Community Systems Strengthening Project: The successes and challenges perceived and experienced in Gugulethu, South Africa

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Abstract

Community participation is an effective strategy for strengthening health systems and progressively realising health rights. For meaningful community participation to occur, the capacity of formal or informal community organisations and mechanisms involved in addressing social determinants of health needs to be strengthened. One way of doing this is through training. There is minimal research on the efforts of community structures set up to address social determinants of health and health needs in communities, following training to strengthen their capacity. This study sought to evaluate the successes and challenges of a particular Community Systems Strengthening Project which, between 2016 and 2019, set out to train health committee members and community health activists in Gugulethu, South Africa. In so doing, it investigated whether and how the health committee members and Community Health Activists assumed an activist role in the community and are engaging in meaningful community participation.

A mixed methods evaluative study was conducted in two phases during 2020-2021. The first phase was a scoping review of available literature, followed by an evaluative study including review of project documents, observation by attending events organised by the project and other community organisations, and in-depth interviews with health committee members (2), community health activists (4) and project staff (4). The training intervention was found to have influenced the health committee members and Community Health Activists thinking, understanding and practice in their community efforts to address social determinants of health. Therefore, adequate support, training, and an enabling environment can facilitate meaningful community participation in health. Ultimately, these measures will contribute to the progressive realisation of the right to health and the right to community participation, and ultimately health system transformation. The limited adaptability of the intervention, limited resources, participant perceptions and sustainability were found to be obstacles to meaningful community participation.

This dissertation consists of two parts. The study protocol, Part A, outlines the rationale of undertaking this research and the proposed methods. Part B consists of the journal ready manuscript which presents the results and discussion of the research findings.

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Abbreviations

CCA	Community Change Agent
CDU	Chronic Dispensary Unit
CHA	Community Health Activist
CESCR	UN Committee on Economic, Social and Cultural rights [
CSDH	Commission on Social Determinants of Health
CSS	Community Systems Strengthening
DFID	Department for International Development
DoH	Department of Health
DSD	Department of Social Development
ECD	Early Childhood Development
GC	General Comment
HC	Health Committee
ICCPR	International Covenant on Civil and Political Rights
ICESR	International Covenant on Economic, Social and Cultural Rights
IDI	In-depth Interview
LMIC	Low and middle-income country
NCD	Non-communicable Diseases
NHI	National Health Insurance
PHC	Primary Health Care
PHM	People's Health Movement
PHM-SA	People's Health Movement South African Chapter
SDH	Social Determinants of Health
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organisation

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PART A: Protocol

Community Systems Strengthening Project: The successes and challenges perceived and experienced in Gugulethu

Introduction

The Alma-Ata declaration (1978) on Primary Health Care (PHC) was inspired by health system reforms, social & human development and underpinned by the key principles of PHC (social justice, equity and participation) (Lawn *et al.* 2008). The Declaration draws attention to the notion of health as an outcome of social determinants (nutrition, early child development, housing, education, safety and inclusivity), which are societal factors that determine the manner in which people grow, age, live and work (Marmot *et al.* 2008). Various sectors and actors need to collaborate to ensure comprehensive health provision and improvement (World Health Organization 2000, Chircop *et al*. 2015), given that the underlying social factors that determine a population's health status are interconnected and can promote or limit the capacity of citizens to participate in processes relating to their health. Furthermore, the Declaration points out the responsibility of governments for the health of its citizens and advocates the right of people to be involved in the planning and implementation of their own health care. This is expected to facilitate participation in decisions relating to their health and equity in health (McCoy *et al*. 2012).

Participation, was first introduced when the WHO Constitution was opened for signature in July 1948 (Hunt and Backman 2013), thus participation emerged as one of the salient factors in realising the right to health and fostering equity in health. The notion of community participation as a strategy for improving health has been widely discussed in literature with studies that have explored the concept and found it to be effective in achieving better health outcomes (Loewenson and Rusike 2005, Padarath and Friedman 2008, Glattstein-Young and London 2010, Haricharan and Learning Network 2012, McCoy *et al.* 2012, Meier *et al.* 2012, Waweru *et al.* 2013, Hunt and Backman 2013, Kamuzora *et al.* 2013; Kilewo and Frumence 2015, Maluka and Bukagile 2016, Karuga *et al.* 2019)

The importance of involving communities in matters that affect their health and on social causes of ill health is further reiterated in the Declaration of Astana, 2018. Following on from the Alma-Ata Declaration, 1978, in October 2018, at the Global Conference on Primary Health Care in Astana, Kazakhstan, member states committed to "*…address economic, social and environmental determinants of health and aim to reduce risk factors by mainstreaming a Health in All Policies approach*"(World Health Organization and United Nations Children's Fund 2018) Among other commitments, the delegates and authorities present also committed to *"…support the involvement of individuals, families, communities and civil society through their participation in the development and implementation of policies and plans that have an impact on health"* (WHO and UNICEF 2018)

South Africa was found to be the most unequal country on the globe (WHO and UNICEF 2018). It was reported that black South Africans, the unemployed, households headed by females, children, large families and the less educated were the worst affected by the inequities in income and wealth (Gous 2018, World Bank 2018). Inequities that persisted because of the legacy of Apartheid in South Africa have extended their effect to poor health statuses among; poor, vulnerable, and marginalised members of the

South African population. Furthermore, the voices of marginalised groups continue to be excluded from the decision-making processes which has then significant impact on their health (WHO & UNICEF, 2018). This has then perpetuated existing health inequities. Some studies have reported poor health system performance and barriers to health access as main drivers of health inequalities among poor and vulnerable communities (Friel *et al.* 2011, Senanayake *et al.* 2017, WHO and UNICEF 2018). The low socio-economic status, the lack of access to transport, access to clean water, poor sanitation, poor nutrition as well as the neglect of the key principle of community participation continue to contribute to the ill-health experienced among poor and vulnerable groups (Adler et al. 2016, World Bank 2018, WHO and UNICEF 2018). This then highlights the importance of addressing social determinants of health through the developing and implementing of interventions which; foster, support and sustain community participation, while simultaneously promoting the progressive realisation of the right to health and the right to community participation.

Several scholars have highlighted that community participation in health takes various forms (Campbell *et al.* 2008, Adongo *et al.* 2013, Gregson *et al.* 2013, Angwenyi *et al.* 2014, Musesengwa and Chimbari 2017, Mash *et al.* 2019, Meiring *et al.* 2019). One way of facilitating community participation is through health committees (HCs), also referred to as health facility committees (HFC), clinic committees (CC), community health committees (CHC) or health unit management committees in some countries[1]. This strategy of using HCs as vehicles of community participation to make provision for the representation of the community is commonly found in the Southern African Region (Loewenson *et al.* 2005, Gregson *et al.* 2013, Mash *et al.* 2019, Ankomah *et al.* 2021), and in other low– and middle- income (LMICs) countries (McCoy *et al.* 2012). Furthermore, these bodies are viewed as crucial in strengthening and improving health outcomes in health systems (McCoy *et al.* 2012, Mulumba *et al.* 2018).

In South Africa, Section 42 of the National Health Act (NHA) No. 61 of 2003 provides for the establishment of HCs (Department of Health 2004). By law, each primary health facility should have a HC and it should be comprised of some community members, one or more local government councillors and the facility manager (Department of Health 2004). Furthermore, the body should serve as a link between the primary level of care health facility and the community in each area (Department of Health, 2013). The NHA requires provincial governments to develop legislation that stipulates the functioning of health committees in provinces of South Africa (Department of Health 2004). In the Western Cape, the Western Cape Health Facility Boards and Committees Act No. 4 of 2016 was passed in July 2016. The Act calls for the establishment of boards, with clear functions and procedures, to govern hospitals and committees established for primary health care facilities (Department of Health 2016). However, even though there is legislation outlining the functions of HCs, the terms are vague, and participation is constructed as a privilege rather than a right (Haricharan and Learning Network 2012). The lack of clarity and specificity in the legal and policy framework undermines the Act, as some health authorities and policymakers may not feel compelled to engage HCs or appreciate their contribution to the formal health system (Mulumba *et al.* 2018). In this instance, it is evident that a SDH such as government policy can impact the capacity for

[1] There are various terms used for health committees, depending on the region or country. In South Africa the terms commonly used for the structures mandated to facilitate community participation at the grass roots level are health committees (HC), health facility committee (HFC) andclinic committee (CC) (DOH, 2004). For this study, the preferred term is health committee (HC).

community participation in health. Ultimately, this may compromise progress in the realisation of the health rights of poor and marginalised communities when the organisations which are beneficial in addressing social determinants of health are inconsistently supported by policies at a national and provincial level.

In addition, community participation can also be fostered through the presence of community "change agents" (Rifkin 2009). In some contexts, these "change agents" are formally organised and are traditionally known as Community Health Workers (CHWs). In the context of this study, "change agents" are referred to as community health activists (CHAs). Community change agents have significant impact on poor health behaviours and empower communities to collaborate on the provision of health care by addressing underlying determinants of health (Rifkin, 2009).

Literature Review

A scoping review was conducted (see Methods) to describe international, regional, and national stipulations for the right to health and the right to participation. The scoping review also described community systems and how they fit into the overall health system. A detailed overview on health committees as channels for community participation, health activism and the empowerment of health activists was also presented. The latter was supported by literature on the benefits and challenges of building the capacity of community members to address social determinants of health.

There is growing consensus that meaningful community participation is key in improving health outcomes and health status of a population. Literature reviewed showed that for full potential of health committees (HC) as vehicles of community participation to be realised, more research must be conducted. The research should be guided by any training interventions that aim at building the capacity of meaningful participation. This will shift the focus from research on health committees in relation to health facilities, which has been the focal point of most previous studies on health committees. This shift, in turn, will contribute to knowledge on the progressive realisation of the right to health and realisation of the right to meaningful participation. It was done by, firstly, reviewing literature which outlined the interface between community systems and the health system. Secondly, by reviewing literature on the right to health and the right to community participation. Thereafter, theories on community participation and findings from studies which were conducted to examine the concept of community participation through HCs and organised community members who form community systems were reported.

How community systems relate to the health system

Broadly, a health system is a composition of all organisations, people, networks, resources, and institutions devoted to taking actions which are primarily intended to restore, promote, and maintain the health of a population (WHO 2007). While the purpose of the health system is to improve people's health and facilitate health service delivery, SDH which operate outside the health system also strongly influence people's health (Marmot *et al.* 2008). Therefore, SDH should be considered when thinking about strengthening health systems and improving population health outcomes. Similarly, the performance of a health system influences social factors which affect a population's health (Friel *et al.* 2011, Reeve *et al.* 2015, Senanayake *et al.* 2017, World Health Organization (WHO) and United Nations Children Fund (UNICEF), 2018). As interest in health systems research and in improving health systems is growing, there

is no clear agreement on the role of community systems and civil society in strengthening health systems (Sacks *et al.*, 2017). Furthermore, there is a lack of knowledge on the specifics activities or processes which can be undertaken to support community systems with the ultimate goal to improve health systems (Sacks *et al.* 2017). The primary mandate of a health system is to serve people who are often organised into communities which can also be organised as systems. For the reasons above, it is important to look at the community systems in relation to the health system when assessing how SDH are addressed at a community level.

There is consensus that there is no single or fixed way of defining a community (MacQueen *et al.* 2015, Mash *et al.* 2019). In this study, a community will be understood as a dynamic and fluid group comprising of people with distinct and varied connections (The Global Fund 2014). These connections can be based on shared experiences, history or background, health status, geographical location, living situations, religious or cultural beliefs, values, or identity (Mash *et al.* 2019). Communities are "*not necessarily territorial, as they can also include social groups united by activities or interests (such as savings or labour groups), and in a range of spaces (whether for example, international or virtual)*" (George *et al.* 2015). It can be deduced that a person can be a part of more than one community at any given time (The Global Fund 2014). The intersection of spaces which community members may occupy at any point means that communities are also governed by power relations. Communities can therefore be sites of social exclusion, where voices of those who are powerless are not heard or community empowerment, where power dynamics can be challenged (George *et al.* 2015).

In line with this understanding of communities, The Global Fund explains community systems to be "community-led structures and mechanisms used by communities through which community members and community-based organizations and groups interact, coordinate and deliver their responses to the challenges and needs affecting their communities" (The Global Fund 2014:1). Acknowledging that communities are equipped with; resources, networks, structures, and ways to address health issues, it is evident that they have the potential to play instrumental roles in promoting, maintaining, and improving health. When communities organise to take action to improve community health, they form community health systems (Machingura *et al.* 2011, Machingura *et al.* 2012, Van Ryneveld *et al.* 2020, Loewenson *et al*. 2021). In this way, they intersect with the national health system as they form the unit whose health outcomes are the focus of health systems goals as well as the social space that determines the success of health interventions (George *et al.* 2015).

Furthermore, although an effective health system is considered a core institution in any society, in many countries, health systems are collapsing and failing to meet the needs of populations (Sheikh *et al.* 2014, South and Phillips 2014) Consequently, this poor performance of health systems gives rise to serious and widespread human rights problems as the right to health is compromised (Meier *et al.* 2012). The progressive realisation of the right to the highest attainable standard of health is facilitated by an effective and integrated health system, which encompasses medical care and gives attention to addressing the underlying determinants of health (Meier *et al.* 2012). The health system should therefore also be responsive to national and local priorities, and accessible to all members of a population (Sheikh *et al.* 2014, South and Phillips 2014). Hence, building and strengthening integrated health systems will facilitate sustainable development, poverty reduction, economic prosperity, improved health for individuals and

populations, and ultimately, significantly contribute to the progressive realisation of the right to the highest attainable standard of health.

The right to health

Health and public health, viewed through the lenses of human rights can catalyse significant health policy gains (Meier *et al.* 2012). The World Health Organisation explains that human rights[2] are stipulations that ensure that all people can live with dignity, respect, agency, and autonomy to demand basic human needs (WHO and UNICEF 2018). The right to the highest attainable standard of health ("the right to health") is thus a fundamental human right (Hunt and Backman 2013). The right to health was first introduced in the WHO constitution (1946). Following this, international human rights treaties such as the Universal Declaration of Human Rights [UDHR], 1948; the International Covenant on Economic, Social and Cultural Rights [ICESCR], 1966; the International Covenant on Civil and Political Rights [ICCPR], 1966; The Alma Ata Declaration, 1978; and The Declaration of Astana, 2018 have recognised and concretised the right to the highest attainable standard of health. This follows The Vienna Declaration and Programme of Action, at the World Conference on Human Rights which declared that human rights are interrelated, indivisible, interdependent and universal(United Nations 1993) . Literature and practice have shown that the right to health is interrelated to, interdependent and indivisible from other social, economic, political civil and cultural rights (Leary 1994, Kinney 2000, Hunt 2016). Accordingly, the right to health as defined by the WHO goes beyond the right to be healthy, which a state cannot guarantee due to other biological predisposing factors or socio-economic conditions (beyond the control of the government) which may make certain individuals more prone to illness(London and Baldwin-Ragaven 2006), to include SDH.

Furthermore, in 2000 the UN Committee on Economic, Social and Cultural rights [CESCR) elaborated on the right to the highest attainable standard of health with General Comment (GC) 14[3]. The Comment unpacks the nature of the right to health and provides states with guiding criteria for its progressive realisation. Moreover, GC 14 establishes four elements: availability, accessibility, acceptability, and quality, which can be used to monitor the progressive realisation of the right to health through application to health care services, health facilities, goods, programs, and underlying determinants of health (Hunt and Backman 2008). Hence, considering the indivisible, interdependent nature of human rights, health interventions or programmes impact both health and human rights. Therefore, "complementary and indivisible approaches to advance human well-being" are essential in promoting the right to health (Vizard 2001).

In addition to the international standards, in Africa the right to health is recognised in regional human rights treaties which include: The African [Banjul] Charter on Human and Peoples' Rights, Article 16; The African Charter on the Rights and Welfare of the Child, Article 14; and The Maputo Protocol, Article 14.

[2] Human rights are stipulations based on obligatory laws that bind the state and its actors to act in ways to "*respect*": avoid interference with the right to health through a state's actions or lack thereof, "*protect*": limit the actions of third parties that may undermine the right to health, and "*fulfil*": take positive steps to achieve the right to health these rights for all its citizens (UN 1993). All human beings are entitled enjoy human rights by virtue of being human and on an equal, non-discriminatory basis. Human rights are interrelated, interdependent and indivisible (UN, 1993, CESCR, 2000, UN, 2013)

[3] Expert interpretation of the right to health contained in the ICESCR.

Similarly, in South Africa, The Bill of Rights makes provision for the right to health in several sections of the constitution. In their paper discussing the human rights obligations that health professionals have in health care, London and Baldwin (2006) clearly outline the sections of the South African constitution which make provision for health rights, as illustrated in Table 1.

Table 1 Health rights in the constitution of South Africa

Category	Provision: Right …	Section
Health care services	to have access to health care services, including reproductive health care to emergency health care	Section 27.1(a)
Underlying conditions needed for health	to access information 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 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 realisation of further education to have access to sufficient food and water to have access to social security	Article 32 Article 24 Article 12 Article 15 Article12.2(c) Article 26 Article 29 Article 27.1(b) Article 27.1(c)
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
Foundational rights affecting health	to dignity to equality (non-discrimination) to life to lawful, reasonable and procedurally fair administrative actions	Article 10 Article 9 Article 11 Article 33

Source: Author, drawing from Bill of Rights SA, 1996, London and Baldwin, 2006.

The provisions listed above, coupled with its signing of the ICESCR soon after democracy and the ensuing ratification of the covenant in 2015 show South Africa's recognition of the right to health and the importance of addressing underlying conditions which influence health or the realisation of the right to health. Furthermore, domesticating international human rights laws is an indication of the country's commitment to upholding human rights, specifically progressively realising the right to health.

The right to participation

In its interpretation of the right to health, General Comment 14 states that participation in health systems should include decision making at local, national, and international levels (CESCR 2000). This is to advocate for agency at the community level. To emphasise the importance of the principle of participation in health, the UN CESCR (2000) argues that, "A further important aspect is the improvement and furtherance of participation of the population in the provision of preventive and curative health services, such as the organization of the health sector, the insurance system and, in particular, participation in political decisions relating to the right to health taken at both the community and national levels". Furthermore, in the sections that discuss the development of national health strategies, the participation of the people to be served by those strategies is constantly called for (CESCR 2000). The stipulations in General Comment 14 point to the right of any individuals or groups to participate in any actions undertaken to promote and fulfil the right to health (CESCR 2000) .

The stipulations mentioned convincingly show that all individuals and communities are entitled to active and informed participation on issues concerning their health (Hunt and Backman, 2013). In the context of health systems, this includes participation in identifying overall strategy, policymaking, implementation, and accountability (Hunt and Backman 2013). Therefore participation is a fundamental right that features in health systems and an important tool to strengthen health systems (George *et al.* 2015). Consequently, understanding participation as a human right places an obligation on states to enable participation through various mechanisms (Haricharan and Learning Network 2012).

In addition to the human rights perspective, participation can also be understood through the lens of the Primary Health Care approach (PHC). The latter approach is guided by health systems reforms of WHO member states. In its fourth and seventh article, The Alma Ata Declaration on Primary Health Care (PHC) points to the responsibility of governments for the health of its citizens and advocates the right of people to be involved in the planning and implementation of their own health care to facilitate participation in decisions relating to their health and equity in health (WHO 1978). This declaration has recently been followed by the Declaration of Astana (2018) which reiterates the importance of involving communities in matters that affect their health and focusing on underlying determinants of health (World Health Organization (WHO) & United Nations Children Fund (UNICEF), 2018). Community participation as a principle for PHC therefore places emphasis on the necessity of collective action to provide health for all, however, this principle can manifest in different forms.

