addressed ▪ Mutual respect between individuals and between organisations
▪ Expectations have not been made clear for what is expected from member organizations. ▪ In effect, tasks that needed to be completed often take longer than they needed to and decisions about the functioning of the network have been delayed unnecessarily.	
▪ Attendance/ time keeping!	▪ Commitment to the LN is there
▪ South African NGO Coalition (SANGOCO)	▪ Potential to share learning's with these organisations.
▪ We as researchers have not always been able to quickly capture and disseminate the learning from members to other members	▪ Able to respond to organisation's needs ▪ LN as a support structure; can draw on when in need of relevant information and assistance in projects and programs

7.4.1 Lack of communication

The challenges show that ongoing concerns were raised regarding the lack of communication, poor relationships, mistrust, a lack of collaboration, power imbalance, unequal participation and ownership of information and unclear expectations of the LN were recurring themes that emerged from the SSIs, FGDs and the DA.

7.4.2 Lack of clarity on the vision and missions

An additional challenge experienced by the CSO members is the initial lack of clarity of the vision, mission and objectives of the LN. This resulted in members questioning the value of participation in the LN. According to the theory on drivers of successful networks discussed previously, it is important for members to have a clear understanding of the purpose of a network in order for them to take a position on the 'fit' of their own organizational vision and mission.

> *"At the beginning, we could not see how this would actually benefit us. An understanding only came later. When you are a struggling community-based organization and you belong to the LN, I think we started out with an expectation." CS1*

> *"At first, I didn't understand … because I would just sit there and just trying to find out where I fit into this." CS2*

> *"Some objectives were not part of our scope … how can we just get objectives that are going to speak directly to what it is that we as an organization want to benefit from." CS3*

7.4.3 Sourcing of funding

The sourcing of funding for training activities was found to be problematic for one of the members CS1. The member reported that the training activities were not relevant for the needs of all the CSO members. The member challenged the exclusionary decision-making process when proposals for funding were formulated, as participants of the LN were not consulted. According to the member, training offered should be relevant to the activities of the communities and that it should build capacity for them to deal with the human rights violations. The member commented that training offered should not just be training because training is available.

> *"It should build the capacity of the people to deal with the actions or the task to maintain the task that they are busy with … I am going to say that the information on the topic presented means that if you speak about it you are informed on that topic. But it does not automatically build your capacity to do what you are supposed to do or to do what you want to do … our challenge is getting from here to there." CS1*

The member referred particularly to funding received for a particular program. The member questioned the allocation of the funding to an external provider and that members of the LN were not approached to co-ordinate the project. The member

also questioned the methodology that was to be utilized in training communities. The underlying concern was that the appointed facilitator designed the content of the training manual and that the LN members were not invited to participate in the development thereof. Further, the member was concerned that members of the communities were not consulted in determining their training needs and that the training was imposed upon them.

> *"If you don't know how the world works, when you look at what is happening in communities and the needs that there are … outsiders are not the answers to the problems … the people who live in the communities they know what is needed … How can you go and facilitate a manual when you don't even know what is inherent in that community"? CS1*

The member further spoke about conflict between members of the academic group. The conflict further entrenched her distrust for the academic members The member was the only CSO respondent that referred to the role of a specific academic member and the conflict that was caused when she perceived that the academic member as being a 'gate keeper' of information. The member felt that when they needed to address certain issues with the academic member, that those issues were not raised at the LN meetings and that her academic colleagues protected the academic member.

> *"So, there were players and there was a referee".*

CS5 reflected on the challenges particularly with the academic members and concurred with CS1 regarding the role of the academic members. The challenges were reported to be the absence of a shared identity, funding received for the LN activities, the power imbalance and the lack of transparency. The member verbalized the same response when she was initially interviewed about trust, conflict and transparency in the LN.

CS5 substantiated her statement by saying that all members of the LN work together and have a shared identity but that the academic institution worked in isolation outside of the LN. The academic institutions do not see themselves as being part of the LN and that causes confusion amongst members when they need to verbalize a concern particularly around the funding raised for the LN. The

member further elaborated on the lack of transparency because the proposal and budget for the LN community project was not shared with the LN members.

> *"This is where the challenge arises because for me if the LN is a conduit, why should we be referring to the academic institution … the academic member is the receiver of the funding; it does not go to the LN. The LN's funding is challenged through the academic institution; and I think that is where most of the challenges arise … because who do you go to, who do you speak to if you have a problem. Do you take it to the LN? Do you take it to the academic institution? What do you do? We never knew what the financial situation of the LN was. And for me, financial transparency of the LN was never one of the things that we spoke about within the LN." CS5*

The member further expressed that the power of financial control of the LN was vested in academic members and that decisions were taken outside of the LN Exco. The member then questioned the power of the Exco in decision-making.

> *So, where's the Exco in all of this? So, the questions that has always been coming up in the Exco and within the LN for as long as the LN exists is the question: where are decisions made- is it within the Exco or is it outside of the Exco and who makes those decisions.? CS5"*

Despite the challenges that the members experienced over time in the LN, the two members and their community participants remained committed to the LN. The reasons shared for the commitment is that they had been empowered through active participation in the following LN meetings: Review and Reflect, Strategic Planning and Planning.

The FGD participants were not directly involved in the LN Executive Committee and planning meetings. They reported on the benefits and not the challenges.

In order to address and resolve the challenges in networks, Scott and Hoffmeyer (2007) argue that networks must be re-assessed or even re-negotiated among members on an on-going basis. According to the authors, a network that demonstrates and communicates its value as a space of learning, innovation and advocacy are in a position to continually renovate and revitalizes itself.

A1 reflected that because the new members on the Exco lacked experience and agency, she feared that similar patterns of mistrust and power imbalance could emerge. The member however recommended that the outgoing members should be coaching and mentoring the new members.

> "At least (my new representative on the Exco), had an advantage because I could unpack that meeting with her. The other new members just went to the Exco meetings … and sitting there they actually feel anxiety when they walk into the next meeting … and the new people coming in where there is tension within the Exco that they would come back and rather bring the negative experience back than see the positive of them being part of that particular process." (A1)

The discussion on the achievements however show that the LN members remained committed to the improvement of the relationships amongst the members because of the value of shared skills, information and knowledge that enabled members to provide health and human rights programs to communities. As a result of the improved relationships, trust was developed and members were provided with an opportunity to get to know about each member's programs. Further, mutual respect and power issues were more easily discussed, challenged and addressed.

The members viewed the LN as a support structure that could be drawn upon when support and assistance was required to execute programs. It was also stated that bridging relationships with external structures and organizations was made possible through the linkages that each member brought to the LN. Through sharing knowledge with external stakeholders, an opportunity exists for the LN members to develop bridging and linking relationships that is key in developing partners for collaborative action. The LN members also viewed the LN model as a best practice model for CSOs to form clusters/networks with the view to accelerating the implementation of Health and Human Rights programs in communities.

7.5 LEARNING NETWORK MILESTONES AND LESSONS LEARNT

The following section presents the milestones and lessons learnt but also documents the reflective thinking on why the milestone occurred and how members felt about the milestone. Table 7.3 lists the milestons and lessons learnt pertaining to the development of social capital in the LN and describes the lessons learnt solicited during the Review and Reflection meeting in relation to each of these milestones.

Table 7.3: Milestones and Lessons learnt of the Learning Network (DA 29 June 2010)

Milestone	Why did it occur?	How do you feel about it?	Lessons Learned?
Creation of the LN	Created a learning space Provides CSOs with access to information	Our involvement in the LN (through participation in meetings, discussions, access to info) has enhanced individual and organisational capacity and knowledge on health rights.	Participation in the Learning Network has increased individual and organisational knowledge and capacity on health rights.
Establish an executive committee	People with decision making powers needed to be present for LN to move forward. Some of the CSOs have a history of organisation and mobilisation.	Good and accountable governance is vested in the principle of inclusion and power sharing /joint decision making amongst member organisations. Not all members attend and participate; resulted in power kept with the same people rather than being shared equally. It was a good thing!	Some people have commitment issues; this inhibits progress. Happened earlier than expected; perhaps not all organisations were on board at the time. Now, I think everyone is on board. Participatory research is organic and a network of CSOs is dependent upon the will and leadership of member organisations. A network like ours can only progress if member organisations are committed to see it moving forward.

			Forming a network is complex and requires the building of trust.
Developing a shared strategic plan	The network developed an identity of its own and members felt a need for systematic planning	Good to set objectives and plan how to achieve them. Important to develop shared ideas and objectives	Our planning was overambitious; Funding is a major obstacle to operation and sustainability of a network. Timelines are important for network members to be able to monitor progress.
Building equality & participation in LN (e.g., CSO running sessions)	Consciously challenged within LN. Part of our reflection led us there.	Glad we are doing this. Sometimes it is hard to be criticised as a Higher Education Institution but is important and is part of our learning.	For how higher education institutions should engage with communities (e.g., service learning) It is constant process.
Information flow	Organisations requested it.	Good. Partners are informed on information, funding opportunities, seminars, workshops	Organisations and individuals have benefited from these shared opportunities.
Networking within the LN	A CSO offers to host an event. LN CSO requests assistance from another LN CSOs.	Positive; mapping methods can be utilised within our organisation quite effectively Great! First time a LN CSO took initiative to	Shared learning increases each organisations skills capacity. Co-learning is possible when we have built trusting relationships

	Individuals request the event/activity.	host a learning event where all of the other LN CSOs were invited. More are needed.	between organizations (only then are organizations willing to share resources) There is a lot of potential for learning across organisations.

7.5.1 Creation of the Learning Network: Development of Trust and Cohesion

The development of social capital is contingent on the formation of a group or network through which members develop relations for the purpose of knowledge sharing. The review of the DA shows that the LN created a space for shared learning and access to information. Despite the formation of an enabling environment within the LN, the CSO members initially experienced a sense of distrust because of unilateral decision-making and a perceived imbalance of power between the CSO and academic members. In order to deal with the development of trust amongst the members it was agreed by all members that a governance structure should be formed to promote transparency, inclusion and shared decision making amongst the CSO members and the academic partners.

7.5.2 The Establishment of an Executive Committee: Power and Transparency

The milestone on the development of an Executive Committee (Exco) in the LN in (2010) served to reduce unilateral decision-making and power imbalances. The structure served to ensure that CSO members were included in decision-making and that the power in decision-making was balanced between all the members of the Exco.

> *"Initially I don't think people understood what was going on. I think there was definitely a sense of academics versus the community-based organizations and there wasn't this shared power... " CS1*

> *"Well from the top down, I serve on the Exco so I have a fairly good sense of the activities and the funding." CS3*

The development of trust and social cohesion amongst members of the LN enabled the members to develop bonding and bridging relationships that not only created a comfortable space for members to learn new knowledge but also to build individual and organizational capacity on health rights.

Trust and transparency form the basis of bonding relationships between the members and promote a sense of shared identity, social cohesion, equality and ownership. In order to strengthen the internal relationships and social cohesion between the members, it was agreed that the LN should identify a shared vision, mission and objectives.

7.5.3 Developing a Shared Strategic Plan: Collaboration

CSO members further verbalized a need for LN members to get together on specific issues and to identify projects that could be worked on collaboratively. The members developed a strategic plan (DA) for the LN that identified projects that could be done collaboratively. These included the development of human rights materials, research and the need for the development of human rights training, advocacy and lobbying manuals for use in the communities. Cohesion and inclusion was demonstrated through activities that increased solidarity, strengthened social cohesion, improved communication and reciprocal behavior.

7.5.4 Building Equality, Participation, Information flow and Networking

By having a clear vision and mission statement and objectives, the LN members could monitor the attainment of the objectives at the Review and Reflection meetings and assess the progress of the LN itself. Network theories identify various indicators of successful networks such as having a clear mission statement and rules of engagement. The development of network cohesion is important to avoid fragmentation. The network should be able to respond to the needs of the members and build equality in a way that the network remains relevant and worthwhile and that a network will survive as long as members perceive that involvement is valuable.

With access to information and communication technology, communication is more immediate (Thomson 2005). Minutes of all meetings and activities were posted on the UCT Vula site and the LN site where members who were not present at the various

meetings and activities could keep themselves informed and connected to the LN. The LN members further reported a need to network among themselves to build cohesion and identity. One such suggestion was that CSOs should offer to host events and that other members should assist in the activities.

> *"The LN members planned a workshop on mapping of services and offered to host the event." CS2*

> *"Through working together, relationships are strengthened and mutual benefits could be gained. It showed great potential for communities to collaborate on issues of people's right to health. I found the partnerships to be great with the other members- sixteen days of activism- women's day and also the training in disability … I am proud that we can work together as a LN and impact on the communities." CS6*

Further examples extracted from the DA is that member reported that they started working with the health structures and they launched a Disability Forum with all the key stakeholders in the community. Partnerships were also formed with the other members in joint programs such as 'Sixteen Days of Activism to Oppose Violence against Women and Children' and 'Women's Day' activities. Training in disability rights was also done with member organizations.

7.6 DEVELOPING THEORETICAL AND PRACTICAL UNDERSTANDING OF PROMOTING EQUITY IN HEALTH USING A HEALTH AND HUMAN RIGHTS APPROACH

Developing theoretical and practical understanding of health equity using a human rights approach was required for the members to build knowledge and capacity for their human rights programs. Research enables the members to share organizational "triumphs" and to contribute towards the improvements of services in communities. Identifying relevant research topics further produces information from which all members could learn. Through the research process, LN members could learn more about each other's organization and about the health and human rights issues confronted by other members.

