A Study Of The Characteristics, Participant Perceptions And Predictors Of Effectiveness In Community Partnerships In Health Personnel Education: The Case Of South Africa

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A Study Of The Characteristics, Participant Perceptions And Predictors Of Effectiveness In Community Partnerships In Health Personnel Education: The Case Of South Africa

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By

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List of Acronyms

List of Abbreviations

AEA	American Evaluation Association
AI	Academic Institutions (whether medical, nursing or otherwise)
ANC	African National Congress
AOD	Alcohol and Other Drug
BIPH	Border Institute of Primary Health
B:C	Benefits to Costs ratio
B:D	Benefits to Difficulties ratio
CBE	Community Based Education
CBO/s	Community Based Organisation/s
CHW/s	Community Health Worker/s
CM	Community Members
COE	Community-Oriented Education
COPC	Community-oriented Primary Care
Cp	Community Participation
CP/s	Community Partnership/s
CS	Core Staff (full time paid employees of the Partnerships)
Dept/s	Department/s
HP	Health Professions/ Professionals
HPE	Health Professions/ Personnel Education
HRD	Human Resources Development
HS	Health Services (whether local, regional or provincial)
LV	The long version of the questionnaire
MUCPP	Mangaung-University of the Orange Free State Community Partnership Project
NCOEIHS	Network of Community Oriented Educational Institutions for Health Sciences
NETHWORC	North Eastern Transvaal Health Workers & Community Education Project
NGO/s	Non Governmental Organisation/s
NUD*IST	Non-numerical Unstructured Data Indexing, Searching and Theorising
P'ship/s	Partnership/s
Partnership	Any of the partnerships participating in the study
PHC	Primary Health Care
PS	Professional Staff = AI + CS + HS
Quote	Qte
Reps	Representatives
SA	South Africa (republic of)/ South African
SAAG	South African Advisory Group
SAN	South African Network (of P'ships)
SV	The short version of the questionnaire
UNI	Una Nueva Iniciativa: group of Kellogg funded CPs-HPE in Latin America
UNITRA-CPP	University of Transkei Community Partnership Project
WCCPP	The Western Cape Community Partnership Project
WFME	World Federation for Medical Education
WHO	World Health Organisation
WKKF	W.K.Kellog Foundation, for brevity also referred to as "Kellogg" or the "Foundation". It should not be confused with the Kellogg Corporation

Terms used interchangeably

Partnerships, coalitions and alliances
Participation and involvement
B:C and B:D

Declaration

This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

Signed: Walid El Ansari (candidate)

Date: 26/July/1999

Statement 1

This thesis is the result of my own investigations, except where otherwise stated.
Other sources are acknowledged by footnotes giving explicit references. A bibliography is appended.

Signed: Walid El Ansari (candidate)

Date: 26/July/1999

Statement 2

I hereby give consent for my thesis, if accepted, to be available for photocopying and for inter-library loan, and for the title and summary to be made available to outside organisations.

Signed: Walid El Ansari (candidate)

Date: 26/July/1999

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Summary of Thesis

A community coalition is a formal alliance of organisations, groups and agencies that have come together for a common goal. Collaborative partnerships between the health professionals and the communities they serve have received attention as a strategy for achieving health gain and are spreading globally. This partnership approach has a potential for a synergistic maximization of impact and has been advocated as a means to increase citizen participation and ownership among under-privileged groups. Despite the popular appeal and theoretical promise of this approach, the precise domains that need to be fostered by the stakeholders to implement this complex model remain unclear.

The aim of this study was to investigate and compare the characteristics and perceptions of the CPs' stakeholders as regards the structural characteristics and operational parameters of the partnerships, as well as the correlates of effectiveness and impact for each participant group. Of particular interest was to identify the characteristics which enable partnerships to fulfill their organizational tasks and goals, regardless of the scope or complexity of purpose.

The five CPs were located across South Africa and aimed at Health Professions Education reforms. Quantitative data was collected from 668 coalition members and qualitative data from 46 strategic participants. The partnerships' documents were also scrutinized and ample participant observations were undertaken. The data was then pooled and the comparison groups were constructed: the professionals, comprising of staff from the academic institutions and the health service providers, the community members and the full-time paid employees of the partnerships, the core staff.

The analyses of the partner's opinions and views as well as the predictors of accomplishment of diverse stakeholders hold lessons for managers concerned with health coalitions. Generally, training and development seem to be the main thrust of the partnerships' missions. The observation is that clarity of roles, procedures and responsibilities is imperative. Clarity requires transparency to each others agendas. Although there was an under-representation of the youth, there seemed to exist a mixture of various levels of satisfaction in the partnerships, with the community members in need for more sense of ownership. The findings also point to that consultation in decision making seem to be lacking with unilateral decision making taking place. This might lead to power struggles and hidden agendas between the partners that could hamper the advancement of the partnerships.

Explanation of why stakeholders are satisfied or committed or what explains their views on effectiveness and activity levels of their partnerships may inform efforts in other settings. With diverse partners, it is important to be somewhat cautious in the consideration of the stakeholders engaged in these collaborative efforts. Partners working together need not be considered homogenous entities. The groups come from different backgrounds, organizations and cultures. The attitude to be created in collaborative interventions is one of a clear understanding that embraces the different origins and aspirations of the stakeholders and recognises the mutual roles, responsibilities, resources and limits. Only by paying due attention to their individual values and weaving it into a common vision can the partnership process be taken forward.

Background

Over the past decade, there is evidence to suggest that, particularly in the developing world, medical science and technology has not achieved the remarkable improvements for the majority of the people that they did in the industrialized nations in the 19th and 20th centuries (World Bank, 1975). These facts have led to the view that in the absence of dramatic breakthroughs in medical science, the greatest potential for improving health is through changes in what people do for themselves. For this reason, there has developed a great deal of interest in involving the non-professional in health care activities. Public involvement is beginning to be seen as the key to stimulate a radical health improvement for the majority of the world's people, especially the poor. What is needed is an effort to make interventions and concepts popular with the people for whom these are intended. 'Knowledge or technological breakthrough' alone is not sufficient to improve the health of the people— a 'social breakthrough' is equally important (Kumar and Murthy, 1989).