Forms of community participation

Community participation is expected to result in; better governance of the health system, amplified community voices, empowerment of marginalised groups, service providers and policy makers becoming more responsive to demands made by citizens, curb corruption, and improved health outcomes (Maluka and Bukagile 2016). These health outcomes include; improved quality of care, delivery of appropriate health services for the population, citizens, and patient satisfaction (Maluka and Bukagile 2016, (WHO 1978, Cornwall and Gaventa 2000, WHO 2008) This is due to the needs and voice of the communities being served being considered when mapping out and implementing health strategies.

Several articles in a systematic literature review convincingly argue that community participation in health can take on various forms (McCoy *et al.* 2012). Drawing on Pretty's (1995) theory of participation, they highlight that participation can be manipulative, passive, consultative, incentivised, practical, or functional or through self-mobilisation where community members get together through their own initiative to address the needs of their community (McCoy *et al.* 2012). This theory builds on the Arnstein's seminal work on community participation theory.

Arnstein (1969) conceptualises participation as the power that citizens or communities have. To explain this, Arnstein (1969) developed an eight-step ladder depicting the different forms of citizen participation. On this ladder, each step up signifies an increase in the power and control people have in decision making processes which impact their lives (Arnstein 1969). The eight steps are further organised into three categories: "Nonparticipation", "Tokenism" and "Citizen Power" (Arnstein 1969). The first two steps "Manipulation" and "Therapy" are classified under nonparticipation (Arnstein 1969). At these lower and unmeaningful degrees of participation authorities manipulate communities into cooperating with them and buying into their decisions. There is no allowance for the community's voice to be heard. Maluka and Bukagile, (2016) convincingly build on this notion by highlighting that in so doing the authorities control any pressure to be accountable that may come from citizens. Tokenism is characterised by "Informing", "Consultation" and "Placation" (Arnstein 1969).

At these levels of engagement citizens are informed about the decisions the authorities have made and may be consulted. However, the participation is not meaningful as there is no guarantee that the authorities who hold the power will heed the people's views (Arnstein 1969). The next category which Arnstein (1969) terms "Citizen Power" encapsulates "Partnership", "Delegated Power" and "Citizen Control" (Arnstein 1969). Partnership is a step towards what Arnstein (1969) considers meaningful participation. At this step, authorities and community members come to an agreement about how to work together in the planning and decision-making processes (Arnstein 1969). Following this, the next step towards meaningful participation is delegated power (Arnstein 1969). Here, citizens have power and they exercise it in making decisions on health plans, programmes or strategies (Arnstein 1969).

Citizen control is at the top of the ladder. At this level which is considered meaningful participation, citizens exercise their decision-making power and control over a health programme, structure, or institution (Arnstein, 1969; Maluka & Bukagile, 2016). Similarly, (Hunt and Backman, 2013) affirms this conceptualisation of meaningful community participation by arguing that for members of a community to participate meaningfully in facilitating their health and well-being power should be shared between them and health authorities. This notion is further supported by George et al. (2015) who point out that the degree of control over an initiative or power that a community commands in a program is a defining factor when examining community participation.

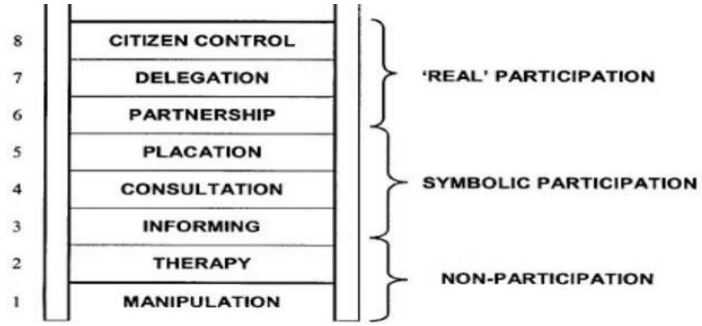

Figure 1 *Arnstein's Ladder of Community Participation*

Source: Arnstein, 1969: 217

Furthermore, participation can be distinguished as either formal or informal (McCoy *et al.* 2012). Informal forms of community participation often arise out of the community (Williams 2006) through self-mobilisation as explained by Pretty (1995) or emerge from social movements (Brown *et al.* 2004). In contrast, formal modes of participation are those established by laws and official policies (McCoy *et al.* 2012). These can be structures within the health system, or they can be groups such as community health workers or community change agents which operate through NGOs, CBOs or CSOs (Rifkin 2009, Glattstein-Young and London 2010, McCoy *et al.* 2012). Other mechanisms for community participation include dialogues and fora at the national level which bring different stakeholders together for decision-making and health system accountability processes, as seen with Brazil's health councils (George *et al.* 2015). In addition, in low- and middle-income countries a predominant mechanism for community participation is health facility committees (HFCs) or health committees (HCs) (McCoy *et al.* 2012). Similarly, in their study to assess meaningful levels of participation in health systems, McCoy, Hall and Ridge, (2012) report that most countries in East and Southern Africa have HCs as a mechanism for community participation.

These vehicles of community participation make provision for the representation of the community (McCoy *et al*. 2012). However, they do note that only three out of the 16 countries they assessed have laws on these structures of community participation (Loewenson and Rusike 2004). This goes to show that although there is consensus on the value and benefits of HCs as vehicles for community participation, their effectiveness may be limited by the lack of legislation to support their establishment. Furthermore, While some researchers convincingly argue that having HCs as vehicles for community participation results in the amplified voice of communities and ultimately contributes to achieving better health outcomes, some studies have found that action taken to facilitate community participation, through HCs, does not always yield meaningful community participation in practice (Loewenson and Rusike 2004, Padarath and Friedman 2008, Goodman *et al.* 2011, Kamuzora *et al.* 2013, Waweru *et al.* 2013, George *et al.* 2015, Kilewo and Frumence 2015, Maluka and Bukagile, 2016, Karuga *et al.* 2019).

Several studies report that levels of meaningful participation of community members are often limited by the unwillingness of local authorities to share the decision-making power with selected community members who may be serving the community in various community structures that make up community (Loewenson and Rusike 2004, Padarath and Friedman 2008, Goodman *et al.* 2011, Kamuzora *et al.* 2013, Waweru *et al.* 2013, George *et al.* 2015, Kilewo and Frumence 2015, Maluka and Bukagile 2016, Karuga *et al.* 2019). This also highlights how a SDH such as the distribution of opportunities can affect community

participation (Loewenson and Rusike 2004, Padarath and Friedman 2008, Goodman *et al.* 2011, Kamuzora *et al.* 2013, Waweru *et al.* 2013, George *et al.* 2015, Kilewo and Frumence 2015, Maluka and Bukagile 2016, Karuga *et al.* 2019). Ultimately, this compromises the realisation of the right to health which The International Covenant on Economic, Social and Cultural Rights (ICESCR) comprehensively articulates as, the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (Ssenyonjo 2017).

Degree of community participation

Several studies report that the unwillingness to share decision-making power with HCs stems from a lack of trust in their capabilities and strained relationships between the local authorities and the HC members (Goodman *et al.* 2011, Kamuzora *et al.* 2013, Waweru *et al.* 2013). There is often poor communication between them, constant contestations of power, and the underrepresentation of the vulnerable and marginalised groups in decision-making bodies which results in an inability to fully engage HC members and to tap into their potential (Padarath and Friedman 2008, Kilewo and Frumence 2015, Maluka and Bukagile 2016, Mulumba *et al.* 2018, Karuga *et al.* 2019). Consequently, when the voices of the community are excluded from the decision-making spaces, the social factors that impact their health and wellbeing are not prioritised (George *et al.* 2015).

On the other hand, Lawn *et al.* (2008) and Rifkin (2009) convincingly argue that various community structures, organisations and networks have close links with communities and, therefore, better understand the social issues that their communities are grappling with and the different health challenges experienced by community members. Health committees (HCs) and the community networks formed by community health activists (CHAs) are often embedded in the community, therefore, better understand the issues facing those that are most affected by different health challenges (Lawn *et al.* 2008, Rifkin 2009, George *et al.* 2015). As a result, they have a unique ability and responsibility to identify, understand and respond to the needs of those who are marginalized and vulnerable in societies and those who experience inequitable access to health, other basic services and social factors that have an impact on health outcomes (Loewenson and Rusike 2004, George *et al.* 2015). To support this assertion, previous research on human rights-based approaches to improving population health outcomes has shown that even in settings with resource constraints, community participation through empowering HCs can advance the right to health (Glattstein-Young and London 2010, McCoy *et al.* 2012, Hunt and Backman 2013, George *et al.* 2015). To maximise on the close links that the HCs and CHAs have with communities in working to address social determinants of health, it is important for them to operate in collaboration with local government authorities, civil society organisations, research institutions and other local community groups (Maluka and Bukagile 2016). The appreciation of this unique ability held by HCs has resulted in growing and increasing efforts to strengthen them.

Gaps in the literature and justification for study

This review has shown that there is copious literature on the policies and legal frameworks with provision for the right to health and the right to community participation as well as stipulating the establishment of HCs, the factors influencing their effectiveness and functioning and recommendations on how to build the capacity of these bodies. Conversely, there is a dearth of research and literature on efforts to build and strengthen the capacity of HCs to lead health improvement efforts in South Africa. Furthermore, not much

is known about CHAs and the work that they are doing in their communities. Previous research on HCs in South Africa revealed that a lack of a clear mandate and adequate training was crippling HCs and undermining their potential as vehicles of community participation (Haricharan 2013, Mulumba *et al.* 2018). These studies also revealed that civil society networks can lobby authorities and make strong claims to rights entitlements (Haricharan 2013, Mulumba *et al.* 2018). In addition, it was revealed that for HCs to effectively assume their role of giving the community a voice and for them to effectively respond to the communities' needs, they must take on initiatives to address and respond to the social determinants of health most relevant to the community they serve (Haricharan 2013). However, in the South African context, following these findings not much research has been done to reveal what has followed the efforts to build the capacity of HCs and community members actively involved in addressing community health needs as well as doing work to contribute to the well-being of the community.

Furthermore, the studies reviewed show that most of the research has focused on HCs interfacing health facilities. Not much has been written with a focus on the interface between HCs and community members involved in addressing health needs in the community. Bearing this in mind, this study therefore seeks to evaluate the successes and challenges of the training of health committee members and CHAs through the CSS for Health Project. It seeks to assess how the training has influenced the thinking, understanding and practice of health committee members and CHAs when addressing social determinants of health in their community. In so doing, it will investigate whether and how the HC members and CHAs have assumed an activist role in the community, and if they are engaging in meaningful community participation, thereby contributing to the progressive realisation of the right to health and the right to participation.

Study Setting

As a result of these findings, the University of Cape Town (UCT) Health and Human Rights programme, in collaboration with two civil society organisations (CSOs) in the Western Cape: Training for Transition and Women on Farms, launched the Community Systems Strengthening for Health project (CSS for Health, 2016). This intervention was implemented to build the capacity of health committee members and CHAs to address and respond to social determinants of health, in three under resourced[4] areas in the Western Cape province of South Africa: Belhar, Gugulethu and Klapmuts. Through this project, health committee members and CHAs received training in child protection, health promotion, food and nutrition and peace building as these were identified as the predominant social determinants of health in these under-resourced communities. To identify these, a baseline study consisting of a household survey, key informant interviews and abstraction of routine surveillance data recorded by public service organisations was conducted. The baseline assessment reported that the communities were characterised by high unemployment with 69% of the 600 Households surveyed receiving at least one grant, there were significant cases of High Blood Pressure and Diabetes across sites, there was good child clinic attendance but various concerns of child neglect. The findings also showed that households in these communities experienced regular daily to monthly hunger and limited access to food parcels. The responses from the baseline study also revealed perceptions of neighbourhoods as unsafe. Following these findings, one of the recommendations of the baseline assessment was to train health committee members and CHAs in

[4] Characterised by low socio-economic status and poor access to health services.

health promotion, child protection, peace building, and food and nutrition. The rationale is that empowering health committee members and CHAs with adequate information, the practical knowledge and skills to address social determinants of health, leadership skills, networks with established NGOs and partnerships and linkages with local government, will equip them to support and lead community members in taking ownership and responsibility for their own health.

It has also been highlighted that one of way of addressing social determinants of health to improve health outcomes is through tapping into the available and existing community resources by strengthening the capacity of HCs, and other community structures (Glattstein-Young 2010, Machingura *et al.* 2011, Machingura, Loewenson et al. 2012, Haricharan *et al.* 2021). This can be done by equipping them with the information, skills, and practical knowledge to meaningfully contribute to the welfare and wellbeing of the communities they serve. Previous studies cited in this literature review have pointed out the benefits of HCs as vehicles for community participation, the contextual factors that influence their functioning and the challenges they experience in their operations (Goodman *et al.* 2011, Kamuzora *et al.* 2013, Waweru *et al.* 2013, George *et al.* 2015). However, in the South African context, not much is known about what has happened following the implementation of the CSS for Health Project and about CHAs. The question that this study seeks to address is "**Has the Community Systems Strengthening (CSS) for Health Project training influenced the work of health committee (HC) members and community health activists (CHAs) to address the social determinants of health and, if so, how?"**

Aims

This study aims to evaluate the successes and challenges of the training of health committee members and CHAs through the CSS for Health Project. It seeks to assess how the training has influenced the thinking, understanding and practice of health committee members and CHAs when addressing social determinants of health in their community. In so doing, it will investigate whether and how the health committee members and CHAs have assumed an activist role in the community and are engaging in meaningful community participation. In addition, the study seeks to generate evidence to inform decision making in adapting the intervention to other sites, locally and regionally. It is hoped that documenting the results, the gains, and the challenges that the training activities have yielded will reinforce the health committee members and CHAs' efforts and encourage them to keep channelling their energy to efforts that contribute to the advancement of the community's health. Ultimately, this will also generate evidence which can also be used to shape policy that supports community participation, the progressive realisation of the health rights of the poor and marginalised and facilitates social justice.

Objectives

The aims of this study will be achieved through the following objectives:

- Describing the training of health committee members and CHAs.
- Exploring the health committee members' and CHAs' perceptions and experiences of the training
- Describing and exploring the activities and outcomes achieved because of training in the CSS for Health project.
- Exploring the role of health committee members in providing a supportive or leadership role in addressing social determinants of health in their community.
- Exploring the challenges perceived and experienced with the training and its implementation.

Methodology

This study is based on a larger intervention, the Community Systems Strengthening (CSS) for Health Project. A description of the intervention is provided in Box 2 below, followed by a logical framework model (Figure 1) which gives an overview of the interventions activities and anticipated results.

BOX 1: Mini thesis as part of larger participatory study

This mixed methods evaluative study is a sub study of a larger participatory intervention (the CSS for Health Project as described in **Box 2**).

It will be describing and exploring the implementation phase of the CSS for Health intervention. The CSS for Health project was implemented in three stages. The first phase was the training where participants attended workshops and project events that would facilitate the acquisition of new knowledge on social determinants of health and skills to address these in their community. The subsequent implementation phase entailed participants using the knowledge and skills they had acquired from the training to do the work they are involved in in their communities and to start up initiatives to address social determinants of health. The last phase was the mentoring phase. At this stage of the project, participants who had iniatives running in their respective communities had regular group meetings, faciliatated by the project coordinator, where they shared their positive and negative experiences and exchanged ideas.

This thesis is therefore embedded within and will draw on the broader study materials, including project reports, baseline surveys, colloquium reports, workshop reports, project summary documents, other theses, and meeting minutes.

It will also rely on the trust and relationships already established with the key stakeholders, as they are the gatekeepers of the study site.

Box 2: The Community System Strengthening for Health Project in the Western Cape of South Africa

The CSS for Health project is a joint participatory intervention being conducted by the UCT Health and Human Rights Programme in collaboration with Training for Transition, Women on Farms which are CSOs in the Western Cape in South Africa; Health Committees (HC) in Belhar and Gugulethu, under the Cape Metro Healthcare Forum, and Health Monitors in Klapmuts. The intervention was implemented to strengthen existing community networks and organizations to address social determinants of health in three sites: Belhar, Gugulethu and Klapmuts[5] .The capacity of these community networks will be developed with HCs providing a leadership role. HCs, also referred to as Clinic Committees or Health Facility Committees were established by law in the National Health Act No. 61 of 2003. According to the NHA (Department of Health 2004), every primary level care facility should have a HC which should be comprised of the facility manager, one or more local government councillors and some community members (Health 2004) These bodies should be accountable to the communities they serve, ensure the efficient delivery of services, and serve as a link between the health facility and the community (McCoy *et al.* 2012)**.**

[5] These sites are under resourced communities that continue to experience health inequities, following the apartheid regime which was characterised by a system of political, economic, and social structures that worked to serve the interests of the white minority (Coovadia *et al.* 2009). The members of the South African population that live in these communities are still vulnerable because of the structural inequalities of the apartheid regime (Coovadia *et al.* 2009, Learning Network 2018). Poverty and inequality remain as legacies of apartheid social engineering, and government is still unable to provide most of the community members with effective services (Coovadia *et al.* 2009, Learning Network 2018).

The CSS for Health project intends to develop the agency of the HC members and CHAs in the under-resourced communities by implementing activities that develop their capacity for advocacy and community-based action to address the social factors that impact the health of the people that live in these areas (Learning Network 2016). Through community activities, training to strengthen leadership skills, networking skills, communication skills and rights literacy, and mentoring, the intervention seeks to strengthen the capacity of HC members and CHAs to engage in action that makes them part of the solution to the issues the communities are facing. This is being done through facilitating improved awareness of health issues and how to prevent them and devising practical ways of rendering services or solutions, with a focus on peace building, access to food and nutrition, child protection and health education and promotion (Learning Network 2016). Additionally, the training is intended to strengthen the HC members to provide leadership at community level (Learning Network 2016).

According to Rossi *et al.* (2004), the ultimate success of any programme, project or intervention is contingent on its design and the plausibility of its underlying logic. Figure 2 below shows the logic model of the CSS for Health project:

Inputs	Activities	Outputs	Outcomes	Impacts
Staff: UCT, TFT, WFP	Basic **training** related to: - Child protection - Nutrition - Peace building - Health education - in Gugulethu (Belhar & Klapmuts) - Mentoring - Additional training - Gugulethu HC in process of implementing basic training, weekly interaction with trainer	- Early Childhood Centres supported to comply with child safety regulations (peace building) - 30 peacebuilders trained - Food gardens started (Nutrition; Belhar) - Number of community (health) activists involved in monitoring services (3 pilot communities) - 45 health educators trained - 29 family/food and nutrition supporters graduated - No intervention (29 participants received basic training, 3 started their own food gardens)	- Development of strong links with neighbourhood watch groups (peace building) - Number of community health activists taking part in actions to address social determinants of health - 6 ECDs supported - 86 more children attending ECDs.	- Safer environments. - Improved access to health and social services for the poor and marginalized in 3 pilot communities in the Western Cape - Community members actively lead and undertake advocacy actions - Health committees and health activists actively taking part in actions to address social determinants of health.
Staff: UCT, TFT, WFP Various stakeholders: DoH, Min of Health - WC	Number of: - Community advocacy actions participated in - Community dialogues addressing health and social determinants of health organised - National colloquium of HCs participated in 1 provincial dialogue of health organised by Minister of Health – WC	- Number of community health activists who participated - 20 participants are attending an adult education program at UCT following an intensive selection process - 9 Provinces and DOH represented at Colloquium of HCs	- Establishment of important networks with national and provincial health dept. at national colloquium - Collaboration with Dept. of Social Dev less successful	- Strengthened coordination of services through community leadership, networks, partnerships and linkages with local government.
Staff: UCT, TfT, WFP	Training - content and skills, leadership and adult learning, capacity building	Community dialogues to discuss social determinants of health, health activism, health committees, project experiences and lessons reached, with wide range of policy makers, CSO and public officials Active chronic illness club supported by 4 HC members. 5 Individual HC members are active in doing home visits Gugulethu has a functioning chronic club, 4 trained HC members monitor services at 2 clinics	The extent of child abuse and teenage pregnancy, women's reproductive health, domestic and community violence, poverty and hunger and coping with chronic illnesses	Improved governance and access to health and social services for the disadvantaged and marginalised.