7.7 OUTCOMES MAPPING AND PROGRESS MARKERS

Outcomes mapping is used for planning and assessing projects. Through the process, progress markers are identified and reflect the change required for the members to

understand and fulfil their roles and responsibilities as implied in the vision statement of the LN. Progress markers further identify actions and interrelationships amongst members.

In order to ensure that the milestones were monitored and mapped, an Outcomes Mapping and Progress Markers exercise was undertaken.The progress markers utilized by the LN members during were those labelled as *(i) Expect to see; (ii) Like to see; and (iii) Hope to see.* During the mapping exercise the following categories were reflected on:

- Governance
- Co-operative relationships and capacity building
- Empowerment for the realization of the right to health
- Partnerships for the protection of human rights
- Reciprocal learning
- Collaborators work with the LN based on a shared vision about the right to health
- Policy creation and implementation

From the record of the outcome mapping, members reported both positive and negative experiences in the LN. Nevertheless, the LN members expressed their commitment to find solutions to ensure that the LN remains sustainable.

For example, despite previous review and reflections on the governance structure, the members reported that there remained a lack of transparency and an imbalance of power. A suggestion was made that,to balance the power dynamic. the chairperson should be rotated amongst the LN members at each meeting. Further, that the meetings should be hosted on a rotational basis at each of the members' organizations. The proposals to rotate chairing and venues aimed to shift the power imbalance and to promote accountability and ownership. It further served to develop agency for those members who required facilitation and reporting skills.

At a Strategic Planning Meeting held on 26 February 2010, the LN members posed an additional question regarding to '*where we are'.* An expectation of the members was to differentiate between operational and strategic plans, review the plans and fill the gaps where necessary. At a follow up Strategic Framework Development Review held on 10 February 2011, the LN members reviewed the structural framework of the LN Exco. At a Final Strategic Planning Meeting held on 18 April 2011, it was decided that the strategic plan should be converted into an operational plan for three years. This would enable the LN members to map the progress markers as identified at the outcomes mapping workshop. The members further identified factors such as LN members' capacity to design campaigns and the ability of the LN to support external stakeholders in strengthening their campaigns.

Table 7.4 presents the feedback about the strategic issues of the LN and how to resolve them (Final Strategic Planning Meeting held on 18 April 2011).

7.8 KEY STRATEGIC ISSUES AND RESOLUTIONS(18 April 2011)

Table 7.4: Key Strategic Issues and Resolutions for the achievement of the LN Goals and Objectives (2011). Sourced from DA

	Strategic Issues	Resolutions
Communication (one-way)	Apathy was identified as being a problem amongst members and that it resulted in reduced communication between the member organizations. It was found that at times, the CSOs lack the capacity to avail themselves to participate in LN activities and that if the CSOs' priorities do not "fit" with the LN, they see no value in participating.	A shift in focus from health to include the social determinants of health; and that the right to health should be explained in a manner that is clear to the CSOs. It was further resolved that a platform should be created where the concerns and priorities are tabled and that decisions should adopt the bottom- up approach.
Unequal relationships	A need exists for the Exco to be a transparent decision-making body,	It was resolved that the Exco representatives should give

(decision-making, partnerships)	with members who have clarity on their roles and responsibilities. A clear decision-making system needs to be put in place where decisions are taken with the participation of all members.	feedback to their member organizations and that decisions affecting individual member organizations should be discussed with the organization concerned, including other Exco members.
Funding (pragmatic shift away from health committees to the determinants of health and human rights)	Funding was sourced for research and training of the CHFs. It was resolved that there should be a shift of emphasis back to the determinants of health and human rights, while also including health committees; and that there should be a shift back to Participatory Action Research and other inclusive approaches.	It was resolved that joint workshops with member organizations be held to identify member's needs, to plan action research and future research as well as lobbying and advocacy in keeping with the Millennium Development Goals. Regarding future funding, the approach should be to identify funders who are flexible and who understand the activities of the LN as well as seeking more sustainable funding.
Participation (commitment and CSO responses)	The concern was that the members felt that the academic members took unilateral decisions and that there should be a shift in the balance of power and decision-making.	It was resolved that the Exco should make collective decisions. In order to shift the balance of power, members should be provided with opportunities to participate in seminars, conferences and opportunities to learn as well as travel. Members should also be given recognition for their inputs in the development of LN materials and there should be a mutual benefit for all members.

Structure (role and function of the LN/ Constitution/ Memorandum of Understanding - MoU)	The structure of the LN should be unpacked and that a review of its functioning and decision-making structures should take place. A need existed to clarify the role and function of the Exco and to design a Memorandum of Understanding (MoU) that details procedures for conflict resolution, attendance and participation, proxies in the event that the organization's representative cannot attend meetings, decision making, communication protocol, authorship and acknowledgements of members' participation in research activities and co-branding. In terms of the identity and membership of the LN, it was questioned whether the LN as a "closed network' should be responsive to requests from other organizations for membership.	While it is necessary to define the roles and function of the LN and the development of procedures for participation, it may result in the LN being restrictive and that members may leave due to the restrictions. The focus should be on building members agency and identity with the LN.
Capacity of LN members (writing, training, advocacy and lobbying)	To use the capacity of the members of the LN to assist others in the network and that shared learning should take place using the Review and Reflect methodology.	Members are respected for their expertise and that their skills should be cascaded to other member organizations within the LN.

Numerous strategic issues were identified. The use of academic language with CSO members which presented a barrier to communication, was a particular concern. Some of the CSO members had little or no tertiary qualifications and as such, they were silent participants. The recurring theme of unequal relations and power imbalance was raised again and it was resolved that the structural arrangement of the LN be reviewed. It was suggested by the LN members that they should be acknowledged, be given recognition for their inputs in the development of materials and research and for their expertise that could be cascaded to other members in the LN.

Members further reflected on the macro and micro dimension of social capital within the LN. Macro dimensions refer to the institutional context in which organizations operate. Institutional context refers to the roles, responsibilities, decision-making and communication protocols within the LN. The members however voiced their concerns about the over-regulation of the structure as it could result in members withdrawing from the LN. Absenteeism was seen as a symptom of the underlying matters in the LN and a need was verbalized to further explore the reasons for the absenteeism. It was suggested that members who were not attending should be contacted to ascertain the reasons. The members called for flexibility within the LN and to find ways of functioning that facilitates the participation of all network members.

The micro dimensions refer to the potential contribution that organizations and networks make to development as well as the values, norms and trust involved. In the absence of trust and trustworthiness, networks such as the LN may over time experience recurring strategic issues as members programmatic needs change over time. The LN structural arrangements needed to be flexible in order to adapt to change.

Commitment as a micro dimension of social capital was identifiable, despite the challenges reported in the previous sections of this chapter. The LN members committed themselves to continued participation and presented resolutions that should 'spot light' and focus on the needs of the individual organizations, for example, it was reported that the LN activities focused more on health structures and systems and that the focus should be expanded to focus on the social determinants of health. It was resolved that because members have individual needs, a space should be created for members to share their needs amongst each other. Research relevant to the various needs should be identified to inform plans for action research as well as other types of future research to enhance their community-based right to health programs.

Going forward and being mindful of the strategic issues, the members adopted a proactive approach through sharing success stories that their organizations had experienced. The Review and Reflect Minutes over the period 2015-2017 show that questions regarding knowledge generation and knowledge acquisition for the development and implementation of health and human rights programs were covered

during the meetings.The questions are summarized as follows: (1) how members informed their communities on their right to health; (2) whether members documented their best practice about their right to health programmes; (3) how to promote access to learning opportunities for member organizations, and (4) how to use the learnings to support advocacy programs. This is consistant with the data emerging from the SSIs and FGDs.

Table 7.5 presents the summary of success stories shared by the CSO members.

Table 7.5 Summary of Feedback on Success Stories.

CSO Feedback on Success Stories by the Particpants	
Communities informed about their right to health (use of LN materials)	*"Implementation of the auto-photography project in their communities."* *"A cleaning and recycling project was initiated as an outcome of training the community members on the right to health (R2H). Some of the items recycled were used in a children's drama. The drama was intended to inform/educate others in the community about a healthy environment."* *"One thousand pamphlets were distributed at a women's day event."* *"Used 237 pamphlets on community health centers at libraries, clinics, places where social workers re working on disability and human rights (HR) campaign."* *"Extended the right to health and disability rights training to the northern suburbs."* *"Utilization of posters for information sharing."* *"The CSO held a Women's Health fair and spoke about the right to health (R2H) with approximately 300 women at one venue."* *"Assisted with the piloting of the toolkit. The training was rolled out to members of the health and nutrition center."* *"A LN academic member conducted R2H training with families and service workers. Further training included the toolkit on the R2H,*

	distribution of pamphlets and a session on the Patient's Rights Charter." *"Did training on the pamphlets and distributed at a women's day programme."* *"Creating own materials profiling the health forum and the work that they do. Busy with a collage of activities for the past three years."*
Documenting best practices in realizing the right to health (organizational research skills).	*"Participated in the auto-photography project and a member was asked to document the photographs as a case study for the use in promoting the work of the CSO and in their campaigns for a healthy environment."* *"The CSO was approached to document best practice around the right to health."* *"The member planned on doing FGs with health committees about the understanding of health and disability rights."* *"The data of the FGs was analyzed and used to develop a paper for a conference."* *"The CSO is focusing its attention on incorporation of HR and disability more actively."* *"The CSO planned a workshop on mapping of services and of the discussion of Participatory Action Research (PAR) process."* *"Research on health committees as a vehicle for community participation and learning lessons on best practice for community participation."*
Promote access to learning opportunities for member organizations (share learning from training information)	*"Presentation of the auto-photography project at the Review and Reflect workshop."* *"Presented a seminar on epilepsy with medical practitioners. The LN members requested the CSO to present the seminar for health forum and committees."* *"Invited LN members to join the FGs on health and disability rights."*

	"Facilitated a seminar at an academic institution on disability sensitization." *"Hosting a workshop on mapping and PAR process for LN members."* *"Participated in the development of a policy brief on health issues in collaboration with public health students assigned to the LN."* *"Presented a workshop on adult education for members of the LN."* *"The CSO requested a workshop on mentoring and mapping process from another CSO."*
Use learnings to support advocacy	*"Attended a Regional Meeting in Uganda on sharing best practice on health and human rights programs within the organization."* *"Utilized the knowledge to train staff at a hospital about the Batho Pele principles (consultation with service users; service standards such as access to health; courtesy; Information on treatment and care; openness and transparency; the ability to redress violations and that the services should have value for money)."* *"The creation of a policy brief for advocacy on health issues faced by women."* *"Training of home-based carers, and to link the training of health care workers with another organization."* *"The representative attended an advocacy workshop and was asked to do the closing remarks. The representative believed that the CMHF were invited because of its work with the LN."* *"Using knowledge to monitor rights violations and complaints at the health committees for a period of time to assess patterns."* *"Using the NGO week to set up a dialogue on the R2H and to lobby the portfolio committees and standing committees on health".*

As a result of the recurring patterns of challenges during the research period and particularly between 2015-2017, the members verbalized a need to reconstruct the LN to adapt to change, to inspire the members to continue to be part of the LN and to

become more involved, to get a better or common understanding of the LN aims, objectives and purpose as well as to reflect on whether it works and to get to know other partners. The expectations further included the need to accommodate the needs of other organizations, integrate their programs into the LN and make it more relevant to all members.

The minutes of the Exco meetings held in 2015 and 2016 show that members continued to participate in meetings and LN activities. These discussions focused on CSO collaboration on the right to health programs, reflection on the LN goals and activities as well as planning of future projects.

7.9 ACTIVITIES AND FUTURE PROGRAMMES OF THE LEARNING NETWORK

The activities and future plans were documented at a feedback LN meeting held in March 2017. The purpose of the meeting was to review the activities per member organization and to present future projects that could be done in collaboration with other members. The members further identified which of the programs would be done collaboratively. The programs ranged from addressing the social determinants of health such as poverty; skills development and employment; promoting the acceptance and inclusion of persons with disabilities through disability sensitization training programs; protecting the rights of vulnerable groups such as farmworkers and marginalized women; availability of drugs for chronic diseases; training health workers to work with women for the prevention of alcoholism; and collaboration on inputs in the SA Liquor Bill.

Table 7.6 presents a summary list of activities and the aims of the activities. Members are anonymized as presented in Chapter 5.