In 1978, the members of the World Health Organisation (WHO) endorsed the Alma Ata declaration and Primary Health Care (PHC). Its characteristics were: (a) reorientation of the health services; (b) a more even distribution of health resources; (c) inter-sectoral coordination; and (d) the active participation of the community (WHO, 1987). Following the Declaration, several countries embarked on programmes that emphasized community participation and other aspects of the PHC approach. Thus, community participation, considered the heart of the PHC by some (Ahmed, 1978), gained pace and abundant momentum.

The key to PHC was identified as community participation (Cp) (Rifkin, 1987) and the enthusiasm for public involvement in health has gained great popularity over the last decade. The concept has been seen in the first instance as a panacea for the ailing health care systems in most countries. In reality, the concept is complicated, confusing and not clearly understood or agreed upon by all those who share the sentiments of a broad role for laymen and communities in health care. Unless the concept is dissected, analyzed and examined, it is more than possible that it will be rejected as a bad experiment and return all health care to the hands of the medical profession (Rifkin, 1981). To date, however, the involvement of communities in decisions about health and the delivery of health services remains one of the most difficult and least understood principles of PHC. While the slogan is often expressed, the promotion of Cp and development of PHC programmes to improve the health and life of slum and squatter dwellers remains elusive (Rifkin, 1987).

Differences of opinion, however, occur in views as to how the public can effectively participate in health care activities and Rifkin (1981) concluded that there is no singular, homogenous view about the role of the public. She focused on several issues that may help answer major questions about public involvement: (a) the issue of professional domination of the field of health care; (b) the issue of organizational management. How can suitable organizations be created and maintained to sustain the defined level of participation in health activities?; and, (c) the issue of how to get the public involved. How can the public be motivated and mobilized to become involved in health activities?

In parallel, (Eng *et al.*, 1992) reported that for PHC providers and managers to actually engage in the dynamics of the community empowerment, a great deal must change in the usual patterns of education and practice. The focus of these changes may include:

(1) paradigm shifts and changes for the health care professionals to include the community in the field of vision; (2) engagement: of the detached "clinical" perspective to serve the cause of community organisation and empowerment. and removing the barriers that come between professionals and members of the community; (3) inclusion of other providers in the PHC network e.g. a spectrum of professionals, pharmacists, lay people, alternative and faith healers, acupuncturists, and informal carers; (4) learning new skills: the knowledge and skills taught to most health care professionals offer little to prepare them to function effectively in empowering communities; and, (5) changing institutions. In order to build communities, the institutions to which they relate must change in response to community needs and desires.

Globally, there is a movement of change in health systems, and transformation of the education of the health professionals who will operate them. These changes, many of them still at the level of concepts and ideas, while at the early stages of implementation, reflect a response to societal pressures, and concern of the health professions with issues like cost-effectiveness, quality of life, self care, prevention, life style, equity and social justice, to name only a few (Kisil and Chaves, 1994). The Alma-Ata Declaration of 1978 (WHO, 1978), and the Edinburgh Declaration of 1988 (World Federation for Medical Education, 1988), both provide the propositions for the innovative movement (Kisil and Chaves, 1994).

The community-based educational concept represented an important trend in current methods of education as a whole. It involved the integration of education and productive work within the learning process and the participation of all those involved in the actual work. The idea was introduced into

educational practice before the concept was recognized or the term coined (WHO, 1987). Community-based education is associated with efforts to involve students and, more generally, educational institutions in national development and to combine theory with practice. Community-based educational programmes have not been very successful in developing countries because of the benefit derived from the services of the students by both the country and the community involved, especially if it is in a remote or poor, suburban or urban area where the services are needed most (WHO, 1987).

At the 1989 General Meeting of the Network of Community-Oriented Educational Institutions for the Health Sciences (NCOEIHS), new emphasis was put on partnerships between universities, governments and communities in order to achieve the common goal of "Health for All by the Year 2000" as promoted by the WHO. The Kellogg Foundation, amongst others has made these Community Partnerships in Health Professions Education (CP-HPE) a major priority by investing over $50 million in the US sites over a five year period and additional funds overseas. These CPs-HPE were large scale demonstration projects at seven sites around the United States and in several other locations in Latin America and Africa. These initiatives, involving three types of paired relationships (university-community; university-local health system; local health system-community) provided the idea and the experiential basis for an innovative programme bringing the three partners together in a joint effort.

The aim of the CPs was to provide undergraduate medical, nursing, and allied health students with the opportunity to learn and experience team-based, non-hospital PHC in community settings. Goals of the CP-HPE projects encompassed preparing health professionals for community-based primary care practice; creating a mutual investment between communities and future health professionals through joint community service projects; strengthening the process by which community agencies and constituencies become part of the decision making for education, research and services; developing multi-disciplinary teams to provide health care in the community; conducting community-based research that explores the communities' concerns; and influencing the policy for the long term sustainability of health professions education in primary, community-based care. They aimed to promote institutional change. Knowing how strong resistance is to change in universities and health systems, very early in the development of the programme an evolutionary approach, based on incrementalism and gradualism, was suggested (Kisil and Chaves, 1994). The commitment was also to develop additional academic initiatives in community-based health care to assure that this becomes a bona fide scholarly endeavour. This would include community research, community education, and community service. The emphasis was on the community as a *bona*

fide partner and investor in the effort. The goals were an understanding of the concepts of primary prevention for entire villages, cross-cultural competency, and community health development.

Real CPs are more than identifying and consulting key partners in health in order to ensure compliance with prescriptions and utilization of services. It is not community participation induced and directed by one member of the CPs or from any source outside the community. It is a process in which the community invests itself in terms of ideas, experience and skills, takes risks, and determines the role of the other partners and the mechanisms for joint decision making and action. All partners decide on appropriate inputs from each partner, according to their strengths, resources and limitations, and from external sources. They also agree on equitable sharing of benefits and losses. External inputs and skills augment rather than replace the local ones. The greatest benefit should be the ability of the community to have greater control over their lives and situation. The complexity of each partner need be recognized, as each partner is not a homogenous entity. They may not be able to quickly agree on a common course of action (within the entity) necessary for the partnership. Many of them may not see CPs as defined in the initiative as a priority.

Butterfoss *et al.* (1993) reported that in general, a myriad of factors affect partnership functioning, implementation and maintenance. These included:

Formalized Roles & Procedures: is the degree of formalisation: degree to which rules, roles and procedures are defined precisely, varying from less intense agency "get-togethers" in which the personnel merely become acquainted with one another, to more extreme encounters in which definite operating responsibilities are held among organizations. It is the explicitness in so far as details are concerned. A formal agreement may be broad and sweeping, and it may not standardize the exchange relationship.