Figure 2 CSS for Health Project Logic Model Framework for Gugulethu (Mort *et al.* 2019)

This study is a mixed methods evaluative study in six phases which will evaluate the successes and challenges of the training of health committee members and CHAs through the CSS for Health Project.

Figure 3 below shows the two phases and four sub- phases of the evaluative study, and a detailed explanation of each phase follows.

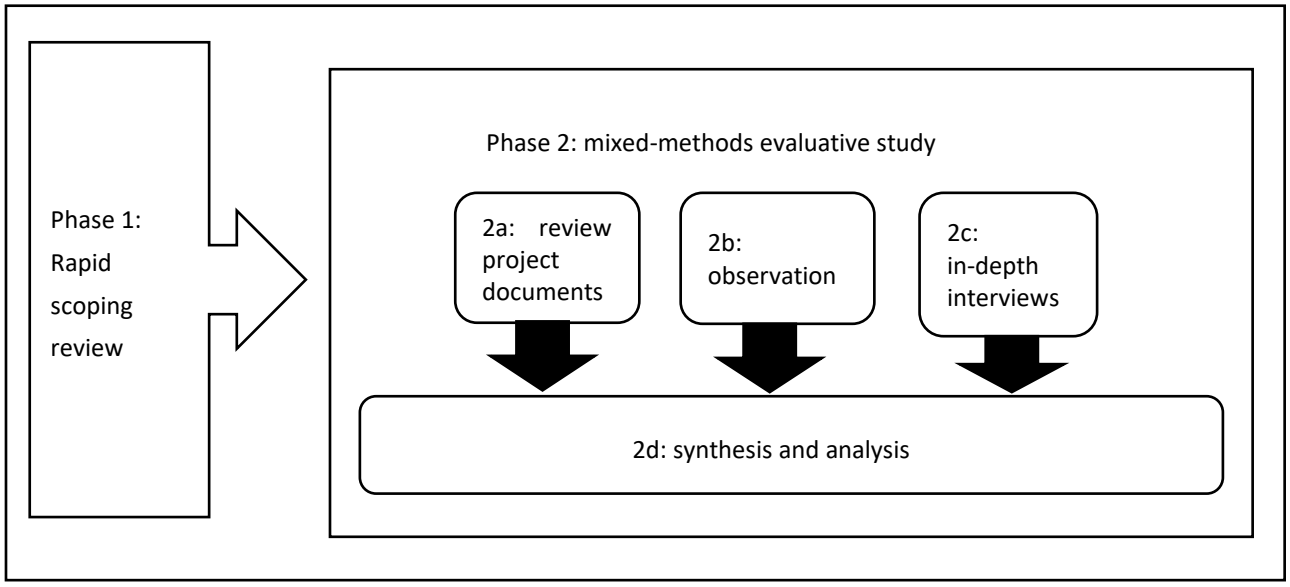

Figure 3 Mixed methods evaluative study in six phases

As shown in Figure 3 above, a rapid scoping review will be conducted first. While the protocol is being considered for ethics approval, phases 2a and 2b will be undertaken. After obtaining ethics approval, phases 2a, 2b, and 2c will take place simultaneously in an iterative process. The data to be analysed in phase 2d will be generated in these phases.

Phase 1: Rapid scoping review

As this is an evaluative study, a rapid scoping review will be useful for the systematic mapping of the literature available on the advocacy and activist roles of HCs and CHAs and building their capacity (Arksey and O'Malley 2005). It will also allow the researcher to identify key concepts, theories, sources of evidence, and the gaps that exist in research (Arksey and O'Malley 2005). The rapid scoping review will be focused on understanding the advocacy and activist roles of HCs and CHAs in the context of low- and middle-income countries (LMICs) as well as in a South African Context. It will therefore assist in the identification of search terms for the literature review, which will point out the roles, factors influencing the roles of health committee members and CHAs, and the themes that will be used to assess whether the capacity development of the health committee members and the CHAs trained through the CSS for Health project has led to meaningful community participation and the assumption of an activist role in the community.

Objectives of the literature review

The objectives of this literature review are:

- To describe community systems and how they fit into the overall health system.
- To describe international, regional, and national stipulations for the right to health and the right to participation.

- To review literature on health committees as structures for community participation.
- To highlight the gap in literature on efforts to build and strengthen the capacity of health committee members to be at the forefront of health improvement initiatives in South Africa health activism and the empowerment of health activists.
- To highlight the gap in literature on the benefits and challenges following an intervention to build the capacity of community members to address social determinants of health.

Literature search strategy

A scoping review was conducted to identify key words to be used to search the literature for work relevant to community participation. The data bases that were searched include PubMed/Medline, Africa-Wide Information and CINAHL on EBSCOhost, Scopus, Google, Google Scholar and PRIMO. Following this, the reference lists of publications relevant to the study were searched. The World Health Organisation's website was searched for policy statements and conference papers relevant to the study and the researcher manually searched or review articles online.

The following search terms were used for the literature search: "community systems strengthening", OR "capacity strengthening", OR "capacity building", OR "community participation", AND "health committee" OR "health facility committee", "clinic committee" AND "community members" or "community change agents".

Inclusion and exclusion criteria

During the literature search, there were no date restrictions. Publications were restricted to those situated in low- and middle-income countries. This was done to ensure that the context of the literature is relevant to where this study is situated. Publications in a language other than English were excluded as these could not be translated.

Phase 2: Mixed methods evaluative study

A convergence mixed methods design will be used. This type of design will allow for different but complementary data to be collected on the training. Project documents will be reviewed to gather descriptive numbers on the number of trainees and the number of initiatives that have been supported and started in the implementation stage, following the training in Gugulethu. Concurrent with this quantitative data collection, qualitative data will be collected through review of project documents, observation, and in-depth interviews (IDIs) which will explore the perceptions and experiences of the health committee members, CHAs, CSS for Health Project team and partner local service providers involved in the training in Gugulethu. As this is an evaluative study, a convergence mixed methods approach will allow the comparison, validation, and corroboration of findings.

Phase 2a: Review of project documentation

Some existing project documents: baseline surveys, project information, colloquium reports, workshop reports, project summary documents will be assessed to examine what has been written and the quantitative data available on the CSS for Health project to date. In reviewing the project documents, the researcher will be looking out for the reported successes, adaptations, and failures of the intervention. The researcher will also use written reports about an activity to probe the opinions of informants. The project documents will therefore provide quantitative and qualitative data that will be synthesised and

triangulated with the primary data that will be collected, to describe and explore the activities and outcomes achieved because of training in the CSS for Health project. The review of existing project documents will also serve to give context of the intervention. A list of the project documents available for review is given in Table 2 below**.**

Table 2 List of available project documents

Title of Project document	**Availability**	**Information contained**
Proposal: Baseline Assessment of factors affecting the Social Determinants of Health in three Communities in Cape Town	have	Proposal to conduct a study of the overview of the social factors affecting the health of community members in 3 sites: Belhar, Gugulethu and Klapmuts, and to report the health status of the people living in these communities before the implementation of the CSS for Health intervention. The Log frame of the CSS for Health project.
Report: Documenting lessons learned from the Training and Capacity Building activities of the Community System Strengthening (CSS) Project activities implemented in Belhar, Gugulethu and Klapmuts (February 2018 – June 2018) Community System Strengthening (CSS) Documenting Lessons learned from the training and capacity building activities – Interview guide *Community System Strengthening (CSS) Documenting lessons learned from the training and capacity building activities* - Methodology	Have	A report documenting how the trainees and facilitators experienced the training activities of the CSS for Health project – the extent to which the project was aligned to its intentions (Process Evaluation). The questions asked (interview guide) when conducting the study to investigate how the trainees and facilitators experienced the training activities of the CSS for Health project – the extent to which the project was aligned to its intentions The methods used when conducting the study to investigate how the trainees and facilitators experienced the training activities of the CSS for Health project – the extent to which the project was aligned to its intentions
Log frame of the Community Systems Strengthening for Health Project	Have	The logical framework of the CSS for Health project showing the indicators, baseline figures, targets, assumptions, inputs, activities outputs, outcomes, and impacts of the CSS for Health project.
Community Systems Strengthening for Health Project Interim Narrative Report **(1 June 2017 – 25 May 2018)**	Have	Assessment of the implementation of project activities.
Socio-Economic Justice for All – CSO Support Programme **Grant Application Form**	Have	Rationale and aims of the CSS for Health project written for funders. The initial proposal for the intervention.
Community Systems for Health Programme: Gugulethu Community Mapping.	Have	Background information on the community, population statistics, community challenges and existing community networks.
Meeting minutes	Need to request	Meeting minutes show the discussion points of the project. They will indicate the updated information with regards to the progress of the project and the views, thoughts, opinions of some of the stakeholders. They will also show the voices directing the project.
Community Systems Strengthening for Health Project Quarterly Reports	Have; available online	Quarterly reports outline the project activities and outcomes within a quarterly period. They will show the number of participants attending project activities, the activities which have taken place and the initiatives established within a period of about three to four months.

Phase 2b: Observation

The researcher will observe project public events, relationships amongst stakeholders during project public events and meetings, the non-verbal cues of participants during the in-depth interviews, the interview setting, and the nuances of the interviewer and interviewee relationship. These observations will be recorded in a field note diary. Furthermore, formal, and informal communication and ideas will also be recorded in the field note diary. This will provide an audit trail and improve rigor through data triangulation. Observational data will permit the researcher to understand the project to an extent beyond what is possible using insights of others, from IDIs and FGDs (Gliner 1994, Adami and Kiger 2005). Furthermore, it will provide the researcher with a greater understanding of the context and how the intervention is conducted (Royse *et al.* 2010). Information obtained via observations will allow a broad understanding of how the intervention has kept to the planned course, and provide insight into the operations of the training of the CSS for Health Project (Cresswell *et al.* 2013). Observations of project public events and meetings will be participative in nature to facilitate gaining the trust of gatekeepers and participants, and access and acceptance into the community to take field notes. Descriptive and reflective notes about the project activities that the researcher attends will be taken. The researcher will prepare her notes as soon as possible after the observation, providing a "rich narrative description of the people and events under observation" (Cresswell *et al.* 2013).

Phase 2c: in-depth interviews with 12-15 stakeholders

In-depth interviews (IDIs) will be conducted. Between eight and twelve IDIs lasting forty-five minutes to an hour will be conducted with the stakeholders that the researcher has access to: health committee members, CHAs, project manager, project administrator, Gugulethu trainer, project coordinator, City of Cape Town health personnel and members of local CBOs, NPOs and NGOs. The IDIs will be held at a local community hall in Gugulethu. They are particularly useful for probing those participants who are unable to comfortably express their views and share their experiences in a group setting (Petty *et al.* 2012). They are also useful when it is challenging to get busy people with conflicting schedules to find a common time to meet and have a discussion. In this case, it will be difficult to get local service providers from different organisations into one room at the same time, therefore interviews will be scheduled at a time most convenient for each person. IDIs help to explore new information from the participants' points of view (Petty *et al.* 2012) . In this study, they will serve to as a tool to explore the meaning, opinions, understanding, and experiences that exist within the group of stakeholders.

Every participant will be asked to give informed consent. Participants will be briefed on what the research entails, including the possible risks and the benefits of taking part in the study. Participants will be given an opportunity to ask the researcher to clarify any information given. After reading and understanding the consent form and information sheet, each willing responded will be asked to sign a consent form before the interview begins. Gugulethu community members are predominantly *Xhosa*-speaking, and some participants may have been trained in Xhosa and might want to freely express their views in their mother tongue. All potential participants will be asked if they prefer to use English or Xhosa, to maximise their capacity to consent to participating in the IDIs. If a participant chooses to communicate using Xhosa, a trained *Xhosa*-speaking research assistant will be asked to obtain consent and conduct the interview as the researcher is not a *Xhosa* speaker. The interviews will be conducted until the researcher reaches data saturation (Royse *et al.* 2010). Throughout the data collection process, an interview guide will be used to

prompt the researcher and keep track of the relevant questions (Petty *et al.* 2012). Refer to Appendices, Appendix B. The interviews will be audio-recorded and later transcribed for analysis. The transcripts of the interviews conducted in *Xhosa* will be translated into English.

Table 3 In-depth interview participants

Interview participants	n	Inclusion criteria	Exclusion criteria
Health committee (HC) member	4	Stays in Gugulethu. Is part of a community network or CBO. Has participated in CSS for Health project activities.	Did not take part in the CSS for Health project activities. Stays outside Gugulethu.
Community health activist (CHA)	4: 1 from each domain of training	Stays in Gugulethu. Non-HC member. Has participated in CSS for Health project activities.	Did not take part in the CSS for Health project activities. Stays outside Gugulethu.
Project manager, project administrator, trainer, project coordinator	4	Works on the CSS for Health project. Has been involved in the operations of the project activities.	Not familiar with the CSS for Health project. Unfamiliar with the Gugulethu context.
Local service provider: members of CBOs and NGOs, City of Cape Town health personnel	4	Works in Gugulethu. Has knowledge of the CSS for Health project. Has been involved in CSS for Health project activities.	Not familiar with the CSS for Health project. Unfamiliar with the Gugulethu context.

Phase 2d: Synthesis and analysis

To analyse the quantitative data, descriptive numbers and descriptive statistics will be calculated in Microsoft EXCEL. Baseline figures of participants, activities related to training and initiatives will be compared to related figures recorded in project documents. These descriptive figures will then be merged, triangulated, and corroborated with the qualitative findings. The qualitative data will be analysed using thematic analysis. Themes will be coded from particular examples in the data to general themes (Braun and Clarke 2006). These themes will be based on what was done in the CSS for Health training, how the trainees experienced the training, how it was implemented, what worked well and what was challenging in implementing was gained from the training. These themes will be coded when the researcher immerses herself in all the data collected through phases 1 and 2 to synthesise it and familiarise herself with the data. The codes will then be organised into main themes and sub-themes. Following this, they will be refined into final themes that will be included in the final report (Braun and Clarke 2006). The analysis process will be iterative (Braun and Clarke 2006). Thematic analysis helps the researcher to draw out meaning as well as underlying themes that reveal the latent factors and preconceptions that shape people's views (Braun and Clarke, 2006). According to Mark *et al.* (2005), thematic analysis is most suitable for analysing data that have been transcribed from in-depth interviews and documents. Thematic analysis is therefore best suited for this evaluative study and the data collection methods that will be used (Mark *et al.* 2005). NVivo 12 software will be used to manage the coding of the data, development of the themes and to relate the themes (Bazeley and Jackson 2013). In addition, a trail of all the documents reviewed, notes written during observation, the interview transcripts and notes of the analysis process will be kept in a secure drawer to keep an audit trail. This will facilitate the easy tracing of analytic decisions and interpretations of the raw data.

Study population and setting

Gugulethu is the site on which the fieldwork will be undertaken for the purposes of this study. Gugulethu is a township that was established in 1958 when many Indian, Coloured and Black people who stayed in suburban areas were relocated to new areas further away from the low-density areas (Learning Network, 2017). The population of the township is predominantly black African, and it is located on the Cape Flats 18km south-east of Cape Town in the Western Cape Province (Learning Network, 2017). The history under which the township was established has resulted in the residents being plagued by the following challenges: child abuse, neglect, and death; domestic violence; abuse of the elderly; killing of women by their partners; poverty and unemployment; orphans of HIV and AIDS resulting in 8-year-olds attending ARV clinics on their own; alcohol and drug abuse; poor adherence to chronic treatment, and hunger and poor nutrition (Learning Network, 2017). The study will include some stakeholders of the intervention. These are members of the Gugulethu community that serve as community health activists, project administrators and local service providers that are involved with the CSS for health project. The group of stakeholders comprises of a mix of the youth and the elderly members of the community. Out of the three sites in which the CSS for health intervention has been implemented, Gugulethu has been chosen as the site for the evaluative study as it is the site where more initiatives in the implementation phase following the training.

Sampling and recruitment

For this qualitative evaluative study, purposive sampling will be used to recruit the participants that will be interviewed. The approach to this study will be explorative, therefore, the purpose is not to generalise the results found to the whole population but to focus on a specific group of people. This allows for the exploration of the targeted groups perceptions and experiences. As put forward by Shaheen and Pradhan (2019), when conducting qualitative research, sampling is used to gather information from groups or subgroups of interest in a population. To support the purposes of this study, the participants will be recruited through purposive sampling as the researcher is interested in a specific group (Shaheen and Pradhan 2019). The researcher will purposively select the stakeholders in Gugulethu who have participated in the CSS for health project activities and indicate their willingness to participate in the in-depth interviews.

Data safety and management

To uphold the responsibility and obligation to protect the participants' privacy, the researcher will keep all the audio recordings and written notes obtained from the study in a secure and protected cabinet. Softcopy data will be encrypted and stored on the researcher's personal computer and Dropbox. To maintain confidentiality, only the researcher and academic supervisors will have access to the data collected. The researcher's academic supervisors and CSS project manager will guide the write-up of the study findings. As the data is for an existing CSS project that will potentially be used as a model for strengthening community systems to address social determinants of health, the project manager will decide for how long the data will kept. It will not be destroyed as soon as the write-up of this evaluative study is completed because the project will be on course until the end of 2019 and the raw data may be useful for other evaluations and reports on the project. To ensure the confidentiality of the participants throughout this duration, pseudonyms will be used to protect the personal identities of participants.

Ethical Considerations

This study will be undertaken in ways which do not impede or compromise the well-being of the participants. The researcher will take full responsibility to ensure that the participants are not harmed in any way at all stages and phases of the research process. In line with protecting the safety and wellbeing of the participants, for *Phase 2c* of the study the following ethical considerations apply: each participant will be given information about the purpose of the study, the potential risks, and benefits of participating. The researcher will read the information sheet and explain the study to the participant. Subsequently, participants will be asked to read the information sheet and the consent form, refer to Appendix A, and will be given an opportunity to ask questions for clarity. This is to ensure that the participant has fully understood the information provided and what is stated on the consent form. Respondents will be allowed to participate after giving their full consent. It will be made clear that involvement in this study is voluntary and one can withdraw from the study at any stage without any consequences. Participants will be notified that the transport costs for them to come to the venue where the interview will be taking place will be covered.

Privacy and Confidentiality

Berg (2001) states that confidentiality is a conscious attempt to remove any pointers that might reveal the identity of research subjects. Therefore, to maintain confidentiality during this research process, pseudonyms will be used to maintain the participants' anonymity (Berg 2001). All the information attained from project documents and information obtained through IDIs will remain private and confidential therefore no information will be shared with other participants or members of the university. To protect the privacy of the participants, all hardcopy data obtained from undertaking the study, including audio recordings and written notes, will be secured in a protected cabinet. Softcopy data will be saved on the researcher's personal computer and Dropbox. The researcher's academic supervisor and co-supervisor are the only other members of the research team with access to the Dropbox. Electronic data will be stored on devices protected by strong passwords. The primary researcher, supervisor, and co-supervisor, who are directly involved with the research, are the members of the research team who will have access to the data. As the data is for an existing CSS project that will potentially be used as a model for strengthening community systems to address social determinants of health, the program manager will decide for how long the data will kept. All the information obtained from documents and given by respondents will remain private and confidential.