Table 7.6: LN Members: Summary of Activities and Aim of Activities (DA 2015-2017)

Activities	Aim of Activities
	▪ The purpose of the project was to design a handbook of services rendered by CSOs

▪ Solutions handbook ▪ Piloting the poverty stoplight. ▪ Health Servicing: ▪ Sanitary towels project ▪ Addiction prevention	▪ To assess the poverty levels using poverty indicators and poverty dimensions ▪ To integrate health into different programs ▪ To pilot the washable sanitary towels ▪ The member requested assistance from LN members
▪ Partnership building ▪ Advocacy ▪ Learnerships ▪ Occupational Health ▪ Schools ▪ Community Strengthening:	▪ Build partnerships with relevant members and external stakeholders (for the realisation of the right to health) ▪ Collaboration regarding human rights calendar events and present joint programs ▪ The right to employment ▪ Collaboration with health science students to render services ▪ Training learners at schools about disability sensitisation and development of a tool kit for parents ▪ To build capacity through training and building networks
▪ Foundation for Human Rights ▪ National Health Insurance ▪ Right to enjoy the benefits of scientific progress	▪ The focus is on vulnerable groups and persons with disabilities, farmworkers and marginalised women ▪ An opportunity to research the NHI from a rights point of view. A position paper was handed to government ▪ ICESCR is poorly known and people do not know how to access treatment. The purpose of the program is to ensure the availability of drugs

▪ Network on Equity in Health in Southern Africa (Equinet) ▪ Access of people to sign language ▪ Chronic disease ▪ Alcohol prevention ▪ Students ▪ Occupational medicine ▪ Visitors ▪ Inputs in the Liquor Bill	▪ To strengthen health committees as vehicles for participation in the network ▪ To ensure that person with disabilities have access sign language interpreters when required ▪ Doing research around the sugar tax, impact of corporates (sugar producing) on health and research around patients who have failed treatments and what happens in the home environment ▪ Research of the risks of women who have children; training health workers to work with women; developed a tool for community based interventions; utilising the tool in training; developed a manual and a handbook ▪ Members of the LN are engaged in research studies; utilisation of external students in LN member projects ▪ The training of community health workers in disability (management). To facilitate a relationship with the health department to fund the project ▪ Visitors are hosted within the LN and included the development of projects ▪ Community forums were organised for inputs into the bill. The aim was to ensure that the voice of the community is heard in legislation ▪ To host policy workshops to ensure that the community voice is heard (in the promulgation of policies)
▪ Capacity building ▪ Approach to early childhood and	▪ Workshops are held monthly with members of the organisation to enable the members them to complete their goals ▪ The community is informed of activities and are encouraged to participate. Other stakeholders and local government are also informed of the activities. The availability of ECD Centres remains a challenge but the community did not prioritise it as such

development (ECD) and other activities ▪ Substance abuse ▪ Building partnerships ▪ Income generation projects ▪ Cultural identity ▪ Other Projects	▪ The challenge of addiction to substances was prioritised ▪ Partnerships are being formed with relevant community stakeholders to enhance the capacity to render community development services ▪ Organisation members have received training in the formation of co-operatives and registered 7 in various communities. Additional income generation programs are also embarked upon ▪ Programs were designed to inform community members about their cultural identities and visits were undertaken to expose the communities to cultural sites. Reflection took place after the visits and peoples' experiences were shared ▪ Community clean ups; workshops with the youth; soccer teams; hand puppets; candles and other crafts.
▪ Community Strengthening ▪ Reporting, accountability, good governance ▪ Networking	▪ Members participated in two communities ▪ Members send the minutes of the meeting to provincial and local government structures. A need exists to be visible, active and outspoken on health matters in order to lobby for the improvement of health To promote the development of platforms for communities to voice concerns and health challenges.
Source: LN Review and Reflection Meeting in 2017	

The table shows that after a period of 7 years, the members of the CSOs and academic members continued to show their interest in belonging to the LN, and that through their commitment, worked to realize the right to health in their communities.

7.10 SUMMARY

Chapters 6 and 7 have presented the findings of this study, drawing from all 3 sources of data - SSIs, FGDs and DA. Broadly speaking, all three data sources point to

common findings: (a) The LN through a diverse range of activities, was able to generate social capital, both bonding and bridging, which was seen to play a key role in assisting organisations to implement Health and Human Rights programs in their work. (b) This process was uncomplicated. (c) Despite the tensions generated by hierarchies of power and differences between CSO and academic members of the LN, there was uniform recognition of the tremendous benefits and opportunities made available by the LN, which participants valued highly.

The findings of the development of social capital within my research study show that members developed various forms of bonding and bridging relationships within a space that was comfortable and where they benefitted through accessing resources and knowledge not only within the LN but also through linkages with external stakeholders. The development of trust, cohesion, value and inclusion as well as agency were some of the key aspects of social capital that developed within the LN.

There was contestation over who made decisions within the network. Power and trust were key aspects that had to be openly addressed by the network to enable it to reach its goals. While some LN members had prior experience and knowledge of human rights, the LN was able to generate new knowledge and the pathway appeared to be one linked to the social capital and networking generated through the LN, rather than any other pathways.

Collaboration with the LN academic members added further benefits for the CSO members as they developed skills to participate in research and other learning activities.

The value of the Review and Reflection meetings is that members could voice their concerns in a comfortable space. This is evident in the findings discussed in “lessons learnt” and “outcome mapping excercises”.

The sharing of programs and commitments from other members to collaborate in the programs was one of the milestones in the development of the LN. The benefit of collaboration and partnerships further builds and strengthens agency for the realization of the right to health in communities.

Chapter 8 presents the discussion and findings.

CHAPTER 8
DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

8.1 DISCUSSION

In this chapter, I set out the substantive original contribution of this research study in relation to building social capital through a rights based learning network involving CSOs and Academics. With the adoption of a human-rights based to approach to development, London (2003) contends that CSOs use the approach to develop agency amongst the most vulnerable groups. This is supported by Eriksson (2011) who reinforces the notion that when communities can access resources through networks, they develop agency to make effective decisions that affects their health and well being. A range of researchers, London (2003); Cornwell and Nyamu- Musembi (2004); London and Schneider (2012) and Scott *et al*., (2017) agree that in order to realize the right to health in communities, CSOs need to adopt a rights-based approach to service delivery. CSOs play a role in providing information and about training health and human rights instruments. The value of CSOs that provide services in their communities is confirmed by Wilson *et al.*, (2012).

Parker and Murray (2022) assert that there is a global move to recognise the importance of a human rights based approach to health in improving access to and quality of health services which has relevance for the challenges facing South Africa.

The decision to research the role of social capital and social networks for the realization of the right to health in communities was taken in response to the literature that attests to the decline in the health status and access to health care in South Africa post the democratization of the country in 1994 (Reynolds, London and Sanders, 2006; Thomas and London, 2006). These authors contend that, despite the development of enabling health and human rights legislation and the adoption and ratification of the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the International Covenant on Civil and political Rights (ICCPR), people are not aware of their rights and struggle to access services and information about the services.

The research study aimed to explore whether social capital within a Learning Network of CSOs can contribute towards the development of new knowledge in health and

human rights. The Learning Network (LN) for Health and Human Rights had a specific agenda of building individual and collective agency amongst CSOs in Cape Town, South Africa. This study makes an original empirical contribution to this area of study and extends understandings of this area globally. The findings relating to the research questions and research objectives will be set out showing how they extend knowledge and understandings of the current literature in this field globally and in South Africa.

The objectives of the research study were to (i) to analyze the member's organizations' motivation for participation in the LN; (ii) to explore whether and how social capital was fostered within the member organisations of the LN; and if so firstly, to analyze how social capital contributes to the integration and implementation of health and human rights programs; secondly, have alternative pathways of knowledge, skills and values acquisition contributed to the integration and implementation of health and human rights programs; and thirdly, to analyze what the facilitation factors or barriers were in the integration and implementation of health and human rights programs by LN members.

8.2. FINDINGS OF THE RESEARCH STUDY: OBJECTIVES

8.2.1 Motivation of CSOs for Participation in the LN

Within the context of inequality, discrimination and poverty in South Africa, the members of the LN expressed their need to improve their knowledge on health and human rights that would enable them to implement rights-based programmes in their communities.

The LN for Health and Human. Rights was conceptualized in 2008 with the primary objective of building agency amongst members of CSOs to implement health and human rights programmes in communities. Through participation in the LN activities and resaerch, various benefits were accrued to the members that motivated them to participate and remain in the LN. Benefits of participation was a key theme that emerged as motivation for continued participation. Minimal changes in the membership attests to the finding that the majority of members participated regularly in activities and research during the period 2010 to 2017, and that social cohesion developed through participation and collaboration. Social cohesion was developed in the network as they had a common objective of building agency for change. Green

and Janmaat (2011) describe social cohesion as being the “glue that holds society together”.

8.2.2 Exploring whether and how social capital was fostered within the member organisations of the LN

The finding is that the LN for Health and Human Rights generated social capital successfully. The key enabling factors that the researcher found was the development of bonding, bridging and linking relationships amongst its members. The prominent aspects of social capital include trust, altruism, reciprocity, cohesion, power, empowerment, agency, civil society, and civil society organizations. These concepts however differ in terms of the context and the degree that each of them is developed. (Bourdieu,1996; Drydyk, 2008; Kaim, 2013; Krishna, 2003; Lukes,1994; Ling and Dale, 2013).

The study explored the period 2010 to 2017, during which LN activities grew substantially, having been formed in 2008 and which continued beyond 2017. The evidence that emerged in the study showed that bonding and bridging relationships amongst the CSOs and academic members needed a period of time to be developed. Despite the fact that the particpants in this study came from diverse backgrounds in terms of the CSOs that they represent, they all presented with the need to improve their knowledge in health and human rights and on how to integrate the knowledge in their community based programs. Thomson (2005) explains that a greater degree of diversity enables dynamism and innovation. A group of individuals with connections to other social worlds is likely to have access to a wider range of information.

It is evident in the documentary analysis of the LN, that challenges regarding an imbalance of power were experienced particularly by the CSO members. CSO members perceived that the academic members had more power and therefore could not be trusted. Trust between members of a network is viewed as being the “oils and wheels” of social capital (Portes, 1998). Claridge (2020) claims that trust is framed as essential for the existence of social capital and the argument is made that most authors agree that trust and trustworthiness are at the core of social capital.

Mistrust in the LN was based on a perception of a divide between the the academic members and CSOs. The former were perceived to have extensive academic

knowledge of health and human rights and the latter, to be ‘merely’ service providers in communities. Mistrust results in a power imbalance and could influence decision making in ways that shape benefits and other resources (Gilson 2007). VeneKlaasen and Miller (2002) confirms that power plays an integral role in either including or excluding role players and that people who have power, utilize the power to influence the outcome of any program.

Interventions to address the aspect of power were reported in the Review and Reflect Meetings and it was further documented in a report on “Lessons Learnt since 2008” (See Table 7.3). The LN methodology of Review and Reflection (diagram 1), served to provide the enabling space for reflection.

“*Information moves in a circular process of learning, action and reflection.”*

(Stuttaford et al, 2012.)

(Tables 3.2 and 3.3) describe the drivers and indicators of successful networks but do not expand on how to achieve them. Engel, Keijzer, and Ornmark (2006) (section 3.3.2.4) observe that learning networks promote improved performance through processes of collaborative action, appraisal and analysis of activities. However, no mention is made of reflective practices.

An interesting finding was that the academic members interviewed were also aware of the power dynamics. There was no denial of the dynamic which meant that the 'enabling environment' of the LN could work on the issues. If the academic members denied this, it would have been impossible to work on it or proceed as the LN did.

The interventions however, did not completely remove the power imbalances, but the impact of differential power was ameliorated. At the end of the study period, CSO members were still commenting on power imbalances but they felt more confident to engage and vocalise their concerns. The findings further show that a few members of the LN had experience in working with other networks and as such, were empowered through their knowledge and experience to challenge the academic members at various meetings, particularly the Reflect and Review and Planning Meetings (section 7.1.7). This is an indication that the aspect of power does not disappear, it has to be managed.

The spiral of review and reflect methodology used in the LN assisted in managing internal conflicts.

Reciprocity amongst the members could also determine the strength of the relationships between network members. This aspect refers to the giving of benefits to others in return for benefits received. Through the action of giving and receiving, bonding and bridging relationships are formed between members often resulting in cohesion and inclusion. According to Molm (2010), the aspect of reciprocity is a defining feature of social capital i.e., the giving of benefits to others in return for benefits received. Douwes, Stuttaford and London (2018) confirm that power is a strong determinant of behaviours that contributes to equal relationships. This is evidenced in this study when the LN members started collaborating on projects because of the mutual benefits received.

8.2.2.1

The sub objective was to analyze how social capital contributed to the integration and implementation of health and human rights

In addressing the question of whether social capital contributed to health and human rights programmes, the findings show that the objective was realised due to the participants naming their expectations early in the study and collectively, deciding on the projects that they wanted to embark upon. The evidence shows that members participated actively in the co-learning (Table 6.2) and co-research (Table 6.3) activities of the LN, which was experienced positively because of the benefits accrued through these activities. These benefits ranged from simply collaboration through to deeper engagement, and the gaining of an understanding of the social determinants of health as well as a stronger sense of collective action that would make them more effective. Engagement is a process in which members can access resources to achieve collective outcomes.

Eriksson (2010) is specific about defining engagement as a methodology that ensures that communities develop agency and are empowered to take decisions and manage resources. The the rich data that emerged from this study shows that CSOs have built agency and power to take charge of resources resulting in the successful outcomes of the LN.

The CSO Health and Human Rights programmes presented in Table 7.5 are extensive and innovative. The real success is that the beneficiaries of the CSOs received training and they were capacitated to cascade the information to the broader community.

The success of the attainment of the research objective must be viewed within the context in which the learning takes place. The type and methodology of the various types of networks presented in the literature enabled the researcher to understand how networks work and what type of network is best suited for learning, as well as how the learning could result in the integration and implementation of health and human rights programmes Engel, Keizer and Ornmark (2006). The participatory action research methodology of the LN provided the "glue" that held the network together.

8.2.2.2

Have alternative pathways of knowledge, skills and values acquisition contributed to the integration and implementation of health and human rights programs?