Leadership & membership characteristics: whether it is leadership characteristics, a critical factor in maintaining a coalition or; member characteristics, a coalition's primary asset. Each member brings a different set of resources and skills to the coalition. The pooling of member assets is especially significant when participation is voluntary and the coalition has few material resources of its own.

Degree of reciprocity— benefits and costs of participation: a critical dimension of interorganisational relations among autonomous groups is the mutuality of the relationship. Another indicator of reciprocity is the extent to which the terms of the interaction are mutually reached i.e., the extent to which the

conditions of the exchange are mutually agreed upon. This distinction could provide insight into the decision to participate. A high benefit to cost ratio may be needed.

The benefits of collaboration are diverse and include increased networking, information sharing and access to resources; attaining the desired outcomes for the coalition's efforts; enjoyment of the coalition's work; receiving personal recognition; and enhancing one's skills, and attaining more influence and power through the differences of experience and skills. On the other hand, the costs of collaboration include: devoting time to the coalition that is taken from other obligations; overcoming an unfavorable image held by other partners; lacking direction from the leadership or staff of the coalition, perceiving a lack of appreciation or recognition; becoming burnt out; and, lacking the necessary skills and feeling pressured for additional commitment. It may well cost an organization the expenditure of discretionary resources to pursue the potential benefits of interorganizational cooperation.

Organisational Climate: may be characterised by relationships among members, member-staff relationships, communication patterns among members and with staff, and the partnership's decision-making, problem-solving and conflict resolution processes.

Member relationships: although the current literature is limited in addressing the effect that relationships among coalition members have on the climate of a coalition, it is reasonable to hypothesize that positive relationships among members are likely to produce a productive melieu for the coalition.

Member-staff relationships: staff effectiveness may be judged by how well they balance their provision of technical assistance to members with the members' abilities to make informed decisions. Staff seem more likely to improve the atmosphere of a coalition when they possess an appreciation for the voluntary nature of coalitions, and have organizational and interpersonal skills to facilitate the complex, collaborative process.

Communication patterns: unimpeded internal communication among the membership and staff may be the most essential ingredient for enhancing the climate of a coalition. Open communication helps the group focus on a common purpose, increase trust and sharing of resources, provides information about one another's programmes, and allows members to express and resolve misgivings about planned activities.

Decision-making, problem solving and conflict resolution processes: the climate of a coalition may be enhanced when the leadership shares decision making with the general membership, and when the power, resources and authority deferentials are not too great. Shared decision-making may lead to greater understanding and commitment to the issues confronting a coalition. Conflict is an inherent characteristic of coalitions and may arise between the coalition and its targets for social change, among coalitions members and staff, and among coalition partners concerning issues such as leadership, diverse goals, benefits, contributions and representation. How a coalition manages these dynamics tensions affects its cohesiveness and effectiveness. Problem-solving and conflict resolution strategies were less commonly reported as important tools for enhancing the climate of a coalition than are decision-making strategies.

External supports–resource exchange and community linkages: maintaining a coalition is a dynamic process that develops through their linkages between the member organisations and the coalition. It is the process that supports the life of a coalition, in order to keep it from declining and to sustain it against any opposing forces. Coalitions often benefit by linking with individuals and organisations that are active in community affairs.

Satisfaction and commitment: members who perceive a coalition as beneficial express greater satisfaction and often collaborate to a greater extent than members who perceive coalition involvement as costly. The general wisdom holds that coalitions tend to remain durable when the commitment of individual members is strong. Member groups have different levels of commitment that result in varied investments of time, effort and resources.

Skills and training: effective implementation and maintenance of a coalition not only requires motivated and involved members, but also requires that members have the skills or 'capacity to participate' in order to operate an effective partnership and to be perceived as legitimate. Coalitions prompted by state legislation often require training and technical assistance, and the types of assistance that may be required need be tailored to the different stages of coalition development.

Partnership Composition–representation and inclusiveness: the term "community representation" has become quite popular, but no one seems to know a really satisfactory way of identifying community representatives. The term "representation" suggests that there is a relationship of some kind between the representatives and their constituents. Many representatives find this relationship non-existent or at best

weak. Is one to deal with the official leaders or the natural leaders, with staff of community organizations or with grass-roots support? Queries about who they are and how they were selected often prevails. Often it is a minority, the better off, who are more involved. If the poorer and therefor sicker members of the community are not represented in the partnership, then it is unlikely that their perspective will be presented, thus perpetuating inequity. Therefore, participation should not be limited to those who already have some power. Accordingly, the composition of the partnership's board is a factor affecting project sustainability.

Institutionalization/ Sustainability: institutionalization can be defined as the attainment of long-term viability and integration of innovations in organizations. Institutionalization is generally considered to be the final stage of a diffusion process. Many health promotion programmes will not become institutionalized, regardless of how theoretically sound, well implemented, and effective they may prove to be. Organizational innovation literature illustrate that successful programme implementation does not necessarily assure long-term programme viability. Past experiences suggest that many demonstration projects failed to continue once the sponsoring agency withdrew initial funding and other support.

Rationale

In the Health For All (HFA 2000) strategy, the member states of the WHO committed themselves to creating the conditions which will enable all people to enjoy a healthy life by the year 2000. The strategy's focus was on prevention of ill health, the maintenance and promotion of good health and the capacity to resist disease. It soon became evident that these health goals cannot be realised through the services delivered by the health sector alone, but are perceived as a multisectoral responsibility.

The concept of PHC strives to ensure a continuum of preventive and caring services that reflects active involvement and ownership of the communities in which it is practiced (WHO, 1988). The more encompassing definitions of PHC reflect the involvement and collaboration between a variety of practitioners, including nurses, nurse practitioners, physician assistants, dentists, managers, and others (Eng *et al.*, 1992). PHC builds on a participatory approach and recognises the recipient rather than the provider as the central figure in the process.

Health Alliances are being developed globally with both specific and more broad ranging objectives. In many policy areas the call for partnerships across sectors, and the recognition that "wicked issues" cannot be solved by one agency on its own has encouraged both public participation and joint working. The number of funded community health projects that rely on coalitions represent considerable investment of resources (Butterfoss *et al.*, 1993) and the concept of professionals working together in a collaborative mode has gained wide support (Rawson, 1994; Mackay *et al.*, 1995).