Reflexivity

Some level of subjectivity is inevitable in qualitative research as the personal values, beliefs, interests and experiences of a researcher can influence the data collected (Jootun *et al.* 2009). Practising reflexivity gives the researcher an opportunity to self-introspect and reflect on their positionality in relation to the research. This fosters openness and transparency during the research process (Palaganas *et al.* 2017). Reflexivity is therefore a continuous process of reflection by researchers on how their values, interests, beliefs, assumptions, preconceptions, and experiences play out in their practice (Parahoo 2006). It recognizes the role of subjectivity throughout the research process. During this study, the researcher will record her thoughts, beliefs, assumptions, and experiences throughout the research process in a journal (Parahoo 2006). The researcher's journal will provide a step-by-step account of the research process. This will allow the assessment of how the researcher's own perceptions, opinions and experiences have

shaped the research process. It will also show the steps taken by the researcher to limit their influence on the research findings (Jootun *et al.* 2009).

Potential benefits

The successes and achievements of the participants will get to be documented. Coupled with the acknowledgement of their efforts, this can positively reinforce the gains achieved and inspire them to do more to contribute to the realisation of better health outcomes in their communities. The CSS will be able to use these successes, with participants' permission, to market the work of participants to the authorities which may benefit the long-term sustainability of their activities, if they are able to attract institutional support. Participants will receive reimbursement for travel and snacks will be provided on the day of the interview. The study provides an opportunity for participants' perceptions and experiences of successes and challenges in developing or building their capacity through the CSS for Health project within the South African context to be explored. Therefore, the researcher hopes that the findings will add to areas of learning that can also inform the implementation of the intervention in other sites in the country and in the region. However, this is dependent on how the CSS can follow through on dissemination and sustainability of initiatives. The results will also be used by the Learning Network and partner organisations to inform and identify areas of focus for future outcome and impact evaluations that will be conducted at the end of the project. It is hoped that the findings of this evaluative study will also be used to inform adaptations of the intervention as well as to shape policy that makes provision for meaningful capacity development and empowerment of CHAs, community participation and, ultimately, health system transformation.

Potential risks

The study will pose low or minimal risk to participants. While the topic is not sensitive and there are no minors involved in the study, the participants may find talking about how their practice or capacity has changed or developed since taking part in the CSS for Health intervention activities emotive. The questions I ask during the interview might influence the way interviewees think, for example, they might start questioning why they do not get paid for the work they do and start taking action to lobby for payment. Some interviewees might become frustrated and react in an aggressive manner. The questions might also induce discomfort from recounting a time of conflict or reflecting on certain experiences during the activities of the intervention. To minimise this discomfort, the research questions will be open-ended and non-intrusive. In the interests of the wellbeing of the interviewee, if they become emotional during the interview I will ask if they want to stop the interview and refer them back to the consent form that states that they can decide to stop the interview process at any point during the interview. I will also let them know that they can talk or debrief, with me or with one of the project staff members, about what aroused their emotions. I will reassure them that the debriefing session will not be recorded, and the conversation will not be part of the research. If the participant experiences extreme discomfort during the interview process and does not wish to debrief with the researcher or project staff, referral to appropriate counselling services will be made. These referrals will be to NGOs that provide counselling services to Gugulethu community members. Furthermore, as this is an evaluative study the findings may reveal that the intervention did not work. To maintain the confidentiality of all participants, pseudonyms will be used to represent them and all the information they provide will be kept private and confidential.

Dissemination

The findings of this study will be useful to various stakeholders who will be considered in disseminating the results. During the write-up phase of the study, a report back meeting will be scheduled with the CHAs, HC members, project staff, City of Cape Town health personnel and members of CBOs, NPOs and NGOs, to share findings from the research and to obtain feedback from those that participated in the study. This feedback session will allow for any information or contextual factors the researcher may have missed to be considered thereby improving the veracity of the findings and presenting another opportunity for participation for the respondents. In addition, the findings will be put in a format that is accessible to the Gugulethu community members involved in the CSS Project, for example a pamphlet, and distributed during one of the CSS Project workshops. This evaluative study will be submitted as a mini dissertation and as part of the requirements for the Master of Public Health Degree at the University of Cape Town (UCT). The project manager of the CSS Project will be given a copy of the report, as the study is part of the larger CSS Project. It is anticipated that the findings from this research will be submitted for publication in a peer-reviewed journal for a wider audience. The findings will also be presented at a future Learning Network meeting.

Budget

The costs of conducting this study, as outlined in the budget below, will be covered by the Community Systems Strengthening for Health project under the Health and Human Rights Programme, School of Public Health and Family Medicine, at the University of Cape Town.

Table 4 Proposed budget for the study

Item	Cost/unit	Units	Cost
Transport to and from site (fieldworker)	R3.61 per km	240 km	R867
Transport for participants to interview site (IDIs)	R60	15	R900
Transcription of interviews in English	-	-	Author's own time
Xhosa-speaking research assistant	R150	8	R1200
Transcription of interviews in Xhosa	R5 per minute	300	R2400
Translation of transcripts	R50 per page	80	4000
Final product printing of format accessible to community	R5/page	100	R500
Total	-	-	R 10 167

Time Frame

The proposed time frame for the study:

MONTH ACTIVITY	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug
Final Proposal and submission to ethics												
Part A: Protocol												
Draft Literature Review												
Part B: Literature Review												
Ethics Approval												
Review of documents												
Observation												
Recruitment for in-depth interviews (IDIs)												
Data collection: IDIs												
Transcription												
Data analysis												
Write up												
Part C: Journal Article												
Intention to submit												
Submission												
Feedback to stakeholders												
Dissemination												

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Part B: Journal Article

Proposed Journal: Health Policy and Planning[6]

Community Systems Strengthening for Health Project: the successes and challenges experienced and perceived in Gugulethu, South Africa

Tafadzwa Mautsa[7]

Abstract

Community participation is an effective strategy for progressively realising the right to health and strengthening health systems. For meaningful community participation to occur, the capacity of formal or informal community organisations and mechanisms involved in addressing social determinants of health needs to be strengthened. One way of doing this is through training. There is minimal research on the efforts of community structures set up to address social determinants of health and health needs in communities, following training to strengthen their capacity. This study sought to evaluate the successes and challenges of a particular Community Systems Strengthening for Health Project which, between 2016 and 2019, set out to train health committee members and community health activists in Gugulethu, South Africa. In so doing, it investigated whether and how the health committee members and Community Health Activists assumed an activist role in the community and are engaging in meaningful community participation.

A mixed methods evaluative study was conducted in two phases during 2020-2021. The first phase was a scoping review of available literature, followed by an evaluative study including review of project documents, observation by attending events organised by the project and other community organisations, and in-depth interviews with health committee members (2), community health activists (4) and project staff (4). The training intervention was found to have influenced the health committee members and Community Health Activists thinking, understanding and practice in their community efforts to address social determinants of health. Therefore, adequate support, training, and an enabling environment can facilitate meaningful community participation in health. Ultimately, these measures will contribute to the progressive realisation of the right to health and the right to community participation, and ultimately health system transformation. The limited adaptability of the intervention, limited resources, participant perceptions and sustainability were found to be obstacles to meaningful community participation.

Keywords: community health system; community systems strengthening; community participation; health committee; community health activist; capacity building; empowerment; right to health; right to participation

[6] HPP journal instructions for authors are in Appendix G

[7] For this thesis, the student is the sole and first author of this article.

Key Messages

- Training members of community structures or organisations can positively influence their practice, thinking and understanding in their work to address social determinants of health by building their capacity, empowering them, and developing their agency.

- Challenges such as the limited adaptability of interventions, limited resources, participant expectations and sustainability can limit the efforts to facilitate meaningful community participation.

- Measures to sustain the successes of a training intervention past the project timeline should be put in place. Otherwise, interventions to build the capacity of organised community groups stand as check-box exercises without sustainable benefits.

Introduction

Increased pressure on the health system calls for organised community systems to assist in meeting the increased health demands of a population (Mburu et al., 2013). In low and middle income countries (LMICs), the increased pressure the burden of preventable disease and injury places on the health system results in an increased demand for health care services and intersectoral action to address social determinants of health (SDH).The World Health Organisation (WHO) has continuously emphasised on intersectoral and multisectoral approaches in tackling social, economic, and political factors that influence the health of the people and structures of health systems in order to bring equity, or fairness, in health outcomes and service delivery (WHO 2012). These factors include; income, education, relationships and connections, housing, food security, community context, environment, the distribution of resources, opportunities and services, the exchange of goods and services, economic stability, employment and unemployment, discrimination, media, justice and legal systems, incarceration systems, and government policies (Adler et al. 2016, Braveman and Gottlieb 2014, Ndumbe-Eyoh and Mazzucco 2016). Previous studies conducted in LMICs have found that a significant proportion of the burden of disease is attributable to these contextual and social factors which disproportionately affect vulnerable groups (Kreatsoulas and Anand 2010, Schmidt *et al.* 2010, Krech 2012, Scott *et al*. 2017, Wingfield *et al.* 2018). Therefore, it is important to pay attention to addressing these contextual and social determinants of health as they influence health outcomes and, ultimately, community participation and community systems. Over the years, the fight against communicable and non-communicable diseases and, recently, the Coronavirus disease 2019 (COVID-19) have shown that bottom-up approaches involving communities contribute significantly in the responses to these epidemiological and social factors (Ataguba et al. 2015, van Ryneveld et al. 2020).

The call on organised community groups to participate in taking action to address SDH is also supported by several international frameworks on public health and human rights. The latter frameworks put forward health as a human right: General comment 14 on the Right to Health issued by the United Nations Committee on Economic, Social and Cultural Rights, the Alma Ata and Astana Declarations on Primary Health Care, the Rio Political Declaration on Social Determinants of Health, and the World Health

Organisation's Framework on Integrated People-centred Health Services. In these frameworks, participation is described as taking part in decision making concerning health governance (Haricharan *et al.* 2021). They emphasise supporting communities to participate in the design and implementation of policies and interventions which impact their health and well-being thereby adopting a human rights approach (Mulumba et al., 2018, WHO and United Children's Fund (UNICEF) 2018, Haricharan *et al.* 2021). A rights-based approach to health means empowering society to hold the government accountable for meeting the health needs of citizens through, for instance, making them aware of their right to voice their health needs (Douwes *et al.* 2018, London *et al.* 2012). Another important element of the rights-based approach to health is the mobilization of citizen groups for collective action: the behaviour and actions of a group working toward a common goal, to push governments to take actions, and make decisions which contribute to the progressive realization of the right to health (Douwes et al. 2018, London *et al.* 2012, Haricharan *et al.* 2021).

Social solidarity, which is the cohesive social bond that holds a group together and is valued and appreciated by all group members, highlights the interdependence between individuals in a society (Douwes *et al.* 2018). In standing together, individuals can get the sense that they are enhancing the lives of others. Social solidarity is therefore a core principle of collective action, and it has been deemed as essential to the realisation of human rights (Douwes *et al*. 2018). Douwes, Stuttaford and London (2018) conducted a qualitative mixed methods exploratory study to examine the ideas on the elements for collective action held by groups of community members from previously disadvantaged socioeconomic backgrounds. Their study findings showed that trust amongst the actors from the community, civil society and government was needed to foster social solidarity and collective action. They also found that the actors needed to be altruistic and have reciprocal relationships to meaningfully come together and tackle health issues (Douwes *et al*. 2018, Scheneider *et al.* 2021). Furthermore, collective action groups such as Cape Town Together, a community action network formed in response to the COVID-19 pandemic in the Western Cape in South Africa, showed that collective action is highly depended on social capital: informal networks and relationships (van Reyneveld *et al*. 2020, Schneider *et al*. 2021). These declarations also reinforce the importance of addressing broader economic, environmental, and social determinants of health to achieve better health outcomes (WHO 2008, Mulumba *et al.* 2018, WHO and UNICEF 2018, Haricharan *et al.* 2021).

Community participation can take on various forms and has been shown to be an effective strategy for improving population health and wellbeing, and progressively realising the right to health (Haricharan 2012, Kamuzora *et al.* 2013, Kilewo and Frumence 2015, Karuga *et al.* 2019). Arnstein (1969) conceptualises participation as the power that citizens or communities have. In an eight-step ladder depicting the different forms of citizen participation, each step up signifies an increase in the power and control people have in decision making processes which impact their lives (Arnstein 1969). In the last step "Citizen Power", citizens have play an active role and have a significant degree of influence and power in making decisions concerning their wellbeing (Arnstein 1969). Hunt and Backman (2013) affirm this conceptualisation of meaningful community participation by arguing that for community members to participate meaningfully in facilitating their health and well-being power should be shared between them and health authorities. This notion is further supported by George *et al.* (2015) who point out that the degree of control over an initiative or power that a community commands in a program is a defining factor

when examining community participation. Furthermore, for community participation to be meaningful and effective, the role of community structures such as HCs must be expanded to address social determinants of health and the capacity of community systems and organisations also needs to be strengthened to improve their knowledge and management skills (Kilewo and Frumence 2015, Karuga *et al.* 2019). However, inadequate resources often limit the ability of communities to meaningfully participate in efforts to that address their health needs. One way of supporting communities to address the social factors which impact their health is by developing their agency through drawing on the community's capability and building from it (WHO, 2008, Ankomah *et al.* 2021).

Community capability can be defined as the influence of the interrelationships between individuals, groups, organisations, and institutions within a community combined with the existing combined resources which can be invested in addressing community issues (George *et al.* 2015). A community's capacity can be built through community mobilisation or community empowerment (Middleton *et al.* 2021, Vanderslott *et al.* 2021). Community mobilisation is externally driven. It is the way in which communities design, plan, implement and evaluate activities to improve their health and meet their other needs; in a manner that is participatory and sustainable. Community empowerment extends beyond community mobilisation. Through empowerment communities can influence or make changes in their social and political environments to facilitate improvement in their health and quality of life (Mulumba *et al.* 2018). For example, Interviews conducted with stakeholders in the Liberian health system found that engaging the community was a crucial factor in addressing the Ebola epidemic in the country. Communities partnered with health officials to provide community members with information on the infectious disease and to co-identify problems and enact solutions. Health officials also consulted community members when planning interventions, involved them the decision making for local health issues and used community structures to provide services (Barker *et al*. 2020).

In LMICs, previous research on HCs as a mechanism for community participation have focused on HCs interfacing health facilities (Loewenson and Rusike 2004, Padarath and Friedman 2008, Goodman *et al*. 2011, Haricharan 2012, Haricharan *et al.* 2021, McCoy *et al.* 2012, Kamuzora *et al*. 2013, Waweru *et al.* 2013, George *et al*. 2015, Kilewo and Frumence 2015, Maluka and Bukagile 2016, Kuraga *et al.* 2019). Based on the ability of HCs to effectively engage with community members and their knowledge of the community, there is potential for them to work together with other community structures to address community health needs (Ankomah *et al.* 2021). Haricharan (2012) and Haricharan et al. (2021) have recommended extending the role of HCs to addressing SDH. This will create space for meaningful community participation and better responses to health needs. Furthermore, this will also contribute to the realisation of the right to participation, the progressive realisation of the right to health and health system transformation, and ultimately, better health outcomes.

However, there is a gap in the literature with a focus on the efforts of HC members in collaboration with community members to address health needs. Bearing this in mind, this study sought to evaluate the successes and challenges of the training of health committee members and community health activists through the CSS for Health Project. It aimed to assess how the training influenced the thinking, understanding and practice of health committee members and CHAs in addressing social determinants of health in their community. In so doing, the study investigated whether and how the HC members and

CHAs assumed an activist role in the community and engaged in meaningful community participation, as conceptualised in the Arnstein (1969) ladder of participation.

Methods

An exploratory mixed methods study, using both quantitative and qualitative methods, with evaluative elements was conducted in two phases. In the first phase, a rapid scoping review of literature available on the leadership, advocacy, activist roles, and capacity building of HCs and CHAs. The second phase comprised four components: 1) study project documents were reviewed to quantify the number of initiatives that have been supported and started in the implementation stage, following the training in Gugulethu; 2) Concurrent with gathering these tabulations of activities, qualitative data was collected through reviewing project documents; 3) Observation by attending events organised by the CSS Project and other community organisations, and; 4) in-depth interviews with health committee members (2), CHAs (4) and project staff (4).

BOX 1: The Community Systems Strengthening Project

The CSS Project strengthened the capacity and developed the agency of HC members and CHAs by implementing activities which would facilitate the improvement of their capacity for advocacy and community-based intersectoral action. It also aimed to better position them to address the social factors that impact the health and wellbeing of the people that live in the under-resourced areas (3). Through strengthening the capacity of HC members and CHAs to actively participate in actions to address SDH, coordination of services through community leadership, networks, partnerships and liaisons with local government, the project sought to empower community members to improve their awareness of health issues in the community, how to prevent them and devise practical ways of rendering services or solutions, with a focus on four thematic areas: (i) peace building, (ii) access to food and nutrition, (iii) child protection iv) health education and promotion. The CSS for Health Project was structured in three phases: a training phase followed by an implementation phase and ending with a mentoring phase. The operations of CSS project were guided by a Logic Model framework prescribed by the funder (APPENDIX F).

Setting

The CSS Project was a joint participatory pilot intervention which was implemented by the Health and Human Rights Programme in the School of Public Health and Family Medicine at the University of Cape Town (UCT) in partnership with the Non-Profit Organisations (NPOs) Training for Transition (TFT) and Women on Farms Project (WFP), from 2016 until 2019, in the Western Cape in South Africa. The aim of the project was to strengthen the capacity and develop the agency of the HC members and CHAs in under-resourced communities (3): Belhar, Klapmuts and Gugulethu in the Western Cape.

The fieldwork for this research project took place in one of the three sites, via. Gugulethu,[8] a township in the Western Cape in South Africa, and at the University of Cape Town. The project staff were interviewed

[8] Gugulethu is a township that was established in 1958 when many Black, Coloured and Indian people who stayed in the inner-city areas were relocated to new areas further away from the inner city (Learning Network, 2017).

at UCT while the CHAs and health committee members were interviewed at the Elukhanyisweni Community Hall in Gugulethu. The researcher also attended a community dialogue, a march and strategic planning meeting held in Gugulethu. Gugulethu's population is predominantly black African, and it is located on the Cape Flats 18km south-east of Cape Town in the Western Cape Province (City of Cape Town 2018). The history under which the township was established has resulted in the residents being plagued by societal ills such as child abuse, neglect, and death; domestic violence; abuse of the elderly; killing of women by their partners; poverty and unemployment; orphans of HIV and AIDS resulting in 8-year-olds attending ARV clinics on their own; alcohol and drug abuse; poor adherence to chronic treatment, and hunger and poor nutrition (Learning Network 2017). Gugulethu was chosen as the site for the evaluative study because, of the three intervention sites, there were more initiatives in the implementation phase which followed the CSS for Health Project training activities in Gugulethu, and this was the site most easily accessible to the researcher.

Sampling and recruitment

Purposive sampling was used to recruit the participants who were interviewed. As the purpose was exploratory, the aim was to focus on a specific group of people and not to generalise the results found to the whole population. The first author purposely recruited the four members of the CSS for Health Project team, and with the assistance of the Gugulethu training coordinator recruited two health committee members and four community health activists to be interviewed until the point of data saturation was reached (Royse *et al*. 2010). To be eligible to participate in the study, the community health activists and health committee members had to be active and residing in Gugulethu. They also had to have participated in the CSS for Health Project training activities.

Data collection

Data was collected partly through observation when the first author attended three project events held in Gugulethu, between February and November in 2019, and a seminar which took place at UCT. Project documents were reviewed to document the numbers and types of initiatives started under the leadership of community health activists and health committee members were extracted. Themes were also gathered from these project documents, a newspaper article and online report of the CSS for health project and in-depth interviews. An interview guide explored perceptions and experiences of how the CSS for Health Project has influenced the work of the community health activists and health committee members in Gugulethu. Drawing themes from the data sources mentioned above enabled multiple perspectives to be captured and served to triangulate the data. The interviews were tape recorded with permission of the participants and transcribed by the first author.