Section 7.2.1 presents the findings that three of the CSOs had prior knowledge of health and human rights. They were involved in human rights structures before becoming a member of the LN. However, despite the prior knowledge of human rights, all the CSO members stated that they acquired their primary knowledge of health rights through their participation in the LN. The evidence presented in the findings strongly suggest that the methodology applied in the LN, i.e. participation in co-learning and co-reseach activities contributing to the development of social capital had a greater impact in terms of knowledge generation on the members who had previously belonged to human rights structures.

8.2.2.3

This sub-objective sought to analyze what the facilitation factors or barriers were in the integration and implementation of health and human rights programs by LN members

Although the researcher explored the sub-objective, not much discussion was had around the factors that hindered or promoted the implementation of programs. One of the prerequites for participation in the LN, (draft MOU) is that CSO representatives

must be nominated by their organization and that they have the mandate to act for and on behalf of the organization. The madate includes the right to implement the programs that are appropriate for their organisation. The list of acheivements (Table 7.5) and commitment to continue participating in future activities (7.6) confirms that the CSOs' management structure supported the activities of the LN and the collaboration with other members of the LN.

8.2 LIMITATION OF THE RESEARCH STUDY

Limitations of the study included the paucity of recent literature on social capital and the development of social capital within a learning network for the realization of health and human rights. This finding is significant in that the literature review on social capital and networks was not specific in terms of whether and how social capital and networks can build agency in a Learning Network on Health and Human Rights. An additional limitation was the absence of similar case study research studies. This limitation provides an opportunity for further research into similar case studies where social capital in a network builds agency for social change .

The period during which the researcher undertook the study did not enable the researcher to positively conclude that the inputs of the LN members impacted on policy reform. A gap therefore exists in the study and as such, future research on the role of CSOs in government processes for policy reform could be explored.

Regarding the financial sustainability of the Learning Network, the Network was well resourced through funding received from various donors. The funding enabled the Learning Network to embark upon research that provided evidence as to whether and how CSOs and structures such as the community health forums could promote the realization of the right to health. The funding further enabled the LN to develop materials, toolkits on the right to health and training manuals that enabled members to implement "train then trainer' programmes. The programmes that were cascaded through the "train the trainer' programmes broadened the reach in communities and the knowledge enabled community members to create awareness about health and human rights with other groups.

8.3 CONCLUSIONS

The original substantive contributions empirically and conceptually presents research undertaken on an international and national level in relation to learning networks, social capital and co-learning.

International and National Health and Human Rights Legislative Instruments are legally binding. Article 12 of the ICESCR provides strategies that should be used to monitor the implementation of ICESCR at the national and international levels. In the context where the state has failed in its obligations in terms of Socio-Economic rights, CSOs are called upon to play a role in the delivery of health services. The WHO recognises that CSOs can contribute to enhanced health care by providing services in response to community needs and to lobby for equity and pro-poor health policies.

There is a global move to recognise the importance of a human rights based approach to health in improving access to and quality of health service. It was precisely during this period that the field of international health began to give way to what
would ultimately come to be defined as ‘global health’ starting in the late-1980s and the early-1990s (Parker and Murray, 2022). In the context of growing global health inequalities, London (2003) advocates for a human rights based approach that seeks to redress and mobilize communities and vulnerable groups, as well as to develop policy and hold government accountable. Cornwell and Nyamu-Musembi (2004) concur that in the last few years there have been discussions amongst development actors and agencies about a rights-based approaches to development. The authors further state that for some, the grounding of a rights-based approach in human rights legislation makes such an approach distinctively different to others as it lends itself to re-politicizing areas of development work such as the efforts to enhance civil society participation in development. Learning networks that aim to achieve similar outcomes, need to be well resourced and should consist of a combination of experiences that the CSOs bring to the LN and the knowledge that academia add to building agency amongst the CSOs.

London (2008) further explains that a human rights-based approach is critical to address the growing global health inequalities based on the recognition of the inherent dignity and worth of the human person. The prominence of the approach has given civil society a role in raising, advancing and claiming the entitlements of different social groups. In addition, the approach gives CSOs a vital role as participants and watchdogs of policy.

The human rights-based approach frames the social determinants of health as public goods and focuses on the protection of the most disadvantaged individuals and groups. London and Schneider (2012) further emphasize that using a rights-based approach to development promotes the integration of social determinants of health into practices.

The key theme of the South African Health Act relates to community participation. Eriksson (2010) is specific about the definition of engagement as a methodology that ensures that communities develop agency and are empowered to take decisions and manage resources.

Story (2013) argues that while there is growing evidence on the linkage between social capital and health in recent years from research in high income countries, there is a lack of research from poor resourced countries. However, it is precisely in resource poor settings that social capital is an important factor for improving health. The author recommends that future research on social capital and health in the developing world should focus on applying appropriate theoretical conceptualization of social capital in the developing country context. Lau (2014) supports the notion that various factors can impact on the development of social capital and the improvement of health.

8.4 RECOMMENDATIONS

CSOs engage with the most vulnerable groups in communities. The experience of CSOs in this study is similar to findings in the literature that for outsiders, academics or researchers, who seek to gain entry into any community, requires that community members need to be able to trust their intentions. The LN CSO members were initially sceptical, as CSOs did not want to be exploited for their vast experience in working within civil society and sought to protect their constituents from being over-researched by academic institutions. Often this happens in ways that leave the community with no

benefits after the research. However, through the development of trust between the CSOs, their constituents, the academics and researchers, meaningful engagement took place. The lesson learnt was that the objectives of the LN should be clearly stated and that research is not only the domain of the academics. Ownership of the LN should be shared and control of the information should not remain in the hands of the academic institutions.

My study fills the gap in terms of research on the theoretical conceptualization of how social capital and health could be linked in developing countries. As such, the study contributes towards a body of new knowledge of how social capital within a network can influence and shape policies and practice particularly in poor resourced countries that need to address the social determinant of health. This suggests a different route for policy makers wanting to address health determinants; and that civil society activists might want to rethink their strategies for advocating for health at a population level. Policy makers should consider investing in strategies and policies that support civil society actions that build social capital for the realisation of health rights.

The research study further provides an opportunity for future studies into learning networks that builds agency for the implementation of rights-based programmes in communities. This would be in keeping with the global move to recognise the importance of a human rights based approach to health in improving access to and quality of health services.

REFERENCES:

Adler, P, and Kwon, S. (2002) 'Social Capital: Prospects for a New Concept'. *The Academy of Management Review,* 27(1), pp.17- 40. DOI: 10.5465/AMR. 2002.5922314

Agampodi T.C., Agampodi S.B., Glozier N., and Siribaddana, S. (2015) 'Measurement of social capital in relation to health in low- and middle-income countries (LMIC): a systematic review', *Soc Sci Med*.,128, pp.95-104. DOI: 10.1016/j.socscimed.2015.01.005. Epub 2015 Jan 8. PMID: 25596373.

Arnstein, R. A (1969) 'Ladder of Citizen Participation'. *Journal of the American Institute of Planners,* 35(4), pp. 216-224. DOI: 10.1080/01944366908977225

Ashman,D., Charles, C., Cuenca, A., Luca, C., *et al* (2005) *Supporting Civil Society Networks in International Development Programs.* Edition 1. Academy for Educational Development (AED) Centre for Civil Society and Governance.

Attridge-Sterling, J. (2001) *Thematic networks: an analytic tool for qualitative research*. London: Sage Publications.

Babbie, E. and Mouton, J. (2001) *The Practice of Social Research*. Cape Town: Oxford University Press South Africa.

Barbour, R. (2001) 'Checklists for improving rigour in qualitative research: a case of the tail wagging the dog?', *BMJ*, 322(7294), pp. 1115-1117. DOI:10.1136/bmj.322.7294.1115

Baxter, P. and Jack, S. (2008) 'Qualitative Case Study Methodology: Study Design and Implementation for Novice Researchers', *The Qualitative Report,* 13(4), pp. 544-559. Retrieved from http://nsuworks.nova.edu/tqr/vol13/iss4/2.

Bender-de Moll, S. (2008) *Potential Human Rights Uses of Network Analysis and Mapping.* A Report to the Science and Human Rights Program of the American Association for the Advancement of Science and Human Rights (Pp. 46). http://skyeome.net/wordpress/wp-content/uploads/2008/05/Net_Mapping_Report.pdf

Bourdieu, P. (1986) 'The Forms of Capital', in Richardson, J (ed.) *Handbook of Theory and Research for Sociology of Education*. Westport, CT: Greenwood, pp. 241-58. Bourdieu, P. (1992) Three Approaches to Social Capital. Retrieved from Gauntlet, D. 'Making is connecting', https://davidgauntlett.com/portfolio/making-is-connecting.

Bourdieu, P. (1996) 'Understanding', *Theory, Culture and Society,*13(2), pp.1737. DOI: 10.1177/026327696013002002.

Braveman, P. and Gruskin, S. (2003) 'Poverty, equity, human rights and health', *Bulletin of the World Health Organization,* 81(7), pp. 539-545.

Breen, L. (2007) 'The researcher 'in the middle: Negotiating the insider/outsider dichotomy', *The Australian Community Psychologist,* 19(1), pp. 163–174. Burns, R. B. (1994) *Introduction to Research Methods.* 2nd Edition. Melbourne: Longman Australia.

Burt, R. (2000) 'The Network Structure of Social Capital', *Research in Organisational Behaviour*, Volume 22, pp.345-423Burt, R. (2001) *Structural Holes versus Network Closure as Social Capital. New York*. Incomplete reference. I have tried to find it on internet – there are various sources – did you use the version published in this book? In: Lin, N., Cook, K.S. and Burt, R.S., Eds., Social Capital: Theory and Research, Aldine de Gruyter; if not, then complete the reference so that I can finally edit it when you send me the thesis as a whole, that includes you inserting the edited references that you finalise after receiving this version

Centre for Social Protection. (2011) 'Social Protection for Social Justice Conference Report', Institute of Development Studies, Brighton, England.

https://www.ids.ac.uk/download.php?file=files/dmfile/CSPConferenceReport-SocialProtectionforSocialJustice2.pdf

Chapman, A. R. (1996) A "Violations Approach" for Monitoring the International Covenant on Economic, Social and Cultural Rights, *Human Rights Quarterly* 18(1), pp. 23-66.

Chapman, A. R. (2002) 'The Human Rights Implications of Intellectual Property Protection', *International Economic Law,* 5(4), pp. 861–882.

Chapman, A. R. (2010) 'Health & Human Rights', *Health and Human Rights*, 12(2), pp.17–30.

Chapman, A. (2015) 'The foundations of a Human Right to Health: Human Rights and Bioethics in Dialogue', *Health and Human Rights Journal,* 1(17). *https://www.hhrjournal.org/2015/06/the-foundations-of-a-human-right-to-health-human-rights-and-bioethics-in-dialogue/*

Chowdhury, J. (2009) 'Judicial Adherence to Minimum Core Approach to Social-Economic Rights- A Comparative Perspective', *CornellLaw School Inter-University Graduate Student Conference Papers*. Paper 27. https://scholarship.law.cornell.edu/cgi/viewcontent.cgi?article=1055&context=lps_clacp

Claridge, T. (2004) *Social Capital and Natural Resource Management: An important role of social capital?* Unpublished Thesis, University of Queensland, Brisbane, Australia.

Claridge, T. (2018) 'Can social capital be measured'? *Social Capital Research*, 1-5. https://www.socialcapitalresearch.com/wp-content/uploads/2018/09/Can-social-capital-be-measured.pdf?x80079

Claridge, T. (2020) ‘Social Norms and Social Sanctions: An aspect of the relational dimension of social capital, *Social Capital Research.* https://www.socialcapitalresearch.com/social-norms-and-social-sanctions/

Claridge, T. (2020) ‘Social Capital and Poverty Alleviation’, *Social Capital* https://www.socialcapitalresearch.com/wp-content/uploads/2020/01/Social-capital-and-poverty-alleviation.pdf

Cloete, A. (2014) ‘Social cohesion and social capital: Possible implications for the common good’, *Verbum et Eccles*ia 35(3). Retrieved from https://doi.org/10.4102/ve.v35i3.1331.(RetrievedFebruary 2022)

Coleman, J. 1(988) ‘Sociological and Economic Approaches to the Analysis of Social Structure’, *The American Journal Sociology*, 94, pp.S1-S16.

Coleman, J. (1988) ‘Social Capital in the Creation of Human Capital’, *The American Journal Sociology,* 94, pp.S95-120.

Coleman, J. (1990) *Foundations of Social The*ory. Cambridge: Harvard University Press.

Coovadia, H., Jewkes,R., Barron,P., Sanders, D. and McIntire, D. (2009) *The health and health system of South Africa: historical roots of current health challenges,* Retrieved from www.thelancet.com, 374, pp.817-834.

Cornwall, A. and Nyamu-Musembi, C. (2004) ‘Putting the “rights-based approach” to development into perspective’ *Third World Quarterly*, 25(8), pp.1415–1437.

Cox, A. (2005) ‘What are communities of practice? A comparative review of four seminal works’, *Journal of Information Science,* 31(6), Retrieved from https://doi.org/10.1177/0165551505057016

Denzin, N. K., Lincoln S. (1970) *Handbook of Qualitative Research.* Second Edition. London: Sage Publications, Inc.

DeVos, A. S. (1998) *Research at Grassroots level. A primer for caring professions.* Pretoria: Van Schaik Publishers. Third edition. ISBN 0 627 021 73 5.

D'Hombres, B., Rocco, L., Suhrcke, M. and McKee, M. (2007). Does Social Capital determine health? Evidence from eight transition countries. Institute for the Protection and Security of the Citizen. *Health Economics*, 9(1), pp.56-74.