However, despite the general agreement that partnerships are 'a good thing', Butterfoss *et al.* (1993) called for a systemization and understanding of what characteristics lead to producing short and long term impacts on the communities that the coalitions serve. This study is a response to the call to systematise the understanding of partnership functioning and fostering. The general 'gaze' of the investigation is on the process of the collaborative effort as well as the obstacles that diverse stakeholder groups involved in joint working encounter when interacting to align their inputs in a cohesive common effort. In this study, traditionally and historically, the partner groups under investigation had not communicated with each other.

Study Aims & Objectives

General Aim

The aim of this study is to investigate and compare the characteristics and perceptions of the CPs' stakeholders as well as the correlates of effectiveness of the participant groups. Of particular interest is to identify the characteristics which will enable CPs to fulfill their organizational tasks and goals, regardless of the scope, complexity of purpose or method of formation.

Specific Objectives

This sub-study has five main objectives;

1) To determine how coalitions operate and to identify the factors which contribute to coalition competency,
2) To describe the level and type of coalition activities and assess outcomes over the previous years,
3) To compare the stakeholders views' as regards the structural characteristics and operational parameters of the CPs,

4) To identify the correlates of accomplishment and impact for each stakeholder group,

5) To inform the development of support systems, thus disseminating guidelines recommended to maximise the impact of the CPs.

Organisation of the dissertation

In accomplishing the aims and objectives of the study, the dissertation is structured as follows:

Chapters one and two collectively address the CP literature which is widely dispersed between several disciplines including organisational management, health promotion, psychology, public health, sociology and public administration.

In Chapter one, a wide literature review is undertaken. This provides the general theoretical basis for the dissertation and encompasses the PHC movement, community participation/ involvement and the need for both, a change of roles of health professionals and the redirecting of HPE. The more specific literature includes two subsections: to enable the reader to get a flavour of the donor foundation's vision, a somewhat restricted review of other CPs projects initiated by the same funding body that supported the SA CPs–the W.K. Kellogg Foundation Initiatives in the Americas and Southern Africa–is undertaken. This then gives way to a general theoretical examination of the concept of CPs.

Chapter two dissects and analyses the partnership/ coalition concept in great detail, stripping the notion down to its basic interlacing fabric components, from a brief historical perspective to the various definitions and the notion of inter-organizational collaboration. In doing so, a range of structural factors and operational parameters that affect successful partnership functioning, implementation and maintenance are reviewed. These explore issues of formalized roles and procedures; leadership and membership characteristics; degree of reciprocity; motivators; benefits and costs of collaboration; organizational climate; sustainability and empowerment and other miscellaneous factors.

Chapter three describes the methods employed in this research. It is comprised of two subsections. First, the study setting: a broad overview of South Africa's health policy concerns and heath indices, which then narrows down to a review of the main focus of the study - the cluster of five South African CPs-HPE sponsored by the philanthropic organisation, the W.K. Kellogg Foundation. Second, is the section on the study design: the rationale for the use of mixed-methods in this cluster evaluation, theoretical and

conceptual framework/s as well as methodological issues pertaining to details of the quantitative and qualitative research instruments that were employed in the survey and the interviews, as well as the strategy for the analyses of both types of data.

Chapter four presents the findings of the study. First, the quantitative findings related to the structural factors and operational parameters that were indicated in chapter two are shown. These comprise of reliability issues and descriptive, comparative and predictive results for each of the stakeholder groups involved in this collaborative effort, as well as for the whole sample. Second, the qualitative findings emerging from the study are reviewed, clustered under common overarching themes that capture their common essence. The themes include clarity; representation; communication; ownership issues; power deferentials and consultative decision making; capacity building; and, sustainability factors.

Chapter five discusses the study's findings in the context of the literature that was reviewed in chapters one and two, drawing upon both the similarities and contrasts with other relevant research and similar investigations. An in-depth analysis is undertaken as well as a discussion of both the quantitative and qualitative findings weaved together under common themes to furnish complementing pieces of evidence in the greater partnership puzzle. The general themes of the discussion overlap and add to the themes emerging from the qualitative interviews. The include: clarity; communication; member skills and training; representation; involvement and contributions; member relationships, quantity and quality of participation; institutionalization and sustainability; and, organisational and personnel barriers to participation. Finally a discussion of the methodology and the attending reliability issues is undertaken.

Chapter six draws together the pertinent evidence and solid findings, after their discussion, into conclusions and priority areas that could benefit from further attention by the CPs under investigation. The study's recommendations are being fed back to the participating CPs and disseminated through a variety of channels. Chapter six also acknowledges some of the limitations met with during the implementation of the investigation and proposes forward, based on the lessons learnt, suggestions for the direction of future research aimed at bettering the understanding of the functioning and fostering of effective CPs.

The general impression from this study is that the combination of factors and conditions under which each of the partner groups is satisfied or committed to the CP's work are different. Stakeholder groups involved in collaborative efforts are far from being homogenous entities. Partners in joint working

arrangements value miscellaneous and diverse aspects of the partnerships they participate in. Attention needs to paid to each partner's background, organization and diverse value systems. If joint working is to survive, there is need for the professionals to appreciate and value the indigenous abilities of their community members counterparts. The attitude and culture that need be created in interventions that are built on collaboration is one of a clear understanding that embraces the different origins, aspirations and horizons and cultures of the stakeholder groups and recognises the mutual roles, responsibilities, resources and limits. Programme models need consciously incorporate capacity building and transference of skills in their design and implementation.

I . Chapter One

Introductory Literature Overview

In accomplishing the first objective of the study in understanding how coalitions operate and identifying the factors which contribute to their competency, chapter one first deals with a wide literature review. This provides the background context in which partnerships are emerging as part of the PHC movement. Accordingly, this chapter provides the general theoretical background for the thesis and encompasses the PHC movement, community participation/ involvement and the need for both, a change of roles of health professionals and the redirecting HPE. Later in the chapter, the more specific literature includes two subsections: to enable the reader to get a view of the donor Foundation's vision, a somewhat restricted review of other CPs projects initiated by the same funding body that supported the SA CPs - the W.K. Kellogg Foundation Initiatives in the Americas and Southern Africa is undertaken; and then, a general theoretical examination of the concept of CPs.