BOX 2: Project events attended by the researcher

As part of observation, the first author attended a Community Dialogue in February 2019. The community dialogue was led by the CSS Project Gugulethu coordinator. The discussions were structured around the project themes: (i) peace building, (ii) access to food and nutrition, (iii) child protection iv) health education and promotion. During this community dialogue, the CSS Gugulethu coordinator directed break out groups (4) to discuss the themes below:

1. *Masihlale sisempilweni entle*: Let us remain in good health
2. *Masixoxeni ngokwakha uxolo*: Let us discuss peace building
3. *Masiphakameni sikhusele Iintsana zethu*: Let us stand up and protect our children
4. Siyigxotha njani ikati eziko mawethu: How do we secure our food

The researcher also attended a march held in Gugulethu, in Septembr 2019. The picket was organised by the Gugulethu Development Forum in collaboration with Gugulethu Street Committees, a local NPO - Movement for Change and Social Justice, the Neighbourhood Watch, and members of other Gugulethu community networks. The community march was organised to demand a bigger and accessible day hospital in Gugulethu and to call on the government to address the safety issues being faced by the community.
Lastly, in November 2019, the researcher attended a community strategic meeting. Attendees of this meeting included participants of the CSS Project, Gugulethu Development Forum members, Gugulethu Street Committee members, representatives of the Movement for Change and Social Justice, academic stakeholders and Gugulethu community members.

Data analysis

The number of participants who attended the CSS Project activities and the number initiatives started were calculated into frequencies using Microsoft EXCEL (Microsoft Corporation, 2018). The in-depth interviews (10), field notes and data gathered from the project documents were managed and coded manually. A thematic analysis approach was used to analyse the data. The first author familiarised herself with the data by transcribing the interviews, reading through the transcripts, field and observation notes, and the data extracted from the project documents. The transcripts, notes and articles were then inductively coded. Following this, a code book was developed. Similar codes were then grouped into themes and then relationships between the different themes were identified and reported as the findings on the perceptions and experiences of the successes and challenges following the training facilitated through the CSS for Health Project.

Ethical Considerations

The researcher took full responsibility to protect and ensure the well-being of all the participants throughout the research process. Before an interview, each participant was informed about the purpose of the study. Following this, the participants were asked to read the information sheet and consent form, and then given an opportunity to ask questions for clarity. All the community health activists and health committee members who were approached willingly agreed to take part in the study and gave written consent for the interview to be audio recorded. The study was approved by the UCT Human Research Ethics Committee (HREC Reference Number: 745/2019).

Results and Discussion

Claims in this section, unless indicated otherwise, are a result of synthesis of project documentation, observations made by the researcher during the project activities attended, and data collected in project interviews. Bearing in mind the aims of the study, as stated in the introduction, the results will be reported under the overarching themes that emerged from the data collected in response to the objectives outlined. The CSS Project was implemented through various training activities which were documented in project reports. These included basic training to exchange knowledge about child protection, nutrition, peacebuilding, and health education. Workshops were conducted to develop the leadership, advocacy, and public speaking skills of HC members and CHAs attending. These workshops were experiential, with at least 25 participants in each session, and they took place over a period ranging between one and four days (see Table 5 below). The training activities also comprised of community advocacy actions such as picketing, community dialogues, a national colloquium, and a provincial dialogue. This design of the training workshops and activities contributed to the outcomes following the training. As Rossi et al. (2004) have pointed out, the ultimate success of any programme, project or intervention is contingent on its design and the plausibility of its underlying logic. For instance, One of the first activities of the CSS for Health Project was a Community Mapping exercise which was conducted in collaboration with the Gugulethu HC, UCT and the Gugulethu Community Coordinator as a representative of the project team. The result of this exercise was a database of the community organisations operating in Gugulethu. Following this, using contacts and information from the database an information session to introduce the CSS for Health Project was organised. This meeting was attended by a total of 117 Gugulethu community members, including health committee members and members of various community organisations. During this meeting the project team shared the aims and objectives of the CSS for Health Project and the community members in attendance were given an opportunity to choose the project theme they wanted to be a part of. Involving community members from the outset of the project allowed the project to gain the buy-in of the targeted community and, ultimately, facilitated a sense of ownership of the project by those who took part in the training activities. Furthermore, the project team then facilitated linkages with organisations that could collaborate with the trained HC members and CHAs. This provided a platform for guidance from established community groups and local authorities. Throughout the duration of the project, the CSS project team was available to provide ongoing mentoring and support which could be accessed through visits, phone calls and WhatsApp.

Table 5 Training workshops conducted across the four themes of the CSS Project in the period between 2017 and 2019.

Theme	Date of training	Workshop Content	Number of Participants	Duration
Health Education	23-24; 30 -31 August 2017	Discussing chronic diseases: diabetes, hypertension, HIV&AIDS, how to manage them, treatment adherence and supporting those living with a chronic disease or looking after someone living with a chronic disease	45	4 days
Peace Building	5-6;12-13 September 2017	Building and encouraging a supportive environment for vulnerable and families in crisis	30	4 days
Food & Nutrition	20-21 September 2017	Identifying families in crisis with regards to food security in the community	29	2 days
Peace Building	Year 2- Quarter 1: June – August 2018	Facilitation skills and project management to facilitate the establishment of organised entities	25	Regular periods within these 9 weeks
Food & Nutrition	Year 2- Quarter 1: June – August 2018	Food and nutrition professional training: sustainable home gardens, nutritious eating, herbs with health benefits	26	Regular periods within these 9 weeks
All four themes	Year 2- Quarter 1: June – August 2018	Training in health promotion, access to food and nutrition and child protection to raise awareness of current health issues and programmes	6 (HC members)	Regular periods within these 9 weeks
Food & Nutrition	Year 2- Quarter 2: 21 September 2018	Formalising food production Business skills	Unknown	1 day
Food & Nutrition	Year 2- Quarter 2: 9 October 2018	Establishing food and nutrition cooperatives	Unknown	1 day

Source: CSS for Health Project quarterly reports and in-depth interviews.

Empowerment

Health committee members and community health activists were empowered with knowledge on social determinants of health. They got a sense of empowerment through the training, and it contributed to action on the ground. In an in-depth interview, one participant highlighted that:

> "… I've grown a lot since I've started and those are some of the things that I didn't know, and I've become more confident you know about speaking and I know information… I talk from facts because we've learned a lot from here, we've grown you know…" (Participant 6).

For instance, participants trained under the peace building theme of the CSS project could learn from participants trained under the child protection, health promotion, or food and nutrition themes of the project, and vice versa. The knowledge they acquired from the shared learning facilitated by the CSS project gave them confidence to share this information with other community members. Most of the participants explained that this space for sharing and learning from others across the themes of the project made them realise that the themes of the project are interlinked and, therefore, how the SDH are inter-related. This realisation also brought an understanding of how their work intersects:

> "Yes, we were just mixing. So, if there is training for food and nutrition, they um, they call us… there is a garden there at the back of the church. We go there and support those people who do it... Yes, we were there and if there is a child protection program, we were there to support that one because health goes in each and every one of the other three legs." (Participant 5).

This exchange of knowledge amongst HC members, CHAs and community members showed that there was trust built amongst them. The willingness to participate in events or initiatives led by fellow HC

members and CHAs also revealed that the participants of the CSS project had fostered reciprocal relationships. This trust and reciprocity can form a solid foundation for the social solidarity and collective action known to be key elements for strengthening community health systems and for achieving collective goals, such as better community health outcomes. Similarly, in their work with community action networks (CAN) in the Western Cape, South Africa, van Ryneveld et al. (2020) found that to facilitate development and widespread action, relationships must be built to foster trust, the network has to maintain an informal, adaptable structure and it has to collaborate with existing structures such as street committees, health committees or the government. The collaboration can take place when there is trust amongst the actors. Furthermore, this finding reinforces what Douwes et al. (2018) found in their research to explore the experiences and views of health civil society groups on the role of social solidarity and collective action in implementing the National Health Insurance to achieve universal health coverage in South Africa. In line with the findings of this study, they reported that community networks and initiatives characterised by trust, reciprocity and altruism can foster social solidarity and collective action (Douwes *et al.* 2018). Through collective action and social solidarity community groups and civil society can participate in health (London *et al.* 2015, Douwes *et al.* 2018). This contributes to the progressive realisation of the right to health, the strengthening of the CHS and, ultimately, the transformation of the health system.

While some HC members and CHAs perceived shared learning as beneficial, others felt that receiving structured training under all the themes of the project would have facilitated a better understanding of the SDH and how to address them. Although there was sharing of knowledge amongst the participants, some of them perceived being trained by the project facilitators under one theme as working in silos. For some, this made it difficult to make the links amongst the different themes of the CSS for Health project. As one participant expressed: *"*If someone has been involved in all those training then it's, maybe, easier for them to integrate everything*"* (Participant 2).
This may have left some participants with the perception that they are not empowered enough or adequately capacitated to lead or support initiatives and activities to tackle social factors contributing to ill health in their community.

Adaptability
Most of the training activities were conducted in a workshop style. Although an experimental approach was used, all the factors which could negatively impact the interventions of HC members and CHAs could not all be simulated in a workshop. In this way, this mode of delivering the training activities could not fully draw out the nuances, complexity, and dynamic nature of starting and running an initiative in the community for the HC members and CHAs to fully appreciate how broad and complex their work can be. As one participant said:

> "Because the training side was just literally developing training material and then delivering most of that workshop style. So, I won't say that it was a simple side, but when you look at doing something in confined spaces versus having to do something in real life, it's broad, it's out there, it's in the community. Its two very different types of things you're trying to deliver here" (Participant 1).

The CSS project grant application document and the project logic model framework did not allow for adaptations to accommodate the dynamic nature of community engagement and development to the

initially theorised plans documented in the project proposal. In personal communication with one of the project staff members, it was highlighted that it was difficult to adapt the project's logic model framework to factor in changes of socio-cultural, economic, ecological, political, and technological influences (Personal communication with project staff 2019). This resulted in the implementation phase being a challenging process as there was a constant need to balance out the conflicting interests of communities, in their dynamic context, and funders as expressed by one participant:

> "So you have these set indicators that people want to see you implement …and myself also coming from a community development and activist background, you don't want to force people to do things but you are constantly balancing this with the donor requirements. So, implementation was, I think, quite a challenging process, I think for everybody" (Participant 3).

On the one hand, project staff had implementation challenges as one of their objectives was to ensure that donor requirements were met while the capacity building needs of the HC members and CHAs were also addressed. However, it was not always the case that the donors' requirements and participants' needs matched. For instance, at a strategic meeting which the researcher attended, one participant expressed frustration about the First Aid training, as some CHAs received the training for just one day, when in general, basic First Aid Level 1 Training is conducted over two consecutive days. The training was organised through the CSS project, and it was a one-time session. The project implementers could tick the box and consider first aid training completed. However, the participant explained that one day was too little time to grasp all the steps and actions one should take in the event of a life-threatening emergency in the community. Consequently, HC members and CHAs would be left inadequately capacitated to respond in an area which ambulances seldom go because "…they rob the ambulances" (Participant 10).

With these insights in mind, there can be a discussion about the dynamic nature of the community, the versatile needs of the diverse community members, and making room to accommodate the different needs before implementing community systems strengthening interventions involving training. The donor requirements can also be discussed upfront before commencing training in the hope that mutually beneficial operating procedures can be identified. This can mitigate the contentions that can arise from conflicting donor requirements and participant needs when implementing community systems strengthening interventions.

The inability of the workshop style training to simulate all the complexities of community systems, and the unmatching interests of donors reinforces the notion that communities and community systems are dynamic and complex, as has been reported by van Ryneveld (2020) and Schneider *et al.* (2021) in their research which provides insights on CHS. The success or challenges of community systems strengthening programs may have more to do with contextual factors: community's history, economic and political system, and prevailing cultural and social norms, the actors, political, religious, economic, or other power structures; local social norms, and the "collective capacity" of communities than the training interventions implemented. Therefore, case studies, evaluations, and evaluative studies need to fully assess and thoroughly report on the contexts in which interventions are implemented. Community health systems are unique to each context (Schneider and Lehman 2016). Though broad approaches and lesson learned can be applied across contexts, over prescription in community systems strengthening interventions can be counterproductive (Schneider and Lehman 2016).

Leadership, social solidarity, and collective action

Health committee members and community health activists provided a supportive and leadership role, addressing the underlying factors of ill health in their community. For example, as reflected in the project logic model (see Appendix F), project quarterly reports and informal conversations which the researcher had with project staff at project events, the targets for interventions led or initiated by HC members and CHAs who undertook the CSS project training were achieved by over 100% by the end of the project activities, as shown in Table 3 below. The CSS project reports, and logic model highlight that one of the aims of the training was to build the capacity of HC members and CHAs to initiate community interventions and activities to tackle the social ills compromising community health. As one participant highlighted when describing the CSS project training: "an all-rounded kind of learning and respect for people" (Project Staff 1).

Before the CSS project, HC members were primarily involved in work interfacing health facilities and their collaboration with community members was informal and unstructured. The CHAs were independently undertaking work to address SDH in their community. The activities of the CSS project brought together HC members and CHAs with community members. This then facilitated and supported HC members and CHAs to organise to participate in addressing SDH in the community. The project built on the work that was being done already in the community. For instance, one participant who was running a creche explained that before the CSS Project training she could not easily name an issue a child as experiencing even though she was able to pick up that the child is subdued: "Before the training I knew about that, but I couldn't identify the problem of the kids. To say this is the problem. They have a problem, they need attention." (Participant 6). In addition, the project logic model framework (see APPENDIX F) reports that 50% (3) of the total ECDs (6) supported by the CSS Project already existed. This highlights that communities have within them some resources, networks, structures, and ways to address health issues and that they have the potential to play instrumental roles to this end. However, this high percentage achievement of the targets may have also resulted from an underestimation of the community resources and potential, thereby limiting the number of targets sets. This high proportion could also have been influenced by the activities of other projects taking place in the community.

Table 6 Total number of Interventions led or initiated by HC members and CHAs across the four themes of the CSS for Health Project by the end of the project.

Theme	Interventions: end of Year 3	Target
Child Protection	9	2
Peace Building	6	1
Food & Nutrition	27	5
Health Education	4	3
Monitoring services	6	5
TOTAL	52	16

Source: CSS for Health Project quarterly reports and in-depth interviews.

As Table 6 above shows, the HC members and CHAs trained through the CSS project had led or initiated 52 interventions compared to the targeted 16 by the end of Year 3 of the project. Under the Child Protection, the interventions included; supporting the registration of ECDs, and growing and developing aftercare programmes. Interventions under the Peace building theme included: a 'school bus' were

community members took turns to escort children to school, advocacy events to raise awareness on gender based violence, sport and recreational activities for the youth, and schools-based life skills workshops. Those that fall under the Food and Nutrition theme included; food gardens started at community members' homes, a soup kitchen programme, and a food parcel programme. Interventions under the Health Education theme included; supporting existing Health Clubs to provide support for people living with a chronic condition and community dialogues. Those under Monitoring services entailed meetings comprising of health committee members to discuss service provision in the community, any complaints that may have arisen and how these could be addressed. The range of the interventions led by the HC members and CHAs highlights again the potential that exists within communities. Most of the interventions above were implemented to support initiatives which existed before the CSS project training activities. Following these interventions, their operations and reach improved. With the support of the CSS Project team; local organisations including; the Gugulethu Development Forum, *Abalimi Bezekhaya*, Neighbourhood Watch, *Ilitha Labantu,* Gugulethu Street Committees and, Movement for Change and Social Justice; and academic stakeholders, the trained HC members and CHAs were able to lead and initiate more interventions than expected. Further research can be conducted to understand the process of how the initiatives got off the ground and to investigate how the interventions progressed after the end of the CSS Project.

In another instance of illustrating their leadership and supportive role in addressing SDH in their community, CHAs and HC members at the forefront were observed, by the researcher, picketing collaboratively as the Gugulethu Development Forum with Gugulethu Street Committees, a local NPO Movement for Change and Social Justice, the Neighbourhood Watch, and members of other community networks. The march was organised to demand a bigger and accessible day hospital in Gugulethu and to call on the government to address the safety issues being faced by the community. Just over a week after the march the Gugulethu community received a written response to the demands from the Western Cape Member of the Executive Council (MEC) for Health. This suggests that that these community members who had assumed an activist role in addressing the SDH had a voice, and they were undertaking collective action to combat the social issues plaguing their community.
Although the HC members and CHAs were at the forefront of the interventions implemented in the mentoring phase of the CSS project, they did not see themselves as leaders. Their perception was they are doing their part, in the different ways they could, to contributing to the realisation of better health outcomes for their communities.

Furthermore, trained HC members and CHAs were seen confidently engaging local authorities present at community advocacy events. The demands made and questions asked were well thought out and backed up by evidence, as reflected in the excerpt of one of the Memorandums of Demands (Appendix G) compiled in collaboration with other community organisations. Consistent with the human rights theory presented by Douwes *et al*. (2018) and London (2008), the CSS project adopted a rights-based approach to health by empowering HC members and CHAs to take part in advocacy events to hold the government accountable for meeting the health needs of their community through, making them aware of their right to voice their health needs. In addition, the CSS project adopted another important element of the rights-based approach to health by creating an enabling environment for the mobilization of citizen groups for

collective action to push governments to take actions and make decisions which contribute to the progressive realization of the right to health (Douwes *et al.*, 2018, London 2008).

However, empowerment and collective action do not automatically guarantee that governments will take heed of the demands presented by civil society and community groups. For instance, an online news report published by the University of Cape Town Poverty and Inequality initiative on the work of the CSS for Health project highlighted the concern that there was often no feedback from officials to communities on issues raised at community activist events (Poverty & Inequality Initiative (UCT) 2019).

Obstacles to participation

Inadequate human, financial and infrastructural resources limit the ability of self-organised community structures to meaningfully participate in efforts to address their health needs. In this instance, the CHAs and HC members trained through the CSS Project experienced a lack of resources to start initiatives following the knowledge and skills gained from the training sessions. This was pointed out in the presentation given by two of the CHAs at the University of Cape Town Noon Meetings[9] where they shared their experiences of working in their communities and collaborating with researchers at UCT. Some participants shared similar sentiments during IDIs: *"*It's still hard work to get money, it's still hard…" (Participant 5)

"I think more could be done there and I think we ourselves could have done more but you're limited by funding and capacity." (Participant 2)

Furthermore, the absence of social capital was an impediment to undertaking activities to address SDH in the community. For instance, after participating in the training activities, some participants felt inspired and capacitated to implement interventions and initiatives to address the social ills resulting in poor health which plague their community. However, it was difficult for them to execute the ideas and initiatives they had in mind because they did not have easy access to a social network or group doing work to address social determinants of health in the community which they could work with.

"Yes. I think so. People are doing different things around here in Gugulethu… I also want to do things, but I live so far." (Participant 5)

Although equipped with the added knowledge and skills, some of the participants experienced financial and human resources constraints which limited the scope of their work to address social determinants of health in Gugulethu. Due to these limited financial, human, and infrastructural resources some of these participants were only able to support existing initiatives even though they had a desire to start their own projects. This limited the extent to which they could use the skills and knowledge they acquired through the training activities they participated in. Infectious disease management regulations such as social distancing which have been put in place to manage the spread of the COVID-19 pandemic have imposed further limitations on the work and the reach of CHAs, HC members and overall, community systems. Activities such as community dialogues, group training of community members, and picketing can no longer take place. Yet these channels have been proven to be vehicles of health education, health promotion and activism which have been effectively used to contribute to the achievement of better

[9] Weekly meetings organised by the School of Public Health and Family Medicine for various stakeholders to engage in discussions on public health matters. At each meeting a guest speaker presents on a public health related topic. A question-and-answer session then follows the presentation.

health outcomes (van Mierlo 2012, Arreola *et al.* 2014). To continue with the work to address SDH in the community, CHAs, HC members and other community structures may have to revise their activities and devise new ways of tackling the social issues plaguing their communities. Further research can be conducted to see if they have continued with their work to address SDH and, if they have, how they have done so.