Douwes, R. (2012).'Social solidarity and collective action in rights claims for health in South Africa', International Public Health - University Amsterdam /University of Cape Town

Douwes, R., Stuttaford, M. and London, L. (2018) 'Social solidarity, human rights, and collective action: Considerations in the implementation of the national health insurance in South Africa', *Health and Human Rights*, 20(2), pp.185-196.

Drydyk, J. (2008). 'Durable empowerment', *Journal of Global Ethics,* 4(3), pp.231-245. DOI: 10.1080/17449620802496354.

Dudwick, N., Kuehnast, K., Jones, V. N. and Woolcolk, M. (2006) 'Analysing social capital in context', *The World Bank.* Vol. 59, pp. 457- 474.

Dwyer, S. and Buckle J. (2009) 'The Space Between: On being an Insider-Outsider in Qualitative Research', *International Journal of Qualitative methods*, 8(1), pp.54-63. DOI 10.1177/160940690900800105.

Emmett, T. (2000) 'Beyond community participation? Alternative routes to civil engagement and development in South Africa'. *Development Southern Africa,* 17(4), pp.501-518, DOI: 10.1080/03768350050173903.

Engel, P., Keijzer, C. and Ornmark, C. (2006) 'Networking for Learning: The human face of knowledge management?', *Policy Management Brief.* No.18. https://ecdpm.org/work/networking-for-learning-the-human-face-of-knowledge-management

Eriksson, M. (2011) 'Social capital and health--implications for health promotion'. *Global Health Action*. https://doi.org/10.3402/gha.v4i0.5611.

Equitas. (n.d.) 'Our Vision of Human Rights Education'. http:www.equitas.org/english/ed-manuals/vision.php

February, J. (2006) 'Political Participation' in *Reflections and Democracy and Human Rights. A Decade of the South African Constitution (Act 108 of 1996)*, Pp.145-152. Johannesburg: South African Human Rights Commission. ISBN 0-620-36364-9.

Flick, U. 2009. An introduction to qualitative research. London: Sage Publications.

Fukuyama, F. (1995) *Trust: the social virtues and the creation of prosperity*. London: Hamish Hamilton.

Fukuyama, F. (1999) 'Social Capital and Civil Society', Conference paper prepared for 8 November 1999 International Monetary Fund Conference on Second Generation Reforms.
https://www.imf.org/external/pubs/ft/seminar/1999/reforms/fukuyama.htm

Fukuyama, F. (2001) 'Social capital, civil society and development', *Third World Quarterly,* 22, pp. 7-20.

Galdas, P. (2017) 'Revisiting Bias in Qualitative Research: Reflections on its Relationship with Funding and Impact, *International Journal of Qualitative Methods,* Volume 6, pp.1-2. DOI: 10.1177/1609406917748992.

Garten, I., Haythornwaite, C. and Wellman B. (1997) 'Social Networks'. Retrieved from www.jcmc.indiana.edu. (Retrieved February 20220

Gaventa, J. (2005) 'Reflections on the Uses of the 'Power Cube' Approach for Analysing the Spaces, Places and Dynamics of Civil Society Participation and Engagement', Institute of Development Studies University of

Sussex, United Kingdom. https://www.participatorymethods.org/resource/reflections-uses-power-cube-approach-analysing-spaces-places-and-dynamics-civil-society

Gaventa J. (2006) 'Finding Spaces for Change', *IDS Bulletin*, 37(6), pp. 23–33. ISBN-13: 0432.

Gaventa, J. (2021) 'Linking the prepositions: using power analysis to inform strategies for social action', *Journal of Political Power*, 14(1), pp.109-130. DOI: 10.1080/2158379X.2021.1878409

Gilson, L. (2007) 'Acceptability, Trust and Equity', in Mooney, G. and McIntire, D.(eds.) *The Economics of Equity in Health and Health Care: Future Prospects.* Cambridge: Cambridge University Press.

Green, A. and Janmaat, J. (2011) *Regimes of Social Cohesion: Societies and the Crisis of Globalisation*. London: Palgrave Macmillan. https://doi.org/10.1057/9780230308633

Grootaert, C. and van Bastelaer, T. (2002) Understanding and Measuring Social Capital. A Multi-Disciplinary Tool for Practitioners. Washington: World Bank. https://openknowledge.worldbank.org/entities/publication/8f069a0b-b4a4-5c05-bee7-d52c5b583716

Haig, F. (2002) 'Human Rights Approach to Health'.*Croatian Medical Journal,* 43(2), pp.166-169.

Han, S.H., Yoon, S.W. and Chae, C. (2020), "Building social capital and learning relationships through knowledge sharing: a social network approach of management students' cases", *Journal of Knowledge Management*, 24(4), pp. 921-939. https://doi-org.ezproxy.uct.ac.za/10.1108/JKM-11-2019-0641

Harpham, T., Grant, E. and Thomas, E. (2002) 'Measuring social capital within health surveys: Key issues', *Health Policy and Planning*, 17(1), p.106.

Heywood, M. (2009) 'South Africa's treatment action campaign: Combining law and social mobilization to realize the right to health', *Journal of Human Rights Practice*, 1(1), pp.14-36. https://doi.org/10.1093/jhuman/hun006

Holms, A.G.D. (2020) 'Researcher Positionality- A Consideration of Its Influence and Place in Qualitative Research- A New Researcher Guide', *Shanlax International Journal of Education,* vol. 8, pp. 1-10.

Hudson, L. and Ozanne, J. (1988) 'Alternative ways of Seeking Knowledge in Consumer Research', *Journal of Consumer Research,* 14(4), pp. 508-521.

Institute for the Promotion of Disabled Manpower. (n.d.) https://ipdm.co.za

Islam, M. K., Merlo, J., Kawachi, I., Lindström., M. *et al.* (2006) 'Social capital and health: Does egalitarianism matter? A literature review', *International Journal for Equity in Health*, 5(3) DOI: 10.1186/1475-9276-5-3. Israel, B.A., Schulz, E.J., Parker. E.A., and Becker, A.B. (1998) 'Review of community-based research: assessing partnership approaches to improve public health', *Annual Review of Public Health*, 19, pp.173-202. DOI:10.1146/annurev.publhealth.19.1.173.

Kaim, B. (2013) 'Who are we to Care? Exploring the Relationship Between Participation, Knowledge and Power in Health Systems'. (March 2022) http://www.copasah.net/uploads/1/2/6/4/12642634/kaim.participation_knowledge_and_power_in_health_systems.pdf

Kanuha, V.K. (2000) '"Being" native versus "going native": conducting social work research as an insider', *Social Work*, 45(5), pp.439-447.

Keck, E. and Sikkink,K. (1999) *Transitional advocacy networks in international and regional politics.* ISSJ 59/1999 UNESCO.

Kimchi, J., Polvica, B. and Stevanson, J. S. (1991) 'Triangulation: Operational definitions', *Nursing Research*, 40(6), pp. 364-366.

Krishna, A. (2003). *Social Capital, Community Driven Development, and Empowerment.* Washington DC: World Bank Group https://documents1.worldbank.org/curated/en/511391468765604827

Krishna, A. (2015) *How are Civil Society Organizations important for development.* https://sbselearning.strathmore.edu/mod/resource/view.php?id=5695.

Lau, Yan Kwan. (2014) *Investigating the relationship between social capital and self-rated health in South Africa.* Dissertation submitted in partial fulfilment of the requirements for the degree Masters of Public Health (MPH) in Health economics. School of Public Health and Family Medicine, Faculty of Health Sciences. University of Cape Town. https://open.uct.ac.za/handle/11427/6095

Lave, D. and Wenger, E. (1991) *Situated Learning: Legitimate peripheral participation*. New York: Cambridge University press.

Learning Network (LN) Website: https://salearningnetwork.uct.ac.za/

Lefebvrea, V.M., Sorensonb, D., Henchionb, M., and Gellyncka, X. (2016) 'Social Capital Networks and Knowledge sharing Performance of Learning', *International Journal of Information Management,* 36, pp.570-579. http://dx.doi.org/10.1016/j.ijinfomgt.2015.11.008

Lexusnexis: What is Archival Research? https://internationalsales.lexisnexis.com/glossary/research/archival-research

Lieber,C. and Ferri, M. (2004) *NGO Networks: Building Capacity in a Changing World.* A Study Supported by Bureau for Democracy, Conflict and Humanitarian Assistance Office of Private and Voluntary Cooperation. https://pdf.usaid.gov/pdf_docs/PNADB767.pdf

Liebenberg, S. (2000) *Human development and human rights: South African country study.* United Nations Human Development Reports.

https://hdr.undp.org/content/human-development-and-human-rights-south-african-country-study

Lin, N. (2005) *A Network Theory of Social Capital. Handbook on Social Capital*, Oxford: Oxford University Press.

Ling, C., Dale, A. (2013) 'Agency and social capital: Characteristics and dynamics', *Community Development Journal,* 49(1), pp.4-20. DOI: 10.1093/cdj/bss069.

Loka Institute. (2003) 'Powerful Collaborations: Building a Movement of Social Change'. Community Research Network 2003 Conference Newsletter. CRN 6th Annual Conference October 16-20, Sandstone, Minnesota.

London, L. (2003) 'Can Human Rights serve as a tool for Equity?', *Equinet Discussion Paper* 14. *(EQUINET),* Harare and the University of Cape Town, Cape Town. https://www.equinetafrica.org/sites/default/files/uploads/documents/EquinetDiscussionPaper14.pdf

London, L. and Baldwin-Ragaven, L. (2006) 'Human Rights obligations in health care', *CME,Sabinet African Journals,.*Published Online January 1, 24 (1)http://hdl.handle.net/10520/EJC63040.

London, L. (2007) 'Issues of equity are also issues of rights: Lessons from experiences in Southern Africa', *BMC Public Health,* 7(14). https://doi.org/10.1186/1471-2458-7-14

London, L. (2008) 'What is a human rights approach to health and does it matter*?', Health and Human Rights Journal* 10(1), pp.65-80.

London L., Heap, M. and Baldwin-Ragaven, L. (2009) 'Health and Human Rights: New challenges for social responsiveness'*. International Journal of Community Research and Engagement,* 2, pp. 61–81. DOI:10.5130/IJCRE.V210.1165

London, L. and Schneider, H. (2012) 'Globalization and Health inequalities: Can a Human Rights Paradigm Create Space for Civil Society Action?', *Social Science and Medicine,* 74(1), pp. 6-13. DOI: 10.1016/j.socscimed.2011.03.022.

London, L., Tram, K.H. and Stuttaford, M. (2012) 'Filling the gap: A Learning Network for Health and Human Rights in the Western Cape, South Africa', *Health and Human Rights Journal,* 14(1), pp.E88-105.

Lukes, S. (1994) *Power: A radical View.* Ed. 1. London: Macmillian.

Mayosi, B., Lawn, J., van Niekerk, A., Bradshaw, D*. et al.* (2012) 'Health in South Africa: changes and challenges since 2009', *Review* 380(9858), pp. 2029-2043. DOI: 10.1016/S0140-6736(12)61814.

Maycut, P. and Morehouse, R. (1994) *Beginning Qualitative Research: A Philosophical and Practical Guide.* London, Washington, D.C.: Palmer Press.

Mason, J. (2002) *Qualitative Researching,* Second Edition. Sage Publications. ISBN 0 7619 7428 8.

Molm, L. (2010) 'The Structure of Reciprocity', *Social Psychology Quarterly*, 73(2), pp. 119-131.

Moon, J. (1999) *A Handbook of Reflective and Experiential Learning*. London: Routedge.

Mouton, J. (2001) *How to succeed in your Masters and Doctoral studies. A South African Guide and Resource Book*, Pretoria: Van Schaik.

Muller, A. (2012) 'Community Participation in Health', *DENOSA Newsletter*.

Musial, J and Kazienko, P. (2013) 'Social Networks on the Internet', Kings College, London.

https://www.equinetafrica.org/sites/default/files/uploads/documents/EquinetDiscussionPaper14.pdf

Nefdt, W. (2003) *The Transforming Roles of Management Boards in Non-Profit Social Welfare Organisations.* Dissertation submitted in partial fulfilment of the requirements for the Master's degree, Faculty of Arts and Social Sciences. University of Stellenbosch. https://scholar.sun.ac.za/handle/10019.1/53690

Nefdt, W. (2011) 'Social Protection for Social Justice', Centre for Social Protection Conference (13-15 April), Institute of Development Studies, Brighton, England. https://scholar.sun.ac.za/handle/10019.1/53690

Ngwena, C. (2000) 'The Recognition of Access to Health care as a Human Right in South Africa: Is it enough?', *Health and Human Rights,* 5(1), pp. 26-44.

Ngwena, C. (2006) 'Health' in *Reflections and Democracy and Human Rights. A Decade of the South African Constitution (Act 108 of 1996).* South African Human Rights Commission. ISBN 0-620-36364-9.

Parker, R.,and Murray, L, (2022) Introduction: Human rights and global health special issue, Global Public Health, 17:11, 3090-3097, DOI: 10.1080/17441692.2022.2135752
To link to this article: https://doi.org/10.1080/17441692.2022.2135752

Peak, L. and Trotz, A. (1999) *Gender, Ethnicity and Place: Women and identities in Guyana.* London: Routledge.