1.1. Primary Health Care

1.1.1. The PHC movement

In 1978, the 150 plus members of the World Health Organisation (WHO) endorsed the Alma Ata declaration making Primary Health Care (PHC) the focus of their national health policy (WHO, 1978). PHC as an approach to health development involves the total reorientation of the health system. Its characteristics are: (a) reorientation of the health services to enable secondary and tertiary care to support care at primary care level, the first level of contact, thus involving the entire health system; (b) a more even distribution of health resources, with more allocated to primary care and to promotive, preventive, and rehabilitative care than at present; (c) inter-sectoral coordination; and (d) the active participation of the community (WHO, 1987).

Primary care and PHC has been conceptualized in both narrow and broad terms. Narrow definitions include those that consider PHC to be a first-contact medical practice. Those more encompassing definitions reflect involvement of a variety of practitioners including nurses, nurse practitioners, physician assistants, dentists, managers, and others. Community-oriented primary care (COPC) has as part of its definition an orientation towards an involvement of the overall community in services (Deushle, 1982c; Mullan, 1982). The concept of PHC strives to ensure a continuum of preventive and caring service that reflects active involvement and ownership of the community in which it is practiced (Eng *et al.* 1992).

Similarly, Tones (1994) also analogously reported that the health promotion principle has the key attributes of: (1) Equity; (2) emphasis on the physical, socio-economic and cultural environments; (3) the development of 'healthy public policy' and the creation of 'active empowered communities' as two major strategies, and (4) 'inter-sectoral collaboration' (that is, form 'healthy alliances') in order to develop healthy public policy and achieve community and individual empowerment.

In parallel, Rifkin (1987) concluded that if PHC had a chance of succeeding then all social services must be integrated, planning and management mechanisms must be developed, agency work must be co-ordinated and finally, planners must have flexible responses to programmes. Flexibility was the key to enabling programmes to use human potential to meet community needs. This is, that all programme participants, government, non-government organisations, UN agencies, donors and community people need to respond to each others' views in an appropriate manner. Hildebrandt (1994) also reported that community involvement in health, a central concept in health development, is a participatory approach to health care that is organised from the perspective of the recipient. Models for community involvement in health need be flexible so that programmes can be interpreted and implemented in the context of local cultures and resources. Putting community involvement in health into practice thus represents a learning experience for the community, the health professionals involved and those responsible for the national climate in which this change takes place.

1.1.2. Community involvement and the need for change of roles of professionals

There is a growing recognition and belief that major shifts in unhealthy lifestyles and community norms can be accomplished through citizen participation and community development (Howard-Pitney, 1990). Heller (1990) has called for a "return to community" and increased community empowerment to counteract observations that "local communities have diminished power and political influence, with decisions and resources flowing downward from the federal level". Similarly, Watt and Rodmell (1988) maintained that all attempts to define health promotion indicate that health promotion will not succeed without the engagement of the community. Madan (1987) also reported that the notion of community involvement in health, has found wide acceptance in all kinds of political regimes and particularly in the Third World countries. Such involvement is expected to be the best way of providing comprehensive solutions to public health problems.

Brownlea (1987), however, suggested that the prospects for increased participatory approaches in health arenas has to recognize not only the encouraging developments (e.g. the "rights" legislation, global health programs approaches, social action acceptability, growth in community advocacy skills and freedom of information legislation) but also the persistence of some long-standing impediments (e.g. entrenched medical dominance, antagonistic bureaucratic culture, a centralist supremacy, an intractable political economy of health and inhibitory professional paradigms). There are wide variations between societies in the way these developments and impediments are traded off or balanced, ultimately depending upon how such issues as the sharing of knowledge and skills, information access, challenges to power, practices and paradigms are being recognized and resolved in specific contexts.

Reasons for public involvement in health activities range from that public involvement increases the existing health care resources through contributions of manpower, materials and money, to that public involvement provides the conditions necessary for the re-structuring the present health care delivery system which denies health care to the poor and disadvantaged. Advocates of public involvement recognize the limits imposed by financial, social and cultural structures on the ability of medical science and technology to solve existing health problems. They note that curative costs absorb the majority of both government and individual health expenditure and that this expenditure centers on illness and disease rather than on health (Bryant, 1969). They see little evidence that money spent on health services radically improves a nation's health. They argue that health improvements depend more on prevention and promotion aspects of health care, and on the socio-economic-political environment of a country.

The key to PHC was identified as community participation (CP) and the enthusiasm for public involvement in health has gained great popularity over the last decade. The concept has been seen in the first instance as a panacea for the ailing health care systems in most countries. In reality, the involvement of communities in the delivery of and decisions about health and health services remains one of the most difficult and least understood principles of PHC (Rifkin, 1987).

Rifkin (1981) concluded that there is no singular, homogenous view about the role of the public. Instead, she focused on several issues that may help answer major questions about public involvement:

(a) the issue of professional domination of the field of health care. To what extent is the public capable of understanding and implementing activities which have traditionally been the purview of those trained in a highly specialized and technologically sophisticated field? Traditionally, the professional has

denied the non-professional access to both the knowledge and practices. This denial has had social, political and economic consequences. It has created a class of people who in part self-created a demand for their skills and monopolized all decisions about how health resources and skills should be used. This has been widely addressed in the literature (Rifkin, 1986; Antia, 1988; Freyens *et al.*, 1993; Zwarenstein and Barron, 1993).

(b) the issue of organizational management. How can suitable organizations be created and maintained to sustain the defined level of participation in health activities? This concerns the means by which the public can become involved in health care activities and in the development of structures necessary to both encourage and allow the individual and the larger community to make a meaningful contribution to health care. This issue reflects the tension between the need to institutionalize activities in order to ensure endurance and replicability and the necessity to maintain flexibility in order to meet the needs of individual communities and people. Several authors have stressed similar concerns (Giamartino & Wandersman, 1983; Feighery & Rogers, 1990; Rogers *et al.*, 1993; Gottlieb *et al.* 1993; Butterfoss *et al.* 1993)

(c) the issue of how to get the public involved. How can the public be motivated and mobilized to become involved in health activities? At the core of this question is the search for what motivates individuals to participate and how large numbers of people can be mobilized. It seeks to analyze what promotes community participation, and what incentives encourage people to become involved in their own health promotion and maintenance (Rappaport, 1981; Zimmerman and Rappaport, 1988; Zimmerman, 1990; Prestby *et al.*, 1990).

Three types of community involvement are described (WHO, 1987).