On the other hand, the COVID-19 pandemic presents these community structures with an opportunity to work together to respond to the pandemic. This study and other studies conducted in other LMICs have found community structures to be a resource in improving health when supported (McCoy et al. 2012, Loewenson *et al*. 2014). This support may be in the form of mobilising human resources to lead and maintain initiatives and funding to establish and operate the initiatives. In these times of responding to the COVID-19 pandemic, funding which has always presented as a challenge even pre the pandemic may be even more difficult to source.

Sustainability

Some trained CHAs and community members lacked the will to continue with the interventions implemented to strengthen community participation, the community health system and, ultimately the health system. After acquiring knowledge and skills from the training facilitated by the CSS project, the onus was left on the participants to apply what they learnt to address social determinants of health in the community. For example, one participant mentioned that:

"… you can't force people to start up an ECD just because they went and did a child protection course" (Participant 2).

In some instances, some participants did not take ownership of the skills and knowledge they gained from participating in the CSS for Health Project activities, as was voiced by one participant:

"…people start seeing what they're doing as related to CSS…Yes, so you have those challenges. Some people get it and other people still see it as a CSS activity" (Participant 2).

Consequently, this lack of continuity can compromise the sustainability of the gains from community systems strengthening activities aimed at addressing the SDH in communities. In the case of the CSS project in Gugulethu, although resources had been invested in capacitating participants to support and improve their efforts to address SDH, it was not guaranteed that each one would be proactive in implementing the knowledge and skills to improve health outcomes in the community because, in the words of one participant:

"…people like to be spoon-fed. They will sit at home waiting for you, you must call and say now next step is this one" (Participant 10).

Taking ownership of the training activities exhibited by some participants of the CSS project can be attributed to their altruistic nature, as one participant stated in an in-depth interview:

"…our communities need us to strengthen them. The people need us to strengthen the community." (Participant 4).

On the other hand, some of the participants perceived other trainees as viewing the CSS project as external, belonging to the CSS project because they could not take initiative and preferred spoon-feeding, as indicated by the quote above. While it could be their nature, this perspective and attitude can also be attributed to inadequate financial, human, and infrastructural resources. A lack of resources and being required to put in more effort can limit motivation to contribute a common goal such as achieving better

collective health outcomes through addressing SDH. To counter this, a community system strengthening intervention can include an intermediate step to reinforce the training activities through mentorship[10]. In addition, project staff and researchers can share information about funding opportunities and assist with application processes with the participants they encounter.

Limitations

The study could not include personnel from health services, local CBOs, NPOs and NGOs as in-depth interview participants as initially intended due to time and resource constraints. Data from these stakeholders would have further strengthened the triangulation of the main study findings. The data may also have allowed for a more robust analysis and interpretation of the findings. In addition, due to resource constraints a *Xhosa*-speaking research assistant could not be recruited to assist with conducting the in-depth interviews. Therefore, a purposive sampling technique was used to recruit the participants for IDIs who were comfortable with conducting the interview in English. This may have resulted in researcher bias influencing the results as the researcher recruited the participants with the help of the project coordinator. Furthermore, this study focused on one out of three pilot sites and the sample size was relatively small therefore the results cannot be generalised and taken as representative of all the participants of the CSS for Health Project. Nonetheless, the aim of the study was to gather transferrable results rather than make the findings generalisable. Transferability will inform adaptations and improvements of the interventions in other contexts when it is implemented beyond the three pilot sites.

Conclusion

This study's objective was to assess the successes and challenges of a particular Community Systems Strengthening Project which set out to train health committee members and community health activists in Gugulethu, South Africa. The presented findings clearly showed that the CSS Project training, was a success from a bird's eye view as it facilitated capacity building, empowerment, and social solidarity. However, on the other hand the findings showed that limited adaptability, limited resources, and sustainability were perceived and experienced as hindrances to community participation in Gugulethu. The aforementioned, has also been documented in literature reviewed to be huge threats to meaningful community participation as explained by (Arnstein 1969). This is important to note when implementing community systems strengthening projects in other LMICs.

The COVID-19 pandemic has challenged the world to find and devise new ways of operating. This study has shown that there are both opportunities for working together, and challenges presented to communities working to address SDH. Bearing this in mind, further research can be conducted to see whether CHAs, HC member and the various community organisations have continued with their work to address SDH. If they have, studies can be conducted to investigate how they have done so and what the outcomes of the interventions initiated and implemented are. This can be done through qualitative methods where researchers conduct in-depth interviews and focus group discussions with various members of existing community organisations. Process and outcome evaluations can reveal the outcomes of the initiatives established.

[10] Mentoring was mentioned in this section as a recommendation to have it as an ongoing activity instead of as a last phase of the project, as was the case with the CSS Project. At the time when this sub-study to assess the success and challenges of the CSS Project perceived and experienced in Gugulethu was conducted, the mentoring phase of the project had not started. For this reason, it was explicitly left out.

Overall, the successes or challenges of community systems strengthening programs may have more to do with contextual factors: community's history, economic and political system, and prevailing cultural and social norms, the actors, political, religious, economic, or other power structures; local social norms, and the "collective capacity" of communities. Therefore, when conducting case studies or intervention evaluations it is important to assess the contexts in which the interventions are being implemented. Report more fully on the contexts in which programs are implemented will give a nuanced understanding of how the limitations to meaningful community participation can be mitigated. Community health systems are context specific, and though broad approaches and lesson learning across contexts is possible, over prescription in community systems strengthening interventions can be counterproductive (Schneider *et al.* 2021).

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Appendices

Appendix A: Information Sheet for individual interview

The following information sheet is for stakeholders of the Community Systems Strengthening for Health Project in Gugulethu, who are invited to participate in this research study.

PART 1: INFORMED CONSENT DOCUMENT

My name is Ms. Tafadzwa Mautsa. I am a student researcher at the University of Cape Town, and I am being supervised by Professor Leslie London and Associate Professor Jill Olivier at the University of Cape Town. You are invited to take part in the study: ***Community Systems Strengthening (CSS) for Health Project training: The successes and challenges perceived and experienced in Gugulethu.***

Why is this study being done?

The aim of this study is to explore the successes and challenges of the training activities undertaken through the Community Systems Strengthening for health project.

Why are you being asked to take part?

Since you were involved in the training of the Community Systems Strengthening for health project, we would like to find out how you have experienced the training activities implemented by the Community Systems Strengthening for health project, how the training has changed the way you do your work in the community and what you think of the work you do in addressing social determinants of health in Gugulethu.

Voluntary participation

Participating in this study is voluntary. If you do not want to participate in this study, you do not have to. You do not have to decide right now if you want to participate in the study. You can take the information sheet home and then get back to the researcher if you decide to participate.

If you do decide to participate, you can still decide to withdraw at any later stage. For example, if you want to stop the interview at any point, you are free to do so without giving any reasons. You have a right to refuse or withdraw from the study at any stage if you wish. Refusing to participate or withdrawing from the study will not affect your relationship with the researchers, the University of Cape Town or the Community Systems Strengthening for health project staff in any way.

What will happen if you decide to take part in this study?

I will invite you to participate in an **individual interview** and if you agree, I will arrange to conduct the interview at a place and time and day convenient for you.

Your participation will be particularly important in this study as it gives us an opportunity to explore the perceptions and experiences of the successes and challenges of the training activities undertaken through the Community Systems Strengthening for health project.

The interview will be conducted in English or *Xhosa*. You can tell the researcher which one of the two languages you prefer to use. Each interview will take approximately 45 minutes to an hour.

During the interview, I will ask you to share your own views, opinions, and experiences of the Community Systems Strengthening for health project. However, please note that you do not have to share any information that you are not comfortable sharing.

The interview will be tape-recorded, but you will not be identified on the tape and if you feel uncomfortable with being recorded you can refuse.

All the information collected in this study, including the recording of the interview, will be kept in a safe and secure cabinet. The information recorded is private. Only the researchers will have access to the interview recordings because we will create a computer password for all electronic records and information. These records and information will be secured on the researcher's computer in files that can only be accessed with a specific password. These records will also be backed up on the Microsoft One Drive cloud storage, which will also be protected by a specific password known only to the researcher. The tape recordings will be destroyed soon after what was recorded is typed out, word for word into a document.

Both before we start the interview and at the end of the interview, you will have an opportunity to ask any further questions that you might have.

What are the risks and discomforts of this study?

There is little risk to you from participating in this study. It may be that participants end up thinking differently or may experience feelings of guilt or embarrassment in talking about one's own perceptions, opinions and attitudes toward the Community Systems Strengthening for health project. This may be quite a normal reaction and may not be a great disturbance. However, in the event that you are extremely upset, disturbed by your feelings or you feel great discomfort, you will be referred to a professional, at a local organisation in the community, for counselling.

Are there any benefits to you for being in the study?

The successes, achievements and challenges that you think of, and have experienced will get to be documented. Your efforts and the work you have done in your communities will be acknowledged. The information collected will also help us to understand the gains and areas of learning from the Community Systems Strengthening for health project. The findings of this study will also be used to inform the process of setting up the intervention in other places. The information gained from this will help to shape policy that will result in meaningful capacity development, empowerment and community participation for community health activists and health committee members. The results can be used to inform further research to benefit your community.

What you will receive for taking part in this study

You will be given money for transport to the interview venue to participate in this study. There is no other payment for your participation in the study.

Who will see the information which is collected about you during the study?

As indicated above, the information that you share during the interview will be kept private. All information collected will be kept safe in the cabinet or drawer and on password-protected computers. The information will not be shared or discussed with anyone other than members of the research team. However, the Research Ethics Committees may inspect the research records if required. To protect your

identity, a false name (pseudonym) will be used to represent participants' names when presenting quotes in the final report.

Will the results of the research be shared with you?

A report of the research study will be written at the end. This will be made available to you together with a pamphlet to share with you what was found through the study.

What other choices do you have?

Refusing to participate or withdrawing from the study will not affect your relationship with the researchers, the University of Cape Town or the Project in any way. You can also ask the researcher to change or remove parts of the information, if you feel that she has not understood you correctly.

Who to speak to (or contact) if you have any questions about the study

If you have any questions, concerns, complaints, or a problem about the research/ your rights at any point during the study, you may contact me, Tafadzwa Mautsa (cell: 073 470 6959, email: mtstaf003@myuct.ac.za), Professor Leslie London (phone: 021 406 6524 , email: leslie.london@uct.ac.za) or Associate Professor Jill Olivier (phone: 021 4066489, email: jill.olivier@uct.ac.za).

You can contact Ms Lamees Emjedi at the Human Research Ethics Committee in the UCT Faculty of Health Sciences on 021 406 6338 in case you have any ethical concerns or questions about your rights or welfare as a participant on this research study.

You are free to ask any of the people above any questions about the study, if you wish to.

Appendix B: Consent form for individual interview

PART 2: INFORMED CONSENT

I_____ have been invited to participate in research study, CSS for Health: the successes and challenges perceived and experienced by the community in Gugulethu. I have read the information sheet, or it has been read to me. I understand the purpose of the study, the risks and benefits of the study and what is expected of me during the participation in the study. I have been given the chance to ask questions about the study, and any questions that I have asked, have been answered. I consent voluntarily to participate in this interview for the study:

I agree to be interviewed	Yes ☐	No ☐
I agree to be recorded	Yes ☐	No ☐
I agree to be contacted by the researcher	Yes ☐	No ☐

Print name of participant: _____

Signature of participant: _____

Date: _____

Signature of researcher: _____

Date: _____

Appendix C: Individual interview semi structured interview guide

The purpose of this question guide is to allow participants to articulate their perceptions and experience as much as possible. The questions below can be used to facilitate the conversation and to probe and encourage further reflection but do not need to be asked in a systematic fashion.

Tell me about yourself…
What kind of work are you involved in, in the community? What is your role?
For how long have you been doing this work?
What does being a community health activist mean for you?
Which community network, committee or group do you belong to? Probe: Are you part of the Health Committee? If so, how long.
What kind of work, things do you do as a member of this group?
What was it like for you when you started doing this work? - What is it like for you now?
Did you take part in the training of the CSS for Health Project? If so, what training? Can you describe how long it took and what it covered?
How did you find it/ what was it like for you to be participating in it? / Tell me what you think about the training you participated in…
Did you complete the training through to the end?
What kept you involved/ motivated/interested/ to attend? (What made you to keep going to the training?)
What demotivated/ discouraged/ stopped you from attending?
What could have helped you to see the training through to the end?
Did you find the training helpful? What was not helpful or useful?
As a result of the training, has anything changed for you, in the way you do your work? - What has changed for you? Probe if they are undertaking anything that they would not have done if it were not for the training.
How do you think this change came about?
What positive outcomes and negative outcomes have you noticed as a result of the change in the way you do your work, following the training from the CSS for Health Project?
Has anything prevented you from implementing what you learned in the training? If so, please explain.

Appendix D: Project staff semi structured interview guide

The purpose of this question guide is to allow participants to articulate their perceptions and experience as much as possible. The questions below can be used to facilitate the conversation and to probe and encourage further reflection but do not need to be asked in a systematic fashion.

What was your role in the training of the HC members and the CHAs?
Could you describe what the training sessions would be like?
How did they get on board the CSS?
In your view how were the HC members and CHAs doing their work before the CSS training?
How are they doing their work now?
For you, what are the highlights of the CSS training?
What were the challenges of the CSS training, from your perspective?
What would you have done differently?
Did you work with any partner organisations during the training phase?
Any other points you would like to add or comments you would like to make?

Appendix E: Ethics clearance – University of Cape Town Human Research Ethics Committee

UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee

Room E53-46 Old Main Building
Groote Schuur Hospital
Observatory 7925
Email: hrec-enquiries@uct.ac.za
Website: www.health.uct.ac.za/fhs/research/humanethics/forms

06 December 2019

HREC REF: 745/2019

Prof L London
School of Public Health & Family Medicine
Falmouth Building
FHS

Dear Prof London

PROJECT TITLE: COMMUNITY SYSTEMS STRENGTHENING FOR HEALTH: THE SUCCESS AND CHALLENGES PERCEIVED AND EXPERIENCES IN GUGULETHU (SUB-STUDY - 524/2017) (MASTER'S DEGREE - MS T MAUTSA)

Thank you for submitting your response to concerns raised by the Faculty of Health Sciences Human Research Ethics Committee (HREC).

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

Approval is granted for one year until the 30 January 2021.

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period. (Forms can be found on our website: www.health.uct.ac.za/fhs/research/humanethics/forms)

The HREC acknowledges that the student: Ms T. Mautsa will also be involved in this study.

Please note that for all studies approved by the HREC, the principal investigator **must** obtain appropriate institutional approval, where necessary, before the research may occur.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please quote the HREC REF in all your correspondence

Yours sincerely

PROFESSOR MARC BLOCKMAN
CHAIRPERSON, FHS HUMAN RESEARCH ETHICS COMMITTEE
Federal Wide Assurance Number: FWA00001637.
Institutional Review Board (IRB) number: IRB00001938
NHREC-registration number: REC-210208-007
This serves to confirm that the University of Cape Town Human Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical

HREC/ref: 745/2019
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Appendix F: Log Frame of CSS for Health Project

LOGFRAME OF THE COMMUNITY SYSTEMS STRENGTHENING FOR HEALTH PROJECT (ADDITIONAL DETAIL ON ACTIVITIES IN APPENDIX)

	Results chain	Indicators	Baseline	Data from the survey	Targets	Targets	Sources and means of verification	Detail: Impact/ Completion
		To be presented **disaggregated by sex**	**May-17 (End of Yr1)**	**Dec 2017**	**May-18 (Yr2) (End of Yr2)**	**Dec-19 (End of Yr3)**		**Target Completed?**
Overall objective .. Impact	Improved governance and access to health and social services for the disadvantaged and marginalized in 3 pilot communities in the Western	# of functional clinic (health) committees in the target areas	2 of PHC facilities with functional clinic (health) committees	Same as previous	2 PHC facilities with functional clinic committees (Gugulethu and Belhar) Klapmuts: clinic monitors in operation only	3 of PHC facilities in project areas with functional clinic (health) committees	Health Department Facility database	Achieved: CSS Implementation results (quarterly reports): 3 HCs Note on Klapmuts: Klapmuts have challenges as they are a new HC. WFP/CSS assisted in accessing new HCs members by supporting CSS participants during the nomination process and 3 CSS participant in Klapmuts were therefore elected by Provincial DOH. However, DOH has not supported the process as expected in the area which has impacted HC membership for klapmuts. WFP/CSS have specific protocol and processes which need to be effected by DOH.
		# of beneficiaries accessing health and social services in the target areas	No data at start of project	103 of 418 Children between 0-18 years with a recent clinic visit in pilot sites i.e. visited clinic in past 4 weeks prior to survey	To be updated in year 3 follow up survey.	25 % increase of children and adults in project areas accessing services at PHC's	UCT baseline of pilot sites (Community profile)	Achieved: Taken from Baseline follow up/ Endline Survey (MF): YES. children visited a clinic/health facility within the 4 weeks prior to the survey has increased from 27% to 41%.
			No data at start of project	Grants - 249 grants accessed by households in pilot sites. Note: some HH may receive more than 1 grant	To be updated in year 3 follow up survey	25 % increase of children and adults accessing social development services	UCT baseline of pilot sites (Community profile)	Achieved: Endline Survey (MF): Two thirds (67.9%) of Households received at least one government grant in 2017. 2019 two thirds (68.1%) of Households received at least one government grant. If we use the 249 vs 389 than there is an increase of 56%

	Results chain	Indicators	Baseline	Data from the survey	Targets	Targets	Sources and means of verification	Detail: Impact/ Completion
		To be presented **disaggregated by sex**	**May-17 (End of Yr1)**	**Dec 2017**	**May-18 (Yr2) (End of Yr2)**	**Dec-19 (End of Yr3)**		**Target Completed?**
		# of nutrition interventions in pilot sites led by Health Committees and health activists.	2 nutrition interventions in Klapmuts (FIF; Ubuntu NGOs). Belhar two soup kitchens	5% households receive food parcels	Approx. 5% reached via events Mostly training completed with ad hoc access to food at events for children and adults. 25 adults at an event. More activities are planned for year 3	10% of households in pilot sites receive food parcels/ food Calculated from survey: 100 households per site interviewed for food parcels. **10%=10 HH per site**	UCT baseline assessment of services in pilot communities	Partially Achieved: Yr 3 CSS Implementation results (quarterly reports): 20+200+20=240 May 2018 Reported 5% reached in our project using 10 HH per site as the target. (25 people accessing ad hoc soup kitchens) Endline Survey (MF): There was a decrease from 5.0% to 3.4% in Households who had a member who was a food parcel recipient. According to the survey (2+2+5) Belhar, Gugs, klapmuts respectively received any parcel in 2019 8,2,9 in 2017.
			No data at start of project	20 children of households participating in the survey, accessing meals.	15% reached 100 children, however at ad hoc event. More activities are planned for year 3	60% children receive meals at CSS project ECDs in pilot sites	UCT baseline assessment of services in pilot communities	Achieved: Yr 3 CSS Implementation results (quarterly reports): ECDs only: Klapmuts:211+Gugs 56+Belhar 22=289 Incl. ECDS and child focused projects for children: 251+56+75=382 Year 3 total: incl ad hoc food donations: 382+200=582 Previously reported May 2018: 15% (100 children at an ad hoc events)
			2 gardens in Belhar	43 out of 594 (SHOULD BE 300) (11+14+18) households functional food gardens	25% reached 6 food gardens (3 Belhar and 3 Gugulethu)	5 functional food gardens in each of the pilot sites. (Total: 15)	UCT baseline assessment of services in pilot communities	Achieved: Yr 3 CSS Implementation results (quarterly reports): 5+25+2=32. (over 200%) May 2018 reported 6 food gardens in total across sites: 15% reached Endline Survey (MF): %In 2019 -16 out of 278 (5+8+3) =5.75% households functional food garden. 2017 =14.3% DECREASE OF 59.8%
		# of health education interventions in pilot sites led by Health Committees and health activists.	Hypertension 2; TB 2; Diabetes 1 groups in Belhar	Elderly Chronic illness club in Gugulethu	17% : 1 chronic club: Gugulethu	2 chronic illness clubs in each of the pilot site locations (Total: 6)	UCT baseline assessment of services in pilot communities	Partially Achieved: Yr 3 CSS Implementation results (quarterly reports) and discussions with coordinators: 3 chronic clubs (1 klapmuts+2 Gugs): 50% 50 members Gugulethu and 10 in klapmuts Previously reported 1 chronic club at 17% of target in 2018