People First Foundation (n.d.) https://peoplefirstfoundation.weebly.com

Perkins, G. (2010) 'Empowerment', in R.A Couto (Ed.) *Political and Civil Leadership*: A Reference Handbook (pp.207-218). CA: Thousand Oaks, Sage.

Portes, A. (1998) The two Meanings of Social Capital

Portes, A. (1998) 'Social Capital: its origins and applications in modern sociology', *Annual Review of Sociology,* 24, pp.1-25.

Potts, H. (2010) 'Participation and the right to the highest attainable standard of health', Lancet. Elsevier.

Prah, K.K. (2018) *The Challenge of Language in post-apartheid South Africa.* The Centre for Advanced Studies of African Society, Cape Town. University Seminar. Research Gate

Putnam, R. D. (2000) *Bowling Alone: The Collapse and Revival of American Community*, New York: Simon and Shuster.

Ramkissoon, Y. (2016) 'The importance of realising economic and social rights in alleviating poverty and ensuring transformation: Reflections on the functions of the South African Human Rights Commission', *Economic and Social Rights Review*, 17(1), pp.3-7.

Reynolds, L., London, L. and Sanders, D. (2006) 'A global campaign for the right to health', *Critical Health Perspectives.*

Scott, C. and Hofmeyer, A. (2007) 'Networks and Social Capital: A relational approach to primary healthcare reform', *Health Research Policy and Systems*. https://doi.org/10.1186/1478-4505-5-9.

Scott, L., Greer, M., Pastorini, G. and Kosinska, M. (2017) 'Civil Society and Health', *Observatory Studies Series No. 58.* Copenhagen (Denmark): European Observatory Health Systems and Policies. ISBN-13:9789289050432.

Scott, V., Schaay, N., Schneider, H. and Sanders, D. (2017) 'Addressing Social Determinants of Health in South Africa: the journey continues', *South African Health Review*, 27(1). https://hdl.handle.net/10520/EJC-c80ea0402

Scrivens, K. and Smith, C. (2013) 'Four Interpretations of Social Capital: An Agenda for Measurement', *OECD Statistics Working Papers*, 2013/06, OECD Publishing. http://dx.doi.org/10.1787/5jzbcx010wmt-en

Semantic Scholar. 'Sampling in qualitative research: insights from an overview of methods literature'. https://pdfs.semanticshcolar.org

Social Capital Workshop. (2003) 'PRI Project – Social Capital as a Tool' presented at Social Capital Workshop: Concepts, Measurement and Policy Implications, Meech Lake, Quebec. June.

South African Government. (1996) Chapter 9 of the Constitution.

South African Government. (1997) 'White Paper for Social Welfare'. https://www.gov.za/sites/default/files/gcis_document/201409/whitepaperonsocialwelfare0.pdf

South African Government. (2007) 'Patient Rights Charter'. https://www.gov.za/sites/default/files/gcis_document/201409/whitepaperonsocialwelfare0.pdf

South African Government. (2012) 'Executive Summary', National Development Plan. https://www.gov.za/sites/default/files/gcis_document/201409/whitepaperonsocialwelfare0.pdf

South African Government. (2014) 'Batho Pele Principles'. https://www.gauteng.gov.za/Publications/PublicationDetails/%7BA6DD79B6-85DA-40EA-A17A-D2EFA5168F7E%7D

Stiglitz, J., Fitoussi, J., and Durand, M. (eds) (2018) For Good Measure: Advancing Research on Well-being Metrics Beyond GDP, OECD Publishing. Paris, https://doi.org/10.1787/9789264307278-en.

Strecker, M., Stuttaford, M. and London L. (2012). 'Health rights pamphlets: Critical literacy and inclusive citizenship, South Africa', *Health Promotion International*,29(2), pp.339-348.DOI: 10.1093/heapro/das067. Epub 2012 Dec 14.

Story, W. (2013) 'Social capital and health in the least developed countries: A critical review of the literature and implications for a future research agenda', *Global Public Health,* 8(9), pp. 983-999, DOI: 10.1080/17441692.842259.

Stuttaford, M. (2009) 'Methods in health and human rights research: towards a spiral of co-learning', in Coomans, F., Kamminga, M. and Grunfeld, F. (Eds.) *Methods of Human Rights Research*. Antwerpen*:* Intersentia. Pp135-157.

Stuttaford, M., London L. and Glattstein-Young G. (2012) 'Dialogue, Review and Reflect': A spiral of co-learning and co-research to surface knowledge on the right to health. *International Journal of Community Research and Engagement*, 5, pp. 115-134.

Stuttaford, M., Kiewiets, D., Nefdt ,W. and Reynolds, V. *et al.* (2014) 'Conceptualisation and the Implementation of the Right to Health: The Learning Network for Health and Human Rights, Western Cape, South Africa', in Freeman, M., Hawkes, H. and Bennett, B. (Eds.) *Law and Global Health Current Legal Issues,* 16, pp.76-93. https://doi.org/10.1093/acprof:oso/9780199688999.003.0006

Sustainable Development Goal Fund. (2014) From MDGs to SDGs. https://www.sdgfund.org/mdgs-sdgs

Thomas, J. and London, L. (2006) 'Towards establishing a learning network to advance health equity through human rights strategy'. Report to the Centre for Civil Society, University of KwaZulu Natal. Retrieved from www.salearningnetwork.weebly.com.

Thomas, J. (2009) ‘‘Is knowing that you have rights enough?’ Exploring Marginalised Women’s Awareness, Understanding and Practice of The Right to Health’, Masters Dissertation, Faculty of Humanities, University of Cape Town. https://open.uct.ac.za/bitstream/handle/11427/14000/thesis_hum_2009_thomas_j.pdf?sequence=1

Tompson, G. (2005) ‘Networks and Networking - reflections for the future’. *Discussion paper.* Uppsala 2005, Sept 14-17, pp.1-8. https://studylib.net/doc/8795289/networks-and-networking-%E2%80%93-reflections-for-the-future

Thurmond, A. (2001) ‘The Point of Triangulation’, *Journal of Nursing Scholarship*, Third Quarter, 33(3), pp.253-258.

United Nations 2015 Millenium Development Goals Report, New York. Retrieved from: https://www.un.org/millenniumgoals/2015_MDG_Report/pdf/MDG%202015%20rev%20(July%201).pdf

Vega-Romero, R. and Tova, M. (2007) The Role Of Civil Society Organizations: A Policy Engagement

Ventresca, M. and Mohr, J. W. (2001) ‘Archival Research Methods’, in J.A.C. Baum (ed.) *The Blackwell Companion to Organizations,* (pp. 805–828). Oxford: Blackwell Publishing Ltd.

Wenger-Tryner E., and Wenger-Trayner B. (2015) *Introduction to communities of practice. A brief overview of the concept and its uses*. https://www.wenger-trayner.com/introduction-to-communities-of-practice/

Western Cape Network on Disability. (N.d.) www.facebook.com/wcnetworkdisability

Westfall, J., Van Vorst, R., Main, D. and Herbert, C. (2006) ‘Community-Based Participatory Research in Practice- Based research Networks’, *Annals of Family Medicine,* 4(1), pp.8-14.

Wilson, G. Lavis, J. and Guta, A. (2012) 'Community-based organizations in the health sector: A scoping review', *Health Research Policy Systems*, 10(36), Published online Nov 21. DOI: 10.1186/1478-4505-10-36.

Woolcock, M. (1998) 'Social capital and economic development: towards a theoretical synthesis and policy frameworks', *Theory and Society*, 27, pp 151-208.

Woolcock, M. and Narayan, D. (2000) 'Social Capital: Implications for Development Theory, Research and Policy', *The World Bank Observer*, 15(2), pp. 225-49.

World Bank. (n.d.) International Bill of Rights. https://www.worldbank.org/en/about/legal/publication/minimum-core-obligations-of-socioeconomic-rights

World Bank. (2012) World Development Report: Gender, Equality and Development. World Development Report 2012: Gender Equality and Development (worldbank.org)

World Health Organization. (n.d.) Social Determinants of Health. https://www.who.int/health-topics/social-determinants-of-health

World Health Organization. (2001) 'Strategic Alliances: The role of civil society in Health'. Paper no. 1. https://apps.who.int/iris/bitstream/handle/10665/279937/CSI-2001-DP1-eng.pdf?sequence=1&isAllowed=y

Yazan, B. (2015) 'Three Approaches to Case Study Methods in Education: Yin, Merriam and Stake', *The Qualitative Report,* 20(2), pp.134-152.

Yin, R.K. (1994) *Applications of Case Study Research.* Second Edition. Thousand Oaks, Sage.

Yin, R. K. (2014) *Case Study Research, Design and Methods*. Second edition. *Applied Social Research Methods Series,* Volume 5. CA:Thousand Oaks, Sage.

Zainal, Z. (2007). Case study as a Research Method. *Journal Kemanusiaan,* .9, pp.1-6.

INTERNATIONAL STATUTES

United Nations. (1946) Universal Declaration of Human Rights. Retrieved from: https://www.ohchr.org/EN/UDHR/Documents/UDHR_Translations/eng.pdf

Alma-Ata Declaration. International Conference on Primary Health Care. (1978). Retrieved from: https://www.unicef.org/media/85611/file/Alma-Ata-conference-1978-report.pdf

United Nations Convention on the Elimination of all forms of Racial Discrimination. (1969). Retrieved from: https://www.ohchr.org/Documents/ProfessionalInterest/cerd.pdf

United Nations Convention on the Rights of the Child (1990). Retrieved from: https://www.ohchr.org/en/professionalinterest/pages/crc.aspx

United Nations (1966) Protection of Economic, Social and Cultural rights in conflict: United Nations Human Rights: https://www.ohchr.org/Documents/Issues/ESCR/E-2015-59.pdf

United Nations Covenant on Social, Economic and Cultural Rights. (1967) Retrieved from: https://treaties.un.org/doc/treaties/1976/01/19760103%2009-57%20pm/ch_iv_03.pdf

United Nations Covenant on Social, Economic and Cultural Rights. (2000) General Comment No 14. Retrieved from: https://www.refworld.org/pdfid/4538838d0.pdf

United Nations Covenant on Civil and Political Rights. (1966) Retrieved from: https://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx

United Nations Human Rights. (2015) Protection of Economic, Social and Cultural rights in conflict. Report Retrieved from: https://www.ohchr.org/Documents/Issues/ESCR/E-2015-59.pdf

United Nations (2015) Report of the United Nations High Commissioner for Human Rights. https://www.ohchr.org/Documents/Issues/ESCR/E-2015-59.pdf

United Nations Convention on the Elimination of all forms of Discrimination Against Women. (1979) Retrieved from: https://www.ohchr.org/documents/professionalinterest/cedaw.pdf

United Nations Convention on the Rights of Persons with Disabilities. (2007) Retrieved from: https://www.un.org/disabilities/documents/convention/convoptprot-e.pdf

United Nations General Assembly Sustainable Development Goals. (2015). Retrieved from: https://sdgs.un.org/2030agenda

United Nations Millennium Development Goals. (2015). Retrieved from: https://www.un.org/millenniumgoals/2015_MDG_Report/pdf/MDG%202015%20rev%20(July%201).pdf

United Nations. (2015) 'UNDP and Civil Society Organizations: A Policy Document'. https://www.undp.org/content/undp/en/home/librarypage/civil_society/undp_and_civil_societyorganizationsapolicyofengagement.html

World Health Organization. Strategic Alliances. (2001). The role of civil society in health. Discussion Paper No, 1. CSI/2001/DPI. Retrieved from: https://apps.who.int/iris/bitstream/handle/10665/279937/CSI-2001-DP1-eng.pdf?sequence=1&isAllowed=y

SOUTH AFRICAN STATUTES

Republic of South Africa. Human Rights Commission. Act No 40 of (2013). Government Gazette No 16143. Retrieved from: https://www.gov.za/documents/south-african-human-rights-commission-act

Republic of South Africa. The Constitution of the Republic of South Africa. Act No. 108 of (1996). Government Gazette 17678. Retrieved from: https://www.gov.za/sites/default/files/images/a108-96.pdf

Republic of South Africa. The National Health Act N0 61 of (2003). Government Gazette No 26595. Retrieved from: https://www.gov.za/sites/default/files/gcis_document/201409/a61-03.pdf

Republic of South Africa. The White Paper for Social Welfare. (1997). Government Gazette 18166. Retrieved from: https://www.gov.za/sites/default/files/gcis_document/201409/whitepaperonsocialwelfare0.pdf

8.5 ANNEXURES

ANNEXURE: 1

RESEARCH TITLE AND BACKGROUND

Research Title:

The Role of Social Capital in the integration and implementation of Health and Human Rights programmes amongst Civil Society Organisations in Cape Town, South Africa.

Researcher:

Wendy M Nefdt

PhD Student in the School of Public Health and Family Medicine: Human Rights Programme. University of Cape Town.

Research supervisors:

Prof Leslie London and Dr Christopher Colvin: School of Public Health and Family Medicine: Human Rights Programme. University of Cape Town.

Background:

I am conducting a study with the members of the Learning Network for Health and Human Rights. The participants are representatives of 6 Civil Society Organisations[47] and 3 Academic Institutions[48]. The aim is to understand whether and how the information, knowledge and skills that were generated through the Learning Network activities contributed towards the integration and implementation of health and human rights programmes in their organisations.

Research process:

The researcher will conducted Semi- Structured Interviews (SSIs) with all the CSO participants of the Learning Network. The interviews are about their participation in the

[47] Ikamva Labantu. Ikaya Labantu, The Women's Circle, Women on Farms, Epilepsy South Africa, Community Health Forum

[48] University of Cape Town, University of the Western Cape, University of Maastricht

Learning Network, their learning experiences and relationships formed with other member organisations.