The first type, sometimes referred to as nominal or passive; amounts to no more than a one way flow of information to a community through the members attending meetings or receiving information. There is no genuine involvement. It is often reported that there are many participants in an activity, mere attendance at a meeting being wrongly equated with participation.

The second type of involvement is consultation; the community is not only informed but reacts and expresses opinions. This is a fairly low level of involvement since those who are taking part are not necessarily the decision-makers. The consultation should be two-way, especially when it is between

professional educational administrators and the community. To ensure involvement, certain conditions are necessary. These include; (1) a guarantee of freedom of expression and association; (2) a means of ascertaining the effects of expressed opinions and decisions; (3) a means of making the information required available to the community for critical analysis; (4) a basic level of education for self-expression and the formulation of problems; (5) sufficient time to examine information; and (6) a political will on the part of decision-makers to take the opinions derived from the consultation into account. In many cases, these minimal conditions are not present (WHO, 1987).

The third type of involvement implies the sharing of power. The questions that then arise relate to the extent of the community's power and whether legal means or regulations exist that enable it to insist on its point of view being taken into consideration. The conditions described above as being necessary for consultation are equally valid for this type of involvement.

Montgomery and Esman (1971) were concerned with participation by the poor and deprived, not with lobbying or manipulation by well-organised and influential group interests. According to the WHO's categorisation of participation, depending on the community's degree of initiative, the CPs participating in this study, their involvement can be classified as *induced* involvement. This is the most common form of involvement, which results from innovations initiated by the administration rather than the community (WHO, 1987).

Eng *et al.* (1992) reported that both practitioners and educators alike are moving from defining "community" as a physical setting in which care takes place toward an understanding that a community is a "living" organism with interactive webs of ties among organisations, neighbourhoods, families and friends. There is now also an additional recognition that control over health solutions cannot be the exclusive prerogative of the health professions, but must be shared with a community, because both have the similar goal of securing the well-being of those they serve (Evans *et al.*, 1981). Enabling PHC programmes to enhance health through effecting social change in communities necessitates that such programmes empower a community's component parts to mobilise internal social change as a basis for enhancing health.

For PHC providers and managers to actually engage in the dynamics of the community empowerment, a great deal must change in the usual patterns of education and practice. The focus of these changes need include (Eng *et al.* 1992):

(1) Paradigm shifts: An important departure point for shifting the "paradigm" of primary care is the inclusion of the community in the field of vision. The community is often, at best, a static backdrop for managers and is frequently viewed as a "given." This perspective leads to lost opportunities for health care professionals to serve in important community-building Partnerships that could have a very direct impact on the health of the people in that setting.

(2) Engagement: Engagement: the often detached, "clinical" perspective of many practitioners and mangers does little to serve the cause of community organisation and empowerment. It is essential that health care professionals have investment in the success of the community, and remove the barriers that come between them and members of the community.

(3) Inclusion of other providers: a PHC network of providers may include a vast spectrum of professionals, pharmacists, lay people, alternative healers, acupuncturists, faith healers, and natural helpers such as mothers, friends, and clergy members who can provide key services. Exclusion of any of these potentially critical providers has created dual and fragmented systems of care.

(4) Learning new skills: The knowledge and skills taught to most health care professionals offer little to prepare them to function effectively in empowering communities. There are distinct sets of knowledge and skills associated with community empowerment. The day-to-day condition of a community is best understood in a first-hand way. The skills that allow one to practice and manage primary heath care effectively are least likely to be taught and learned in formal educational programmes.

(5) Changing institutions: In order to build communities, the institutions to which they relate must change in response to community needs and desires. The institutions, in short, should belong to the community in every possible way. Health care professionals are well positioned in society to effect changes in these institutions. By virtue of their social status and access to power, physicians have played important roles in a number of institutions across society. Occupying positions of power brings with it opportunities to shape the way institutions serve communities. Conversely, institutions that are community responsive are often uncomfortable for professionals. Such institutions visibly incorporate community members at all levels of decision making and action, and, as such, the culture of these institutions is that of the community--often noisy, abrasive, caring, and passionate. There is little in common between these institutions and those that reflect the polite, controlled, and often elite cultures of middle and upper class professionals.

Among the institutions that need changing are those that educate health care professionals. The model of the well-guarded and isolated medical center rising out of poverty-stricken community is too often the one in which health professionals are educated. The curriculum, which frequently relies heavily on hospital-based learning experiences often carries a message that community members are dependent on and have little in common with the provider. As well, each health care profession has its own unique mechanisms for ensuring that common learning experiences are kept to the minimum (Eng *et al.*, 1992).

The interdisciplinary, community-based learning experiences that are really necessary for adequately preparing PHC professionals are very difficult to insert into the isolated educational systems of the health professions. Here, perhaps more than anywhere else, the need for paradigm shifts is essential. There is a certain challenge in the assumption that our current health care professions' education successfully prepares people to serve their communities, particularly when there are few actual learning experiences that relate to the community. This assumption is also reflected in the lack of involvement of the community in the educational process. On the broader societal level, those institutions and organizations that shape health care professions, education must also be changed. Financing, accreditation, and professional organizations all directly impact how students learn and, later, how communities are served (Eng *et al.*, 1992). Redirecting health care professions education then seems to be the way forward.

1.2. Redirecting Health Professions Education

Developing countries came to realize that models of education from industrialized countries were not producing the sort of personnel who could fulfill their health care needs. The Alma Ata Conference, 1978 confirmed the need to reform health manpower development programmes (Fulop and Roemer, 1982).

In parallel, there is a global movement of transformation of the education of the health professionals (Kisil and Chaves, 1994). This movement, prodromic perhaps of a new paradigm for the whole health sector, gains strength as science and technology puts increasingly powerful instruments in the hands of doctors which incur increasing costs to society without proportional increases in health gains. At the same time, especially in Third World countries, a sizeable portion of the population does not have access to basic health care. Innovative developments therefore became necessary at this stage, now that a 'common' set of ideas and ideals that provide direction to the change movement exist. These developments have been expressed in international forums of recognized authority. The Alma-Ata Declaration of 1978 (WHO, 1978), and the Edinburgh Declaration of 1988 (World Federation for Medical Education, 1988), when read in conjunction, provide the seminal ideas for the innovative movement (Kisil and Chaves, 1994).