	Results chain	Indicators	Baseline	Data from the survey	Targets	Targets	Sources and means of verification	Detail: Impact/ Completion
		To be presented **disaggregated by sex**	**May-17 (End of Yr1)**	**Dec 2017**	**May-18 (Yr2) (End of Yr2)**	**Dec-19 (End of Yr3)**		**Target Completed?**
		# of nutrition interventions in pilot sites led by Health Committees and health activists.	2 nutrition interventions in Klapmuts (FIF; Ubuntu NGOs). Belhar two soup kitchens	5% households receive food parcels	Approx. 5% reached via events Mostly training completed with ad hoc access to food at events for children and adults. 25 adults at an event. More activities are planned for year 3	10% of households in pilot sites receive food parcels/ food Calculated from survey: 100 households per site interviewed for food parcels. **10%=10 HH per site**	UCT baseline assessment of services in pilot communities	Partially Achieved: Yr 3 CSS Implementation results (quarterly reports): 20+200+20=240 May 2018 Reported 5% reached in our project using 10 HH per site as the target. (25 people accessing ad hoc soup kitchens) Endline Survey (MF): There was a decrease from 5.0% to 3.4% in Households who had a member who was a food parcel recipient. According to the survey (2+2+5) Belhar, Gugs, klapmuts respectively received any parcel in 2019 8,2,9 in 2017.
			No data at start of project	20 children of households participating in the survey, accessing meals.	15% reached 100 children, however at ad hoc event. More activities are planned for year 3	60% children receive meals at CSS project ECDs in pilot sites	UCT baseline assessment of services in pilot communities	Achieved: Yr 3 CSS Implementation results (quarterly reports): ECDs only: Klapmuts:211+Gugs 56+Belhar 22=289 Incl. ECDS and child focused projects for children: 251+56+75=382 Year 3 total: incl ad hoc food donations: 382+200=582 Previously reported May 2018: 15% (100 children at an ad hoc events)
			2 gardens in Belhar	43 out of 594 (SHOULD BE 300) (11+14+18) households functional food gardens	25% reached 6 food gardens (3 Belhar and 3 Gugulethu)	5 functional food gardens in each of the pilot sites. (Total: 15)	UCT baseline assessment of services in pilot communities	Achieved: Yr 3 CSS Implementation results (quarterly reports): 5+25+2=32. (over 200%) May 2018 reported 6 food gardens in total across sites: 15% reached Endline Survey (MF): %In 2019 -16 out of 278 (5+8+3) =5.75% households functional food garden. 2017 =14.3% DECREASE OF 59.8%
		# of health education interventions in pilot sites led by Health Committees and health activists.	Hypertension 2; TB 2; Diabetes 1 groups in Belhar	Elderly Chronic illness club in Gugulethu	17% : 1 chronic club: Gugulethu	2 chronic illness clubs in each of the pilot site locations (Total: 6)	UCT baseline assessment of services in pilot communities	Partially Achieved: Yr 3 CSS Implementation results (quarterly reports) and discussions with coordinators: 3 chronic clubs (1 klapmuts+2 Gugs): 50% 50 members Gugulethu and 10 in klapmuts Previously reported 1 chronic club at 17% of target in 2018

	Results chain	Indicators	Baseline	Data from the survey	Targets	Targets	Sources and means of verification	Detail: Impact/ Completion
		To be presented **disaggregated by sex**	**May-17 (End of Yr1)**	**Dec 2017**	**May-18 (Yr2) (End of Yr2)**	**Dec-19 (End of Yr3)**		**Target Completed?**
			Home based care 3 support groups in Belhar	No home visit support groups	33% achieved Klapmuts: 6 clinic monitors involved in home visits/ support	1 support group per pilot site (total: 3)	UCT baseline assessment of services in pilot communities	Achieved: Yr 3 CSS Implementation results (quarterly reports) and discussions with coordinators: 3 support groups: 100 % but not evenly distributed across sites(1 klapmuts, 2 Gugs) Reported 33% in 2018 in relation to support via clinic monitors visiting homes in klapmuts. Now target relates to support groups and not home visits.
		Health committee members and Health activists actively involved in monitoring services, in the three pilot sites	1 HC members from Belhar; 3 members form Gugulethu and 6 Health Monitors from Klapmuts	Same as baseline	100% completed: 15 HC members trained Belhar: 5 trained HC Members remain active to visit clinics Klapmuts: 6 clinic monitors supported by WFP monitor local clinic Gugulethu: 4 trained HC members monitor services at 2 clinics	5 trained health committee members actively involved in monitoring services (Total: 15)	UCT baseline assessment of services in pilot communities	Partially Achieved: Yr 3 CSS Implementation results (quarterly reports) and discussions with coordinators: 80% COMPLETED (Note on klapmuts: Klapmuts not fully operationalised. Previously Klapmuts only had clinic monitors now they have HC Members which been elected by Government (DOH). 2 of these have received training via UCT/ UWC winter school on HC governance. In addition, Klapmuts HC community members are from the CSS project. DOH is still to provide additional training. However additional challenges are facing Klapmuts in terms of further nominations for its HC. New challenges will require additional nominations to DOH.
	OC2: Strengthened coordination of services through community leadership, networks, partnerships and linkages with local government	# of integrated community advocacy actions to address health issues	No groups doing advocacy	2 Community advocacy activities	33% completed: (1 Belhar+ klapmuts+2 Gugulethu) =4 events of 12	4 integrated advocacy actions in each pilot site. (Total:12)	Media Articles; Interviews with participants and key informants; Minutes of meetings; Attendance registers; Pre- and post-training evaluations; Project reports; M& E Reports	Achieved: Yr 3 CSS Implementation results (quarterly reports): 12 events : 100% (6,5,1 events: Klapmuts, Gugs, Belhar respectively totalling 1050+2395+300 respectively)=3745 Previously (2018) reported 33% of target (4 of 12) beneficiaries 17+127+50=194 Total to date: 12+4=16 events. Total beneficiaries to date: 3745+194=3939
		# of events with national and provincial officials to bring attention to priority community concerns	No events in 3 locations	1 event pertaining to the provincial liquor bill and One national colloquium for health	One national colloquium for health	2 events - 1 event addressing social determinates of health and the other addressing health committees.	Media Articles; Interviews with participants and key informants; Minutes of meetings; Attendance registers; Pre- and post-training	Achieved: Yr 3 CSS Implementation results (quarterly reports):5 events held: Colloquium completed.in year 2

	Results chain	Indicators	Baseline	Data from the survey	Targets	Targets	Sources and means of verification	Detail: Impact/ Completion
		To be presented **disaggregated by sex**	**May-17 (End of Yr1)**	**Dec 2017**	**May-18 (Yr2) (End of Yr2)**	**Dec-19 (End of Yr3)**		**Target Completed?**
							evaluations; Project reports; M& E Reports	
Outputs	OP 1. Conduct Child protection, Food and Nutrition, Peacebuilding and health Basic training with a focus on content and skills, in pilot sites .	# of school-based life-skills workshops run across 3 pilot sites	Zero at start of project	No school-based life-skills programmes	65% reached 61 Peace Builders trained in yr. 2. Yr. 1, training took place in klapmuts only=17 Total trained to date: 61+17=78 (78 of 120)	120 peace builders trained (Total)	Training Registers; M&E reports; Meeting Reports	Completed but Partially Achieved: Delivered and reported in year 2: Accumulated Total 78 of 120. Target 65% achieved
					Peace building activities with young people in schools not yet implemented. To commence in year 3	90 young people exposed to information on gender, power and violence reduction in the pilot sites (Total: 90)	Training Registers; M&E reports; Meeting Reports	Yr 3 CSS Implementation results (quarterly reports): 33+60+30+49+40+982=1194 Belhar lifeskills programme at school, Gugs rehab and OASIS projects. KPA in klapmuts
		Better adherence to treatment for patients with chronic illness in the three sites	Zero at start of project	55 health educators trained	80% completed (72 of 90)	90 Health Educators trained (Total: 90)	Training Registers; M&E reports; Meeting Reports	Completed but Partially Achieved: Delivered and reported in year 2, 80% target completed
			No data at start of project	Approx. 80% of chronic patients in care (260 chronic patients and 218 in care)	No Update. To be updated as part of year 3 survey Activities to increase health promotion/ awareness and the like, will be scheduled for year 3.	80% of chronic patients who participated in the baseline assessment are in care in pilot sites	Training Registers; M&E reports; Meeting Reports	Partially achieved: CSS implementation: 50 Chronic patients Gugulethu 10 chronic patients in klapmuts Approx. 60 via chronic clubs + Care accessed via support club: 60 members total: Approx.: 120 people receiving Endline Data: Comparing all intervention groups to all control groups for changes from 2017 to 2019, it appeared that the intervention areas experienced slightly larger improvements in patients with hypertension being in care and attending in the past month than improvements also seen in the controls. In the intervention areas rose from 81% to 95%. The percentage of patients with self-reported hypertension who were said to have attended for care in the intervention areas

	Results chain	Indicators	Baseline	Data from the survey	Targets	Targets	Sources and means of verification	Detail: Impact/ Completion
		To be presented **disaggregated by sex**	**May-17 (End of Yr1)**	**Dec 2017**	**May-18 (Yr2) (End of Yr2)**	**Dec-19 (End of Yr3)**		**Target Completed?**
								rose from 82% to 96%. The percentage of patients with self-reported hypertension attending care clubs rose by more than 50% from 20% to 31% in intervention areas. For diabetes, process measures were also largely improved in the Intervention Group. In the intervention areas, the percentage of patients being in care rose from 83% to 100%, attending in the past month from 70% to 93% and being part of a Care club rose from 15% to 23%. Overall, the evidence suggests intervention areas experienced slightly greater improvements in care measures for both hypertension and diabetes, particularly in the uptake into care groups Endline Survey (MF): 60% in 2017 had a member with chronic illness. Decrease to 57.7 in 2019.
			Zero at start of project	27% or 69 chronic patients are care club members correct	No Update. To be updated as part of year 3 survey Activities to increase health promotion/ awareness and the like, will be scheduled for year 3.	40% of chronic patients in the pilot sites are care club members	Training Registers; M&E reports; Meeting Reports	Partially achieved: CSS implementation: 50 Chronic patients Gugulethu 10 chronic patients in klapmuts Approx. 60 via chronic clubs + Care accessed via support club: 60 members total: Approx.: 120 chronic patients receiving care via support clubs and chronic clubs Endline Data (please see target above for detail i.e. target 80% of chronic patients (pilot sites) in survey are in care) Overall, the evidence suggests intervention areas experienced slightly greater improvements in care measures for both hypertension and diabetes, particularly in the uptake into care groups Previously reported in May 2018: No update
		# of family/ food and nutrition supporters trained to identify families in need food and nutrition support	Zero at start of project	66 family/ food and nutrition supporters were in training	Accumulated total: 42+16=58 64% to date (58 of 90) Total in yr. 2: 42 - Belhar: 9 - Gugulethu: 29 - Klapmuts: 4 And	90 family/ food and nutrition supporters trained (Total: 90)	Training Registers; M&E reports; Meeting Reports	Completed but Partially Achieved: Delivered and reported in year 2: 64% as stated 2018.

	Results chain	Indicators	Baseline	Data from the survey	Targets	Targets	Sources and means of verification	Detail: Impact/ Completion
		To be presented **disaggregated by sex**	**May-17 (End of Yr1)**	**Dec 2017**	**May-18 (Yr2) (End of Yr2)**	**Dec-19 (End of Yr3)**		**Target Completed?**
					Yr. 1: klapmuts 8, Belhar 8: total 16			
		# of Child Protection practitioners trained in early childhood development, child safety and health child development	Zero at start of project	87 child protection practitioners trained in total	Accumulated total: 80+54=134 (149% reached) Yr2: Belhar: 39 participants Gugulethu: Male 1 + Female 32 Klapmuts: 8 people completed Yr. 2 total: 80 And yr. 1: Belhar: 25 and klapmuts:29= total 54 (yr. 1)	90 child protection practitioners trained (Total: 90)	Training Registers; M&E reports; Meeting Reports	Achieved: Delivered and reported in year 2: 134 accumulated total (yr. 1 and 2) across sites. 149% target achieved
					66% achieved (2 of 3 sites) Belhar and Klapmuts have active child protection forums. Gugulethu is still in process of establishing it	3 child protection forums (1 in each pilot site: total 3)	Training Registers; M&E reports; Meeting Reports	Partially achieved: 3 Child focused groups which emerged from CSS in 3 sites: 80% as Belhar not as active. CP and ECD forum in Gugs in klapmuts Previously reported in year 2: 66% (2 out of 3 sites: klapmuts and Belhar) 66% achieved year 2018
	OP 2. Provide leadership and adult learning capacity building training to health committees and health activists of the pilot sites	# of Health Committee members confident in their knowledge and skills to address health issues and social determinants	6 in Belhar and 10 in Gugulethu HC members received basic HC training.	24 participants enrolled in the Diploma in Adult Education course at the UCT	24 participants enrolled in the Diploma in Adult Education course at the UCT	20 participants enrolled in the Diploma in Adult Education course at the UCT	Training Registers; M&E reports; Meeting Reports	100% completed. 17 graduated

	Results chain	Indicators	Baseline	Data from the survey	Targets	Targets	Sources and means of verification	Detail: Impact/ Completion
		To be presented **disaggregated by sex**	**May-17 (End of Yr1)**	**Dec 2017**	**May-18 (Yr2) (End of Yr2)**	**Dec-19 (End of Yr3)**		**Target Completed?**
			2 HC - Belhar - Gugs	2 HC - Belhar - Gugs	66% achieved. 2 sites have active HCs. Gugulethu HC has been active and they are having at least one meeting a month. Belhar HC is also active; however, meetings are less frequent. Klapmuts does not have a HC but they are considering establishing one. Nominations have been sent in.	HCs in target area have at least one monthly meeting.	Training Registers; M&E reports; Meeting Reports	Partially achieved: 80% completed due to Klapmuts which is still in start-up but this is due to DOH election/ nomination process and not as a result of CSS delivery. Thus Mostly a result of DOH not committing to training of HCs as well as delays in communicating approved elected members. This has impacted Klapmuts HC membership and formalising. However meeting has taken place with Klapmuts clinic. Therefore CSS/WFP has achieved in terms of assisting Klapmuts community in this process. In addition CSS has trained 2 of the elected HC members. the other 2 HC's are highly active.
			No mentoring support	12 sessions Belhar; 6 session Gugulethu; no sessions Klapmuts	50% achieved Belhar trainer has been engaging with health activists and the HC. The chairperson of the HC has been active in all activities facilitated by the trainer. Gugulethu HC is active with some members more involved than others and some members attending training. Interactions are regular but it is not yet based on mentoring only.	Monthly mentoring sessions for HCs with expert community advocates or trainers in pilot sites	Training Registers; M&E reports; Meeting Reports	Partially achieved: 66% achieved Gugulethu coordinator and trainer support Gugulethu and surrounding HCs including Klipfontein subdistrict Gugulethu HC members also benefitting from ongoing training provide by co- funding training via NRF on roles and responsibilities as well as facilitation skills and the like Gugulethu and Klipfontein recently benefited from a strategic planning training ad facilitation as part of NRF (co funding) Belhar: CSS participants is now part of BCHF and as benefited from M&E support Belhar and Klapmuts HCs members also benefited from the RTHB training including templates to assist with referrals Previously reported in May 2018: 50%
	OP 3. At least 3 community dialogues in each community, to discuss social determinate of health, health activism and health committees	# of Citizen's led dialogues to discuss heath and health related issues	Zero at start of project	4 community dialogues taking place in the pilot sites	(7+2+3+1)= 13 Belhar: 7 Gugulethu: 2 Klapmuts: 3 UCT 1	9 community dialogues taking place in the pilot sites (3 each site: Total 9)	Training Registers; M&E reports; Meeting Reports	Achieved: Yr 3 CSS Implementation results (quarterly reports): 6+4+4=14 events/ dialogues: 156% achieved Beneficiaries: 551+1133+340=2024 Previously reported in May 2018: 13 community dialogues Total community dialogues to date: 14+13=27
	Op 4: Project experiences and lessons reach, shared	# Awareness raising activities about the project with elected political leaders in	Zero at start of project	1 meeting with the Social Development Department	10% achieved Belhar: Local government officials were invited to all the community dialogues	1 Meetings each with the department of Social Development and	Training Registers; M&E reports; Meeting Reports	Achieved: Yr 3 CSS Implementation results (quarterly reports): 4 Gugulethu 2 Klapmuts

	Results chain	Indicators	Baseline	Data from the survey	Targets	Targets	Sources and means of verification	Detail: Impact/ Completion
		To be presented **disaggregated by sex**	**May-17 (End of Yr1)**	**Dec 2017**	**May-18 (Yr2) (End of Yr2)**	**Dec-19 (End of Yr3)**		**Target Completed?**
	with a wide range of policy-makers, civil society, academic community and public officials	provincial and municipal legislatures, at local level, and amongst NGOs, health departments, local communities and international peers			and the PR ward councillor always attended. Provincial: The CSS project intention and outcomes to date was presented to 3 different DSD departments. UCT: Presented at the Mandela Initiative Dialogue. The conference was a national gathering to investigate and develop strategies to overcome poverty and inequality	Health to share the lessons learned		7 UCT Total: 13 over 600% achieved Previously reported 10%
			Zero at start of project	Not yet	2 policy briefs in progress	3 Policy Briefs addressing issues raised by community dialogues and other integrated meetings and events, submitted to policy makers	Training Registers; M&E reports; Meeting Reports	4 Completed 133 % achieved
			Zero at start of project	no update	2 academic papers to commence	2 academic papers addressing the objectives of the project	Training Registers; M&E reports; Meeting Reports	Partially achieved. 1 complete. 1 in progress
			Zero at start of project	1 DVD on project; Website is updated	2 DVDs on project; Website is updated	Active Project website with updated project material including DVDs and personal stories	Training Registers; M&E reports; Meeting Reports	Achieved: 100%

Source: Evaluation of the Community Systems Strengthening for Health Project in three pilot sites in the Western Cape

Appendix G: Instructions for authors: Health Policy and Planning

Health Policy and Planning improves the design, implementation, and evaluation of health policies in low- and middle-income countries through providing a forum for publishing high quality research and original ideas, for an audience of policy and public health researchers and practitioners. *HPP* is published 10 times a year. *HPP* has a double-blinded peer-review policy. All types of papers are peer reviewed and all article abstracts from each issue are translated into French, Spanish and Chinese.