Focus groups of about 6-8 people per member organisation will further be held to discuss whether the participants of the Learning Network and non-participating members of the organisations have benefitted from the involvement.

Confidentiality:
I would like to tape record the interviews with your permission. All the information will be kept confidential and the information collected will be anonymised. In the final report, I will present group results so as to ensure that individuals cannot be identified.

Feedback:
If you want to see transcripts of the interviews to be sure that they are accurate, I will undertake to provide you with the transcript of the interview. I will hold a feedback workshop on the completion of the study where the results will be shared with you.

Right to refuse:
You are under no obligation to participate if you do not want to and you may withdraw at any stage from the study. You or your organisation will not be penalized should you choose not to participate. However, I would like to encourage your participation to assist me with this study.

Indication of consent:
If you are willing to participate, **please sign the attached consent form** to indicate that you understand the aims and process of this study and that you consent to be interviewed.

Contact details: **Wendy M Nefdt**
Telephone: 021 7039420 (office)
Cell phone: 083 6555759

ANNEXURE: 2

CONSENT TO PARTICIPATE IN SEMI-STRUCTURED INTERVIEWS AND OR FOCUS GROUP DISCUSSIONS

I, _____(name) hereby agree to participate in in an In-depth Interview and or a Focus Group Discussion as per the conditions as stipulated in the attached Consent Form - Annexure 1 of the Research Protocol

Signature:_____

Date:

ANNEXURE: 3

TOPIC GUIDE: CIVIL SOCIETY ORGANIZATIONS

---

1. Motivation for membership in the Learning Network for Health and Human Rights (LN)

What was your motivation for your joining and participating in the LN?

Probe:

- Discuss any personal and or organisational involvement in networks.
- Describe the networks and benefits of engagement.
- What encouraged you to participate in the activities of the LN.
- Did you understand the aims and objectives of the LN prior to your participation.
- Did you expect that the activities of the LN could assist your organisation in the integration and implementation of Health and Human Rights Programmes (HHRP's). If so, explain how.
- Has the LN objectives changed during the course of time and does it currently meet your expectations.

2. Pre-existing relationships and activities

Did you have any prior relationships and joint activities with the LN member organisations and academic partners? Can you describe them?

Probe:

If relationships and joint initiatives were present, how did your engagement with these organisations and academic institutions contribute towards the integration and implementation of your organisation's HHR Programmes.

3. Current relations

Has your participation in the LN has enabled you to form relationships with member organisations and academic partners? Can you describe how?

Probe:

- Explain whether and how the relationships with member organisations and academic partners have enabled the implementation of HHR programmes in your organisation and whether joint initiatives were entered into.
- What type of joint initiatives were entered into and whether these initiatives improved the organisation's capacity to implement HHR programmes.

4. Learning Network interventions and activities

Can you describe the LN interventions and activities you were involved in and your degree of participation?

Probe:

- Awareness of types of activities and interventions that the LN is involved in. Participation in activities such as meetings, seminars, training, research meetings, review and reflection meetings and feedback reports and or any other research activities.
- Whether the interventions and activities enabled you to integrate and implement HHRP's in your organisation.
- Describe the programmes implemented

5. Development of social capital

Does participation in a LN provide you with an opportunity for developing relationships of reciprocal trust?

Probe:

- Do you feel that the LN has promoted and developed a shared identity based on common interests, trust and values (bonding relationships) between yourself, the member organizations and academics.

- Describe which common interests, values and benefits contributed to the development of a shared identity (member organizations and academics).
- Explain the value and benefits of the shared identity for your organization.
- What effect do you think that a separate researcher's meeting has on the development of a shared identity for the LN.
- Has the LN enabled you to connect with resources / organisations / networks / forums outside of its activities (bridging relationships).
- Discuss the process of engagement with external resources/ organisations / networks / forums and provide examples of how you benefitted from the external linkage.

6. Alternative pathways of knowledge and skills acquisition

What knowledge and skills did you have about health and human rights prior to your participation in the LN? What knowledge and skills did you acquire through participation in the LN?

Probe:

- Knowledge of HHR prior to participation in the LN.
- Knowledge and skills acquired through your participation in the LN.
- Additional knowledge received through the LN partners.
- How was the knowledge and skills acquired and has it assisted with the development and implementation of your HHRP's.

7. Organization's response to involvement in the LN

Describe any facilitation factors or barriers that either enabled the implementation or prevented the implementation of HHRP's?

Probe:

- What was your management and colleagues' attitude towards your involvement in the LN.
- Did you receive support from your management and colleagues for the implementation of HHR Programmes.

- Were there adequate resources (physical and human) for the integration and implementation of HHR Programmes.
- Describe any resistance or barriers in your organisation that prevented you from implementing HHR Programmes.
- Discuss any external resistance or barriers that prevented you from implementing HHR Programmes

---

ANNEXURE 4:
TOPIC GUIDE WITH ACADEMICS

---

1. **Participation in the Learning Network for Health and Human Rights**

   Describe your motivation for participation in the Learning Network (LN)***?***
   Probe:

   - What encouraged you to participate in the LN.
   - What experience, skills and knowledge do you have in the field of Health and Human Rights.
   - Discuss your personal history of social responsiveness and or network participation (generally).
   - Elaborate on your experience with CSOs and the value of networking above other kinds of academic outputs.

2. **Learning Network activities**

   Describe the activities you were involved in and your degree of participation?
   Probe:

   - How often did you participate in the activities of the LN (research meetings, seminars, training, review and reflection meetings, feedback reports and or any other activities).
   - Discuss whether you think that the activities that you were involved in have promoted the integration and implementation of HHRP's in the member organisations.
   - Discuss your contribution to the LN and how that interacted with your professional (academic) roles.

3. **Pre-existing relationships and activities**

   Describe whether you had prior relationships and joint activities with the LN member organizations?
   Probe:

- If relationships and or joint activities were present, what is your perception of how your engagement with these organisations contributed towards the integration and implementation of their organisation's HHR programmes.

4. Current relations

Describe whether your participation in the LN has enabled you to form relationships with member organizations?

Probe:

- Do you think that your relationship with member organisations has enabled them to implement HHR programmes in their organisations.
- Have you entered into joint activities with member organisations and whether you think that these activities improved the organisation's capacity to implement HHR programmes.
- Do you feel that the university has benefited (academically or other) from the joint activities and whether and how it improved the university's capacity for further engagement in other networks.

5. Development of social capital

Does participation in a LN promote the development of what is called "bridging and bonding" relationships***?***

Probe:

- Do you feel that the LN has promoted and developed a shared identity based on common interests, trust and values (bonding relationships) between yourself and the member organisations.
- Describe which common interests, values and benefits contributed to the development of a shared identity.
- Explain the value and benefits of the shared identity for the university.
- Discuss whether the shared identity impacted on the promotion and development of CSOs Health and Human Rights Programmes.
- Do you as an academic see yourself as separate or part of the LN as a collective.

- What effect do you think that a separate researcher's meeting have on the development of a shared identity for the LN.
- Has the LN enabled you to connect with resources / organisations / networks / forums outside of its activities (bridging relationships).
- Discuss the process of engagement with external resources/ organisations / networks / forums and provide examples of how you benefitted from the external linkages.

ANNEXURE: 5

FOCUS GROUP GUIDE

---

1. Participation in the Learning Network for Health and Human Rights

Describe whether your Forum's participation in the LN has enabled you to implement Health and Human Rights Programmes (HHRP's)?

Probe:

- How has the knowledge of health and human rights (HHR's) and skills acquired by the Forum's representative on the LN been imparted with the Forum.
- Describe whether and how the knowledge and skills contributed towards the integration and implementation of HHRP's.
- Do you think that HHRP's promote community participation and the realisation of health and human rights.

2. Development of social capital

Does how participation in a LN provide you with an opportunity for developing what is called "bridging and bonding" relationships within the Forum?

Probe:

- Has your Forum connected with resources outside of the LN activities (bridging relationships) that enabled your Forum to integrate and implement HHRP's.
- Discuss the process of engagement with external resources.
- Provide examples of the type of resources and how you were assisted with your HHRP's.
- Do you feel that you have developed a shared identity based on common interests, trust and values (bonding relationships) within your Forum.
- Explain the value and benefits of the shared identity for your Forum and for the development of Forums HHRP's.

3. **Alternative pathways of knowledge and skills acquisition**

What knowledge and skills did you have about health and human rights prior to your participation in the LN?

Probe:

- How was the knowledge and skills acquired and did it assist with the development of your HHRP's.

4. **Facilitation factors or barriers in the integration and implementation of HHRP's**
   - Where there any facilitation factors or barriers that either enabled the implementation or prevented the implementation of HHRP's?

Probe:

- What was the centre managements or other government institutions attitude towards the implementation of HHRP's.
- Were there adequate resources (physical and human) for the integration and implementation of HHRP's.
- Describe any resistance or barriers in your Forum that prevented you from implementing HHRP's.
- Describe any external resistance or barriers that prevented you from implementing HHRP's.

ANNEXURE:6

LEARNING NETWORK
DOCUMENTARY ANALYSIS ARCHIVAL 2009-2017

DATE	TYPE OF MEETING (Mt)	EXTRACT OF DISCUSSIONS	ATTENDEES
2009			
15/01/09	Planning Mt Minutes	▪ Communication officer ▪ Programme plans ▪ Material development ▪ Manual on human rights ▪ Advocacy and lobbying around R2H ▪ Research ▪ Learning training needs	1. UCT 2. UCT 3. Ikamva 4. Ikamva 5. CMHF 6. UCT 7. Epilepsy South Africa Western Cape (Epilepsy South Africa Western Cape)
02/02/09	Exco Mt Notes	▪ Strategic Planning identified the opportunity for LN organisations to get together around specific issues Suggestions: member meeting to share how/whether they have used HR approach in work ▪ Governance. Concerns rose about low turnout. Queried whether members are getting the notices of the meeting	1. UCT 2. Ikamva 3. Epilepsy South Africa Western Cape 4. Women on Farms (WoF) 5. Womes. Circle (WC) No apologies
12/03/09	Email requesting a meeting on 01/04/09		

17/03/09	Exco committee Strat Planning	▪ Vision ▪ Mission ▪ Goal ▪ Objectives 1-5 ▪ Programmes ▪ Creating, managing and dissemination of information o Research o Training o Advocacy and lobbying o Support for members	1. Ikamva 2. UCT 3. Epilepsy South Africa Western Cape 4. Women on Farms (WoF) 5. Women's. Circle (WC) Apology: 6. UCT 7. UWC
20/04/09	Minutes and notes of review and Reflect meetings	▪ Needs analysis ▪ R2H ▪ Advocacy ▪ Health committees ▪ Training ▪ Home based care ▪ Research questions ▪ Responsibilities of member organsations	▪ Epilepsy South Africa Western Cape ▪ Women on Farms (WoF) ▪ Womes. Circle (WC) ▪ Ikamva ▪ UCT ▪ UWC
04/05/09	Exco Minutes	▪ Appointment of interim project co-ordinators post. Member participation in job profile. Person to be located within the member organization. ? wether the organization shall appoint or if LN memebrs want to participate in selection ▪ LN participation. Low turnout	▪ Epilepsy South Africa Western Cape Epilepsy South Africa Western Cape ▪ Womes. Circle (WC) ▪ ▪ Apologies ▪ Women on Farms (WoF) ▪ Ikamva
28/07/09	Exco Minutes	▪ Participation. Only 50% attendance ▪ TWC Collaborative events- 16 days of activism	▪ Women on Farms (WoF) ▪ Epilepsy South Africa Western Cape WC Apology

			▪ UCT ▪
25/08/09	Review and Reflect	▪ Review of organisations projects ▪ What have we learnt ▪ Evaluation ▪ What would we like to discuss next meeting ▪	▪ WOF ▪ WOF ▪ WOF ▪ WOF Klapmuts ▪ Epilepsy South Africa Western Cape ▪ TWC ▪ TWC ▪ TWC ▪ UCT ▪ UCT ▪ UWC
17/11/09	Agenda for Review and Reflect	No minutes available	
2010			
26/02/10	Strat Planning	Review of 2009 Reflect on LN Goals ▪ Obj 1: Communities are informed ▪ Obj 2 Documenting best practice ▪ Obj 3 To promote access to LN opportunities for members ▪ Obj 4 To use learnings to support advocacy around health 2010 Workplan: ▪ Materials ▪ Research activities ▪ Networking ▪ **Time lines for meetings** ▪ Project co-ordinator ▪ Announcements: PERC seminar 19/03 WFP Health fair 21/03	▪ Epilepsy South Africa Western Cape ▪ Women on Farms (WoF) ▪ (WC) ▪ UCT ▪ UCT ▪ UWC Apology 1. Ikamva