For instance, the Edinburgh Declaration adopted by the World Federation for Medical Education (WFME) and by many governments and regional medical education bodies, calls for a world-wide change in health professions education such that the action of graduates will contribute to the improved health status of the population. Some of the goals are: to seek to enlarge the range of settings in which educational programmes are conducted, to include all health resources of the community, not hospitals alone, and; to ensure that curriculum content reflects national health priorities and the availability of resources; to ensure continuity of learning throughout life, shifting emphasis from the passive methods so widespread now to more active learning. This community-based educational concept represents an important trend in current methods of education as a whole. It involves the integration of education and productive work within the learning process and the participation of all those involved in the actual work.

1.2.1. The problem

One of the problems that were identified has to do with the nature of the medical education itself in that students are typically trained within a hospital context. Clinical training takes place in tertiary care hospitals that have facilities not available elsewhere in the country and certainly not available in the places where students are supposed to work after graduation. Hence, students generally have serious trouble adapting to

environments alien to those in which they were trained. In addition, the population of patients seen in an academic tertiary care setting by no means resembles the populations normally seen by physicians.

Most of the medical schools in the developing world have been modelled on their counterparts in industrialized countries of the northern hemisphere. Their educational programmes do not always focus on the health problems of poor, warm climate countries. This often results in a health care situation in which graduated certified doctors find themselves unaccustomed to assess and evaluate the health needs and priorities of their own country and its people. They are incapable of providing effective health education or implementing preventive programmes. They are ill prepared to work in the slums of the cities or to manage a rural health care team. Bollag *et al.* (1982) asserted that objectives need to rotate around: to sensitize students to community health needs to be undertaken from the beginning of their student career; to assist community health efforts and prepare the students to work in any community; and, to develop team spirit toward promotion of community health.

The learning process can be greatly facilitated by direct and concrete confrontation with health problems. Students should be given the opportunity to observe health and disease in their relationship with the environment and with people's habit, both of which are intricately intertwined with each other. Medical education of the traditional kind usually implies that students are only shown the final stage of the process of disease: the sick person who is admitted to hospital. This may result in the students seeing their task as future doctors to be concerned with the curing of individual patients only. A sound and modern philosophy about education as such does not suffice to bring about the desired changes in students who, in the future, are to organize and run the health care system in rural and urban areas. A society which is willing to alter its health care system should not rely exclusively on the idealism of a few who are prepared to work among the poorest and most deprived (Bollag *et al.*, 1982).

1.2.2. Towards the solution: inception of Community-Campus partnerships in HPE

In the late 1950s and in response to these problems, the WHO and other organizations began to encourage the establishment of departments of community medicine in medical schools. This approach, however did not seem to work as intended. Although these departments accomplished many good things, their status within an academic environment forced them to consider the community as a laboratory and to use students as data gatherers rather than involve them in the community to learn and gain the necessary experience to function as a physician in later professional life. In addition, exposure to

community problems was so limited in time and so peripheral to the objectives of most schools that these experiments were bound to fail (Schmidt *et al.*, 1991).

The Network of Community-Oriented Educational Institutions for Health Sciences (NCOEIHS, 1991) represents a group of schools that have pioneered in the area of HPE for more than ten years. The Network was established in 1979 at the instigation of the World Health Organization, as a response to what was felt that medical education was no longer responsive to the health needs of large segments of the population, both in the industrialized and in the developing world.

Accordingly, in 1979 the WHO brought together a group of representatives of 19 medical schools, who decided independently not to make the same mistakes and pioneered a radically different approach. The primary goals of this network were: helping membership institutions realize the importance of community oriented learning; strengthening of faculty capacities related to community-based education; developing technologies, approaches, methodologies, and tools appropriate to a community-oriented curriculum, such as problem based learning; promoting population concepts in the health services system and the curriculum, and; assisting institutions in countries that have a political intention to introduce innovations in the training of health personnel, with the ultimate goal to improve health care and to contribute to the achievement of "Health for All".

Community-oriented education was described as "education that focuses on both population groups and individual persons and which takes into account the health needs of the community concerned". Some of the characteristics of community-orientation were: whether the aims, objectives, and basic principles on which the educational activities of the institutions are based are determined by the needs of the community within which it is located, the extent to which the programme adopts a comprehensive rather than a mainly curative approach to health promotion; and whether programme activities indicate commitment to the goal of Health for All (WHO, 1987).

Similarly, community-based education was described as a means of achieving educational relevance to community needs and, consequently, of implementing a community-oriented educational programme (WHO, 1987). Community-based education is associated with efforts to involve students and, more generally, educational institutions in national development and to combine theory with practice. However, they have not been very successful in developing countries because of the benefit derived from

the services of the students by both the country and the community involved, especially if it is in a remote, poor, suburban or urban area where the services are needed most (WHO, 1987).

These educational institutions stimulated self-directed learning by using instructional tools like problem-based learning, because they believed that the goals outlined above can only be attained by independent adults, aware of their responsibilities to mankind, trained to be lifelong learners, able to work under difficult conditions and with limited resources, and thoughtful users of expensive diagnostic aids. In short, the Network schools tried to implant in their students, even if they pursue a career in tertiary care, an enduring sensitivity for human beings, the context in which these human beings live, and the role this context may play in the grief caused by illness.

Schmidt *et al.*, (1991), however, argued that students should be exposed to the realities of health care in the community as soon as they enter medical school. These postings in the community should not be brief, transient experiences but an important and integral part of the curriculum. A medical curriculum needs be community-based (Bollag *et al*, 1982; Alausa, 1988). Schmidt *et al.*, (1991) also concluded that one important lesson learned is that innovation was not necessarily restricted to the establishment of new schools. Provided that conditions were ripe and a determined leadership was in place, existing schools could change directions in nontrivial ways. For instance, an advantage of the "alternative track", a particularly successful programme strategy pioneered at the University of New Mexico is that attempts at renewal did not disrupt the school as a whole. New ideas can be assimilated gradually into the existing curriculum. This has found much resonance in other countries like China and Thailand.

At the 1989 General Meeting of the Network, new emphasis was put on partnerships between universities, governments and communities in order to achieve the common goal of "Health for All by the Year 2000" as promoted by the WHO (The Network of Community-Oriented Educational Institutions for the Health Sciences, 1991). The W.K. Kellogg Foundation, amongst other funding bodies has made these Community Partnerships in Health Professions Education a major priority by investing over $50 million in the US sites alone over a five year period and additional funds overseas in Latin America and Southern Africa.