Before you submit, please make sure you have followed all the relevant instructions. A checklist for authors is available here.

- Guidance
    i. Improving chances of publication
    ii. Manuscript format and style for all articles
    iii. Prior publication guidelines
- Types of papers
- Submission process

Guidance

Improving chances of publication

As well as the high overall quality required for publication in an international journal, authors should take into consideration:

- Addressing *HPP*'s readership: national and international policy makers, practitioners, academics and general readers with a particular interest in health policy issues and debates.
- Manuscripts that fail to set out the international debates to which the paper contributes, and to draw out policy lessons and conclusions, are more likely to be rejected, returned to the authors for redrafting prior to being reviewed, or undergo a slower acceptance process.
- Economists should note that papers accepted for publication in HPP will consider the broad policy implications of an economic analysis rather than focusing primarily on the methodological or theoretical aspects of the study.
- Public health specialists writing about a specific health problem or service should discuss the relevance of the analysis for the broader health system. Those submitting health policy analyses should draw on relevant bodies of theory in their analysis, or justify why they have not, rather than only presenting a narrative based on empirical data.
- Primarily focus on one or more low- or middle-income countries.

The editors cannot enter into correspondence about papers considered unsuitable for publication and their decision is final. Neither the editors nor the publishers accept responsibility for the views of authors expressed in their contributions. The editors reserve the right to make amendments to the papers submitted although, whenever possible, they will seek the authors' consent to any significant changes made. The manuscript will not be returned to authors following submission unless specifically requested.

Should you require any assistance in submitting your article or have any queries, please do not hesitate to contact the editorial office at hpp.editorialoffice@oup.com.

Manuscript format and style for all articles

Only articles in English are considered for publication.

Prepare your manuscript, including tables, using a word processing program and save it as a **.doc**, **.rtf** or **.ps** file. Use a minimum font size of 11, double-spaced and paginated throughout including references and tables, with margins of at least 2.5 cm. The text should be left justified and not hyphenated.

The **title page** should contain:

- Title - please keep as concise as possible and ensure it reflects the subject matter
- Corresponding author's name, address, telephone/fax numbers and e-mail address
- Each author's affiliation and qualifications
- Keywords and an abbreviated running title
- 2-4 Key Messages, detailing concisely the main points made in the paper
- Acknowledgements
- A word count of the full article

In the **acknowledgements**, all sources of funding for research must be explicitly stated, including grant numbers if appropriate. Other financial and material support, specifying the nature of the support, should be acknowledged as well.

Figures should be designed using a well-known software package for standard personal computers. If a figure has been published earlier, acknowledge the original source and submit written permission from the copyright holder to reproduce the material. Colour figures are permitted but authors will be required to pay the cost of reproduction.

Please be aware that the requirements for online submission and for reproduction in the journal are different: (i) for online submission and peer review, please upload your figures separately as low-resolution images (.jpg, .tif, .gif or. eps); (ii) for reproduction in the journal, you will be required after acceptance to supply high-resolution .tif files. Minimum resolutions are 300 d.p.i. for colour or tone images, and 600 d.p.i. for line drawings. We advise that you create your high-resolution images first as these can be easily converted into low-resolution images for online submission.

Figures will not be relettered by the publisher. The journal reserves the right to reduce the size of illustrative material. Any photomicrographs, electron micrographs or radiographs must be of high quality. Wherever possible, photographs should fit within the print area or within a column width. Photomicrographs should provide details of staining technique and a scale bar. Patients shown in photographs should have their identity concealed or should have given their written consent to publication. When creating figures, please make sure any embedded text is large enough to read. Many figures contain miniscule characters such as numbers on a chart or graph. If these characters are not easily readable, they will most likely be illegible in the final version.

Certain image formats such as .jpg and .gif do not have high resolutions, so you may elect to save your figures and insert them as .tif instead.

For useful information on preparing your figures for publication, go to http://cpc.cadmus.com/da.

All **measures** should be reported in SI units, followed (where necessary) by the traditional units in parentheses. There are two exceptions: blood pressure should be expressed in mmHg and haemoglobin in g/dl. For general guidance on the International System of Units, and some useful conversion factors, see 'The SI for the Health Professions' (WHO 1977).

Manuscript file must include text body. Title Page, Figures and Tables should be uploaded separately.

Prior Publication Policy

[Based on a statement developed by a group of editors of journals that publish articles on health, health services, and health policy. Journals currently using this statement include: Health Affairs, Health Services Research, Inquiry, Journal of Health Politics, Policy and Law, Journal of Health Services Research & Policy, Medical Care, and the Milbank Quarterly.]

Background

The policy of the journals subscribing to this statement is to consider for publication only original work that has not previously been published. Questions about what constitutes previous publication are arising with increasing frequency because of the growth of electronic publishing and the increasing number of reports and papers being produced by organizations and agencies. This statement provides guidance on this issue.

There are legitimate reasons why research may be disseminated before submission to a journal. Active communication among researchers about preliminary findings or the circulation of draft reports for discussion and critique contributes to the eventual quality of published work. In addition, organizations that support or carry our research have an understandable interest in disseminating their work. From the perspective of journals, these reasons for dissemination must be balanced against two considerations. The first is the value of the peer review process. The rules against prior publication are intended to add some assurance of the credibility of published research.

Papers are often improved during the peer review process, with findings, conclusions, and recommendations sometimes changed in response to reviewers' comments. The public and policymakers might be confused or misled if there were multiple versions of a paper in the public domain. Second, from a more parochial viewpoint, journal space is limited, and much time and expense are involved in the evaluation, publication, and distribution of journal articles. Journals must make difficult choices about what to include; there is less value in publishing papers that have already been disseminated to their target audiences.

We discuss here several types of dissemination and provide guidelines with respect to the prior publication question. This discussion is essentially an elaboration of two rules, the first emphasizing previous dissemination of the material, the second stressing disclosure.

• Rule One: If the material in a paper has already been disseminated to a journal's audience, particularly in a format that appears to be a final product, then it is unlikely that a second version will be worth publishing in the journal.

• Rule Two: It is the responsibility of authors to let editors know at the time of submission whether a paper's contents have been previously disseminated in any manner so that the editors can determine whether to proceed with the review process.

Previous Presentations at Meetings

Presentation of a paper at conferences or seminars usually does not jeopardize the possibility of publication.

Working Papers

Dissemination of "working papers" to a limited audience will not ordinarily jeopardize publication. Working paper series are used

by many organizations as a means of enabling researchers to obtain critiques from fellow researchers. Working papers covered by this policy are those that are released by the author or an organization rather than by a publisher, are not advertised to the public, and are marked as drafts that are subject to future revision. HPP will not publish papers for which a similar working paper is already available in the public domain.

Internet Postings

Release via the Internet may jeopardize journal publication under some circumstances. Presentation of the work as a final report is a marker of an attempt to reach a wide audience, particularly when combined with efforts to direct traffic to the work (e.g., via links on other sites) and efforts to attract attention (e.g., press releases). In contrast, if a document is posted on the Internet only to facilitate communication among colleagues with the aim of getting feedback, and if there has been no attempt to otherwise attract the attention of journalists, the public, or the broader research community to the document, then this is unlikely to preclude journal publication.

In general, when posting on the Internet serves similar functions as presentation at professional meetings - facilitating the development of papers and the improvement of the research, influencing future revisions, and not constituting a "finished" product - it would not be considered prior publication. On the other hand, when the Web site posting functions as a virtual version of a conventional publication, which may even be copyrighted by the posting organization, the benefit of an additional publication in the journal will be scrutinized carefully.

In cases where there has been little to no exposure at the time that a paper has been submitted to the journal, but the circumstances surrounding the posting make it likely that a high level of exposure (press coverage, etc.) might occur, then the author should remove a posting as a condition for further consideration of the manuscript.

Authors who post papers on a Web site and do not want it to constitute prior publication should also post a disclosure statement such as: "This draft paper is intended for review and comments only. It is not intended for citation, quotation, or other use in any form." This statement should be kept on the Web site throughout the review process and until the paper is actually accepted for publication in a journal. Once accepted, authors should post a message to the effect that: "A revised final version of this paper will appear in (Journal Name), volume, issue." Authors also should include this statement as a header or footer on every page of the paper.

Formal Reports from Foundations, Academic Institutions, Institutes, Trade Associations, and Government Agencies

The dissemination efforts of foundations, government agencies, research institutes, and other organizations that support or carry out research can complement publication in peer-reviewed journals. If publication in one of our peer-reviewed journals is desired, organizational publications should be timed to coincide with or follow journal publication, with appropriate copyright permissions having been obtained. This sequence ensures that the peer-review process will have an opportunity to correct deficiencies of method or presentation.

Formal, published reports that have gone through an editorial process, that have been intended to reach a wide audience, and that are publicized and available to any interested party (whether free or not) usually will not be considered for journal publication. A paper that is based on such a report might be considered for publication if it were sufficiently different in emphasis or intent. In such instances, the author should explain at the time of submission (or before) how the paper differs from the previously released report and why its publication would represent a distinct and important contribution beyond that version.

Policy briefs

If the findings of a piece of research have been published locally (i.e. in a specific country) with the aim of influencing policy debates in that country then even if the brief is available on the web we may consider publishing an article so long as (i) the brief has not had wide circulation outside the country and (ii) the brief is clearly targeted at policy-making audiences, and hence does not include the detailed discussion of methods and perhaps findings that one might expect in a journal article.

Media Publicity

If results reported in a working paper have become widely known as a result of media exposure (or even if the potential for widespread exposure remains during review), and that working paper is readily available to interested readers (e.g., through a Web site), an editorial judgment will be made whether journal publication would be appropriate. Authors can help protect their work from unwanted media exposure by making clear on working drafts, copies presented at conferences, and other versions that it is a draft that has not yet undergone peer review for publication and that findings and conclusions are subject to change. Authors also should request that any "stories" derived from interviews with the media be embargoed until the work is published or released by the publisher (see, for example, Fontanarosa, P.B., and C.D. DeAngelis. 2002. The Importance of the Journal Embargo. Journal of the American Medical Association 288: 748-750). Any accepted manuscript released to the media should contain the statement: "A revised final version of this paper will appear in (Journal Name), volume, issue." Journal policies involving author contact with members of the media may vary, depending on the issue or journal. Thus, authors should check with the editor before speaking with or distributing papers to members of the media.

Importance of Disclosure

In contrast to the editors' decision whether a certain paper has been disseminated too widely to warrant journal publication,

there is very little judgment involved in whether an author should disclose previous dissemination. Prior to, or at the time of, submission of a paper that has been disseminated in any of the ways discussed previously, authors should bring this to the attention of the editor so that a determination can be made before the paper goes into the peer-review process. In so doing, authors should describe in what form and how the work was previously disseminated and how the submitted manuscript differs from previously disseminated versions. Editors might be receptive to a modified version of a paper that has been widely disseminated if the submitted version has a different focus (e.g., more emphasis on methods, more sophisticated analytic approach, or discussion of developments that have transpired since the initial dissemination). The key point is to let editors know about any dissemination that will have, or is likely to have, occurred before the journal article is published rather than have it discovered during or after the review or editorial process. As part of the submittal, authors should include copies of other related papers that might be seen as covering the same material.

Failure to disclose could preclude publication in the journal or, if already published, could result in a notice in the journal about the failure and may result in a retraction of the article.

Manuscript Preparation

Page 1: **Title Page** – as above.

Page 2: **Abstract**. The abstract should be prepared in one paragraph, no headings are required. It should describe the purpose, materials and methods, results, and conclusion in a single paragraph no longer than 300 words without line feeds. Page 3: **Introduction**. The Introduction should state the purpose of the investigation and give a short review of the pertinent literature, and be followed by:

Materials and methods. The Materials and methods section should follow the Introduction and should provide enough information to permit repetition of the experimental work. For particular chemicals or equipment, the name and location of the supplier should be given in parentheses.

Results. The Results section should describe the outcome of the study. Data should be presented as concisely as possible, if appropriate in the form of tables or figures, although very large tables should be avoided.

Discussion. The Discussion should be an interpretation of the results and their significance with reference to work by other authors.

Abbreviations. Non-standard abbreviations should be defined at the first occurrence and introduced only where multiple use is made. Authors should not use abbreviations in headings.

All **measures** should be reported in SI units, followed (where necessary) by the traditional units in parentheses. There are two exceptions: blood pressure should be expressed in mmHg and haemoglobin in g/dl. For general guidance on the International System of Units, and some useful conversion factors, see 'The SI for the Health Professions' (WHO 1977).

References. References must follow the Harvard system and must be cited as follows:
Baker and Watts (1993) found...
In an earlier study (Baker and Watts 1993), it...

Where works by more than two authors are cited, only the first author is named followed by 'et al.' and the year. The reference list must be typed double-spaced in alphabetical order and include the full title of both paper (or chapter) and journal (or book), thus:
Baker S, Watts P. 1993. Paper/chapter title in normal script. Journal/book title in italics **Volume number in bold** : page numbers.
Baker S, Watts P. 1993. Chapter title in normal script. In: Smith B (ed). *Book title in italics*. 2nd edn. Place of publication: Publisher's name, page numbers.

Tables All tables should be on separate pages and accompanied by a title - and footnotes where necessary. The tables should be numbered consecutively using Arabic numerals. Units in which results are expressed should be given in parentheses at the top of each column and not repeated in each line of the table. Ditto signs are not used. Avoid overcrowding the tables and the excessive use of words. The format of tables should be in keeping with that normally used by the journal; in particular, vertical lines, coloured text and shading should not be used. Please be certain that the data given in tables are correct. Tables should be provided as Word or Excel files.

Types of papers

Health Policy and Planning welcomes submissions of the following article types:

- Original research
- Review articles
- Methodological musings
- Innovation and practice reports
- Commentaries

- 'How to do (or not to do)...' [for example, see Hutton & Baltussen, HPP, 20(4): 252-9] and
- '10 best resources' [for example, see David & Haberlen, HPP, 20(4): 260-3].

ORIGINAL RESEARCH

Manuscripts should preferably be a **maximum** of **6,000** words, excluding tables and figures/diagrams.

The manuscript will generally follow through sections: Title page (as above), Abstract (no more than 300 words), Introduction, Methods, Results, Discussion, Conclusion, Acknowledgements, References. However, it may be appropriate to combine the results and discussion sections in some papers. Tables and Figures should not be placed within the text, rather provided in separate file/s.

For the reporting of statistical analyses please consider the following additional points:

- Focus the statistical analysis at the research question.
- Provide information about participation and missing data.
- As much as possible, describe results using meaningful phrases (e.g., do not say "beta" or "regression coefficient", but "mean change in Y per unit of X"). Provide 95% confidence intervals for estimates.
- Report the proportions as *N* (%), not just %.
- Report *P* values with 2 digits after the decimal, 3 if <0.01 or near 0.05 (e.g., 0.54, 0.03, 0.007, <0.001, 0.048). Do not report *P* values greater than 0.05 as "NS".
- Always include a leading zero before the decimal point (e.g., 0.32 not .32).
- Do not report tests statistics (such as chi-2, T, F, etc.)."

For acknowledgements, figures and measures see above.

REVIEW ARTICLES

Manuscripts should preferably be a **maximum** of **10,000 words**, excluding tables, figures/diagrams and references.

Reviews may be invited. They generally address recent advances in health policy, health systems and implementation. **Systematic reviews are particularly welcomed**, but may not be appropriate for every topic. If authors are submitting a review article that is not a systematic review then the paper should explain why a systematic review was not feasible/desirable, and the review methods should be described in a way that is as clear and as replicable as possible.

The manuscript will generally follow through sections: Abstract (no more than 300 words), Introduction, Methods, Results, Discussion, Conclusion, References. However, it may be appropriate to combine the results and discussion sections in some papers. Tables and Figures should not be placed within the text, rather provided in separate file/s.

Checklists have been developed for a number of study designs, including randomized controlled trials (CONSORT), systematic reviews (PRISMA), observational studies (STROBE), diagnostic accuracy studies (STARD) and qualitative studies (COREQ, RATS). We recommend authors refer to the EQUATOR Network website (http://www.equator-network.org) for further information on the available reporting guidelines for health research, and the MIBBI Portal for prescriptive checklists for reporting biological and biomedical research where applicable. Authors are requested to make use of these when drafting their manuscript and peer reviewers will also be asked to refer to these checklists when evaluating these studies.

COMMENTARIES

Short commentaries on topical issues in health systems are welcomed - please email the editorial office prior to submission. Most such commentaries are commissioned by the editors, but the journal will also consider unsolicited submissions. Commentaries should of broad interest to readers of *Health Policy and Planning*, and while they are not research papers, they should be well substantiated. Manuscripts should preferably be a **maximum** of **1,200 words**, excluding tables, figures/diagrams and references.

The manuscript will generally contain a short set of key take-home messages. Tables and Figures should not be placed within the text, rather provided in separate file/s.

HOW TO DO...OR NOT TO DO

This series is meant to explain how to use a particular research or analytical method (e.g. social network analysis, discrete choice experiment etc.). The research or analytical methods discussed should be well accepted and clearly defined: this category of paper is not meant to address methodological debates but rather to help disseminate and promote the use of well-accepted methodologies.

Manuscripts should preferably be a **maximum** of **3,000 words** excluding tables, figures/diagrams and references.

- The sections must be arranged as follows: i) Title page (as above), ii) Abstract, iii) Introduction, iv) Body of the paper, and v) References. Main sections should be coordinated by the author, and inserted between Introduction and Reference sessions. Please contact our office before submitting a manuscript in this category.

Tables and Figures should not be placed within the text, rather provided in separate file/s.

10 BEST RESOURCES

This 10 best is a series of articles that identify and outline the 10 most useful resources from a range of sources to help facilitate a better understanding of a particular issue in global health.

We often commission these articles but we also hear unsolicited suggestions.

For acknowledgements, figures and measures see above.

METHODOLOGICAL MUSINGS

This series is meant to address methodological issues in health policy and systems research, where there is currently a lack of clarity about accepted research methods. This series is intended to support the development of the health policy and systems research field, through supporting methodological discussion. Manuscripts should preferably be a **maximum** of **3,000 words**, excluding tables, figures/diagrams and references.

- The sections must be arranged as follows: i) Title page (as above), ii) Abstract, iii) Introduction, iv) Body of the paper, and v) References. Main sections should be coordinated by the author, and inserted between Introduction and Reference sessions. Please contact our office before submitting a manuscript in this category.
- For acknowledgements, figures and measures see above.

INNOVATION AND PRACTICE REPORTS

These short reports are narratives from the perspective of health managers operating at the national or sub-national level which focus on innovative approaches to strengthen health systems. Papers should highlight the practical experience of health managers or practitioners involved in taking action to strengthen health systems through innovative activities and new practices. The new activities and practices should preferably have been implemented for a sufficiently long time to allow authors to demonstrate the potential for sustained improvement or change in the health system. Examples might include practices to build capacity, develop new partnerships or restructure relationships within health systems. Papers should identify 2-4 key messages or lessons for consideration in other settings. We will not consider clinical and pharmaceutical innovations and practices. Manuscripts should be a **maximum** of **2,000 words**.

The manuscript will generally follow through sections: Key Messages, Abstract (no more than 300 words), Introduction, Methods, Results, Discussion, Conclusion, References. However, it may be appropriate to combine the results and discussion sections in some papers. Tables and Figures should not be placed within the text, rather provided in separate file/s. In the main body of the paper, sub-headings may be useful to signal key elements of the experience reported. Reports must be led by local practitioners, managers or policy-makers.

Submission process

- Pre-submission language editing
- Authorship
- Originality
- Online submission

PRE-SUBMISSION LANGUAGE EDITING

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