30/03/10	Exco Mt	▪ SANGOCO and LN partnership ▪ Black Sash partnership ▪ Organizational feedback: ESA WFP Ikhaya Labantu Ikhamva Labantu CMHF UCT	▪ Epilepsy South Africa Western Cape ▪ Women on Farms (WoF) ▪ (WC) ▪ UCT ▪ UCT ▪ UWC ▪ Ikamva 1. SANGOCO 2. Black Sash Apology Ikamva WC
13/04/10	Review and Reflect	**Taking Stock of the LN** ▪ Analyze constituency ▪ Who is your network/partner ▪ Benefits ▪ LN responsiveness to members needs **Reflecting on lessons learnt since 2008** ▪ Expectations ▪ Milestones ▪ How have things changed ▪ How do you see relationships between different members ▪ Gaps in LN ▪ How do you apply lessons learnt from LN ▪	1. WOF 2. WFP 3. Epilepsy South Africa Western Cape 4. Women on Farms (WoF) 5. (WC) 6. UCT 7. UCT 8. UWC 9. ESA 10. CMHF 11. CMHF 12. TWC 13. TWC 14. Ikhaya 15. UCT 16. UWC 17. UW Apology UWC
28/04/10	Exco Mt	No minutes available	
18/05/10	Exco Mt	Organisational Feedback ▪ ESA	▪ Epilepsy South Africa Western Cape ▪ Women on Farms (WOF)

		▪ WFP ▪ Ikamva ▪ Ikhaya ▪ TWC ▪ CMHF ▪ UCT ▪ Creative Commons	▪ (TWC) ▪ UCT ▪ UCT ▪ UWC ▪
29/05/10	Review and Reflect	▪ Autophotograhy ▪ Lessons from past meetings ▪ Lessons from each member ▪	▪ WOF ▪ Epilepsy South Africa Western Cape ▪ Women on Farms (WOF) ▪ TWC ▪ UCT ▪ UCT ▪ UWC ▪ UCT ▪ Apology ▪ UWC ▪ IKAMVA 1.
20/07/10	Exco Mt	Organisational Feedback ▪ ESA ▪ TWC ▪ CMHF ▪ Ikhaya Labantu ▪ Ikamva Labantu ▪ UWC ▪ WFP ▪ UCT ▪	▪ ▪ ESA ▪ TWC ▪ CMHF ▪ Ikhaya Labantu ▪ Ikamva Labantu ▪ UWC ▪ WFP ▪ UCT ▪ ESA Apology WOF
17/08/10	Exco Mt	N0 minutes available	
26/10/10	Exco Mt	Organisational feedback: ▪ Communities are informed about their right to health ▪ Documenting best practice	▪ ESA ▪ TWC ▪ CMHF ▪ Ikhaya Labantu ▪ Ikamva Labantu ▪ UWC ▪ WFP ▪ UCT

		▪ Promoting access to learning opportunities for member organisations ▪ Use learnings to support advocacy ▪ SANGOCO WEEK ▪ Toolkit ▪ Perc seminar ▪ UCT Knowledge ▪ Partnership Pilot project ESA TWC CMHF UWC WFP	Apologies ▪ UCT
16/11/10	Review and Reflect	▪ Toolkit on H&HR Nicole ▪ Phasa conference Gabriela ▪ Health Committee Audit Hanne ▪ Auto photography Susan, Maureen,Nicole ▪ Toolkit for disability and HR Ruth	▪ ESA ▪ TWC ▪ CMHF ▪ Ikhaya Labantu ▪ Ikamva Labantu ▪ UWC ▪ WFP ▪ UCT ▪ WFP ▪ 13 CSO beneficiaries Apology UWC
2011			
10/02/11	Strat Framework Development Review	Outcomes mapping ▪ LN Exco ▪ Organisations ▪ Constituencies ▪ Health workers ▪ Academic partners ▪ Collaborators ▪ Policy makers	▪ ESA ▪ TWC ▪ CMHF ▪ Ikhaya Labantu ▪ Ikamva Labantu ▪ UWC ▪ WFP ▪ UCT ▪ WFP ▪ UWC

18/04/11	Final strat planning	▪ Where we are at ▪ Reviewing the framework LN Exco Organisations Constituencies Health workers Academic partners Collaborators Policy makers	▪ ESA ▪ TWC ▪ CMHF ▪ Ikhaya Labantu ▪ Ikamva Labantu ▪ UWC ▪ WFP ▪ UCT ▪ WFP
17/05/11	Exco Mt	▪ Strat Planning follow up ▪ Toolkit launch ▪ Co-authorship of papers ▪ LN opportunities ▪ RTH	▪ ESA ▪ TWC ▪ CMHF ▪ Ikhaya Labantu ▪ Ikamva Labantu ▪ WFP ▪ UCT ▪ WFP Apology ▪ UWC ▪
14/06/11	Exco Mt	▪ Attendance, continuity and decision making ▪ Leadership traiing ▪ Lungelo does not work for Ikhaya anylonger ▪ Forced HIV testing ▪ Materials ▪ Supporting advocacy ▪ Toolkit on T2H requested by CMHF ▪ Train the trainer ▪ LN website ▪ Presenting the work of the LN ▪ Learning opportunities for members	▪ ESA ▪ TWC ▪ CMHF ▪ Ikhaya Labantu ▪ Ikamva Labantu ▪ UWC ▪ WFP ▪ UCT ▪ WFP Apology ▪ UCT ▪ UWC ▪

16/08/11	Exco Mt	Organization feedback ▪ ESA ▪ MHCF ▪ Ikamva ▪ WFP	▪ ESA ▪ CMHF ▪ UWC ▪ WFP ▪ UCT ▪ WFP ▪ MHF Apology ▪ UWC ▪ TWC
14/09/11	Review and Reflect	No minutes available	
11/10/11	Exco Mt	Report back ▪ MHCF ▪ WFP ▪ UCT ▪ Ikamva ▪ TWC	▪ ESA ▪ TWC ▪ CMHF ▪ Ikamva Labantu ▪ WFP ▪ UCT ▪ WFP Apology ▪ UWC ▪ IKAYA labantu ▪
2012			
25/01/12	LN Planning Mt	No minutes available	
14/03/12	Exco Mt	Members to report plans for 2012 Report back ▪ Exco ▪ Organisations ▪ Constituencies ▪ Health workers ▪ Academic partners ▪ Colllaborators ▪ Policy makers ▪ Other	▪ ESA ▪ CMHF ▪ Ikhaya Labantu ▪ Ikamva Labantu ▪ WFP ▪ UCT ▪ WFP Apologies ▪ UWC ▪ IKAYA LABANTU ▪ TWC
16/03/12	Reminder of review and Reflect	No minutes available	

08/05/12	Exco Mt	No minutes available	
12/05/12	Invitation to LN presentations	No minutes available	
03/07/12	Exco Mt	▪ Report back ▪ Other R and R meeting Uganda exchange visits	▪ ESA ▪ TWC ▪ CMHF ▪ Ikhaya Labantu ▪ Ikamva Labantu ▪ WFP ▪ UCT ▪ WFP Apologies ▪ UWC ▪ WOF ▪
4/09/12	Exco Mt	Cancelled due to lack of attendance	
25/09/12	Exco Mt	No minutes available	
19/10/12	Review and Reflect	Feedback on the National health assembly meeting: Discussion on way forward ▪ ESA ▪ TWC ▪ CMHF ▪ Ikhaya Labantu ▪ Ikamva Labantu ▪ UWC ▪ WFP ▪ UCT ▪ WFP	▪ ESA ▪ TWC ▪ CMHF ▪ Ikhaya Labantu ▪ Ikamva Labantu ▪ UWC ▪ WFP ▪ UCT ▪ WFP ▪
08/11/12	Exco Mt	Cancelled due to lack of attendance	▪
2013			
20/02/13	Planning meeting	▪ Brief Review of 2012- SWOT analysis ▪ Achievements 2012 ▪ Plans 2013	▪ ESA ▪ TWC ▪ CMHF ▪ Ikhaya Labantu ▪ Ikamva Labantu ▪ UWC

		▪ EU workpackages-health committees ▪ Areas of synergy in planned work	▪ WFP ▪ UCT ▪ WFP
11/03/13	Exco Mt	No minutes available	
25/06/13	Review and Reflect Mt	Chaired by UCT ▪ Business ▪ What organisations would like to see from LN ▪ Activities LN can assist with ▪ Review of health committee work ▪ Networking outputs ▪ Advocacy outputs ▪ Photovoice exhibition ▪ Community participation dialogues ▪ ESA ▪ TWC ▪ CMHF ▪ Ikhaya Labantu ▪ Ikamva Labantu ▪ UWC ▪ WFP ▪ UCT ▪ WFP ▪	▪ ESA ▪ TWC ▪ CMHF ▪ Ikhaya Labantu ▪ UWC ▪ WFP ▪ UCT ▪ WFP Apologies Ikamva
19/07/13	Exco Mt	Feedback ▪ ESA: Disability toolkit, T2H training. Seminar in Oct/Sep traditional healer etc ▪ UCT ▪ CMHF: PHM, Training using LN pamphlets, Evaluation of pamphlets,	▪ ESA ▪ CMHF ▪ Ikamva Labantu ▪ WFP ▪ UCT ▪ WFP Apologies ▪ UWC ▪ TWC ▪

		community participation, ▪ TWC: Event on 26/08 ▪ Health workers:	
17/09/13	Exco Mt	No minutes available	
08/11/13	Exco Mt	No minutes available	
2014			
03/03/14	Planning Meeting	Received report Facilitated by Yasmin Turton ▪ Expectations ▪ Acheivements since 2011 ▪ Challenges ▪ Key strategic issues ▪ Mission ▪ Goal ▪ Objectives ▪ Prep work for next Exco/ R&R	▪ (LN) ▪ (CMHF) ▪ (UCT) ▪ (Masstricht Univ) ▪ (LN) ▪ (UCT) ▪ (LN) ▪ (UCT) ▪ (IKAMVA) ▪ (Warwick Univ) ▪ (TWC) ▪ (UCT) ▪ (ESA) ▪ (UCT) ▪ (WFP) ▪ (LN) ▪ (TWC) ▪ (TWC) ▪ (LN)
06/05/14	Review and Reflect	Discussions: ▪ Decision making and power in the network ▪ The focus on Health Committeee ▪ Participation in the network ▪ Are we a network Member presentations ▪ Direction points for future work ▪ Challenges in the network	▪ (LN) ▪ (CMHF) ▪ (LN) ▪ (UCT) ▪ (CMHF) ▪ (LN) ▪ (UT) ▪ (IKL) ▪ (TWC) ▪ (UCT) ▪ (ESA) ▪ (TWC) Apology: (UCT)

			(WFP) ▪
03/07/14	Exco Mt	No minutes available	
09/09/14	Review and Reflect	▪ Feedback from each participants ▪ Trust	▪ ESA ▪ TWC ▪ CMHF ▪ Ikamva Labantu ▪ UWC ▪ WFP ▪ UCT ▪ WFP
15/11/14	Review and Reflect	Organisational feedback	▪ ESA ▪ TWC ▪ CMHF ▪ Ikamva Labantu ▪ WFP ▪ UCT ▪ WFP Apology ▪ UWC
2015			
13/02/15	Exco Mt	▪ Recap of 2014 ▪ Programmes ▪ Research ▪ Training	▪ ESA ▪ TWC ▪ CMHF Ikhaya Labantu ▪ Ikamva Labantu ▪ UWC ▪ WFP ▪ UCT ▪ WFP
07/04/15	Exco Mt	No minutes available	
09/06/15	Exco	▪ Organisational feedback ▪ Constituents ▪ Health workers ▪ Academic partners	▪ ESA ▪ TWC ▪ CMHF Ikhaya Labantu ▪ Ikamva Labantu ▪ WFP ▪ UCT ▪ WFP Apolgy UWC

18/08/15	Review and Reflect	▪ Progress on programmes ▪ Research activities ▪ Reflection of relationships/trust ▪ Students	▪ ESA ▪ TWC ▪ CMHF ▪ Ikamva Labantu ▪ UWC ▪ WFP ▪ UCT ▪ WFP
03/11/15	Exco Mt	Recap of activities for 2015	▪ ESA ▪ TWC ▪ CMHF ▪ Ikamva Labantu ▪ WFP ▪ UCT
2016			
07/02/16	Exco Mt	Department of health briefing Feedback	▪ ESA ▪ TWC ▪ CMHF ▪ UCT ▪ WFP
12/04/16	Review and Reflect	No minutes available	
06/16	Exco	▪ Recap of Review and Reflect ▪ Organisational feedback	▪ ESA ▪ TWC ▪ CMHF ▪ Ikamva Labantu ▪ WFP ▪ UCT ▪
15/09/16	Exco Mt	▪ Training- train the trainer ▪ Organisational feedback	▪ TWC ▪ CMHF ▪ Ikamva Labantu ▪ UCT ▪ WFP
04/11/16	Exco	Members not available	
2017			
14/03/17	Matrix of the LN	▪ Solutions handbook ▪ Piloting the poverty stop light ▪ Feedback from organisations	▪ ESA ▪ TWC ▪ CMHF ▪ Ikamva Labantu ▪ UWC ▪ WFP

			▪ UCT ▪ WFP
19/05/17	Exco Mt	▪ Feedback from Matrix ▪ Organizational feedback ▪ Constituents	▪ ESA ▪ TWC ▪ CMHF ▪ Ikamva Labantu ▪ WFP ▪ UCT ▪
30/07/17	Review and Reflect	▪ Progress on programmes ▪ Research activities ▪ Reflection of relationships ▪ Constituents	▪ ESA ▪ TWC x 3 ▪ CMHF ▪ Ikamva Labantu ▪ WFP x 4 ▪ UCT ▪ WFP x3
07/10/17		No minutes	
12/17	Exco Mt	Recap of the year	▪ ESA ▪ TWC ▪ CMHF ▪ Ikamva Labantu ▪ UWC ▪ UCT ▪ WFP