1.3. The W.K. Kellogg CP-HPE Initiatives

1.3.1. CP-HPE in North and Latin America, and South Africa

The Kellogg Community Partnerships for Health Professions Education (CP-HPE) were large scale demonstration projects at seven sites around the United States and in several other locations in Latin America and Africa. They all shared a common set of ideas and ideals, emanating form the Alma-Ata (WHO, 1978) and Edinburgh Declarations (World Federation for Medical Education, 1988). These initiatives involved three types of paired relationships: university-community; university-local health system; local health system-community. The CPs linked university health education programmes with local communities in a collaborative effort to change the way health professionals were educated. The goal of the CPs was to provide undergraduate medical, nursing, and allied health students the opportunity to learn and experience team-based, non hospital PHC in community settings. The vision was exploring community concerns, in which community agencies and constituencies become part of the decision making for the education, research, services and influencing policy. As regards funding, Knott (1995) reported that the Kellogg Foundation has required major matching funds from the participating universities and provided significant technical support, programme leadership, and the dissemination of information about the programme to the media and public policy makers. The foundation has thus initiated and helped to implement these demonstration projects through generous financial support and in many other ways.

In Latin America, Programme UNI (Una Nueva Iniciativa) was set up and now includes 23 projects which are partially supported by the Kellogg Foundation and are currently being implemented in 11 countries of Latin America (Kisil and Chaves, 1994).

Kisil and Chaves (1994) reported that the group of Latin American projects was well diversified. It included both large and small universities in metropolitan areas, and in medium and small cities. The number of participating health professions ranged from two to nine per project. The communities had both urban and rural areas, or solely urban. The health infrastructure ranged from very good to some with limited resources. It was felt that this variety of projects will permit the development of models taking into account a variety of circumstances and conditions. To assist the projects to achieve maximum potential during their implementation phase, the Foundation developed a supporting mechanism for the three project components (academic, local health system and community), for leadership development (to

foster group leadership at project level), and for evaluation (both self-assessment by each project and evaluation of the cluster of projects). In addition, support to networking and to dissemination promoted the sharing of experiences amongst UNI projects and with other institutions. Great importance was being given to the establishment of continuing relationships with WHO, World Federation for Medical Education (WFME) and the Network of Community Oriented Educational Institutions for Health Sciences.

The UNI projects aimed to promote institutional change. Knowing how strong resistance is to change in universities and health systems, very early in the development of the programme an evolutionary approach, based on incrementalism and gradualism, was suggested (Kisil and Chaves, 1994). The Foundation seemed very mindful that many university faculty members are not prepared to teach community health concepts since they have neither studied nor practiced in such settings. Further, the realities of severe shortages of money, facilities, and time mean it would take many years to introduce such changes on an incremental basis. Thus the Foundation was willing to be a funding partner to accelerate the process, provided that there was a genuine institutional commitment to move towards the proposed curricular and other changes. Such a commitment would be evidenced by increasing the investment of its own resources over time, and an agreement to sustain the new academic-community programmes if they meet the pre-set goals and objectives of the university and the community. The commitment was also to develop additional academic initiatives in community-based health care to assure that this becomes a bona fide scholarly endeavour. This would include community research, community education, and community service.

In South Africa, the CPs-HPE are part of a nationwide programme in response to the W.K. Kellogg Foundation initiative in HPE. This educational experience was envisaged to achieve new goals fundamental to the health care provider in the 21st century: increasing the supply of general physicians and exposing students to community-based primary care, and empowering them with skills, knowledge, and attitudes necessary to provide optimal health care to clients in diverse practice settings. The experience needed to also provide support and expertise to the participating communities, of several racial, ethnic and linguistic backgrounds, in addressing priority service issues identified in their community service plans. These embraced providing a range of health services, including public health programmes and community organizing.

All the CP-HPE in SA were ultimately striving to provide high quality multidisciplinary, comprehensive, cost-effective PHC-including a strong emphasis on prevention- to the community. Although each CP was

individualizing its services to meet the needs of its own community, the general commitment was to improve community-based health care by changing the education of HP. A primary focus was to bring HP educators together with people in communities. Through their combined efforts, the partners hope to provide an education for HP students that is focused on keeping people healthy, attending to the sick, and helping them and their families maintain dignity and control.

The CP-HPE initiative attached emphasis on primary prevention applicable to population groups as well as individuals. The vision is of model university-community practices, in the same way that institutions have developed teaching hospitals and clinics in the past. A difference was the emphasis on the community as a *bona fide* partner and investor in the effort. The initiative took the stance that all health professions students should be educated in such settings, as well as in more traditional hospital wards and outpatient settings. The goal was not to recruit students into a particular field of practice but, rather, an understanding of the concepts of primary prevention and community health development.

1.3.2. The selected sites and the academic institutions

To adequately prepare the selected sites, arrangements relating to the assignment of students needed to be made with the local authorities and community leaders. This involved explanations of the educational institution's philosophy and objectives, the criteria used in assigning students to particular segments of the community, and, most important, the community's role as a partner in health manpower training and its own health development. Essential to social preparation was the integration of the students within the community.

Once the community agreed to accept students, joint action with the academic staff and the health services providers became possible. These actions included the collection and analysis of health data and determining health problems; establishing priorities and planning amelioration measures; implementing plans with the help of official and voluntary bodies; and evaluating the community's involvement and outcome of activities. Continuity was to be ensured by outgoing groups of students informing the community, health service staff, and incoming groups of students of continuing activities and planned programmes. At all stages community organization was a basic requirement. When it is weak it needs to be strengthened before embarking on a programme. Community leadership can be built up on existing groups, such as women's, youth, or religious groups, or new groups can be organized. As a general rule, HS staff needed to serve as field instructors and work with the faculty. The practice of appointing staff to

joint health service/educational system posts is strongly recommended (WHO, 1987). Health service staff employed as field instructors needed to be given academic status and prospects of promotion.

In conclusion, the successful implementation of a community-based educational programme demanded the involvement of the community in planning, decision making, problem solving, and evaluation.

The academic institutions, however, entered the CPs process from a position of relative advantage but not necessarily strength. They were better exposed to the outside world and the national context. They had greater access to information and often to material and financial resources. They had structures that were recognized nationally and internationally for communication and management of resources and processes which were vital to the CPs. They also had a greater capacity to process and apply new information which they can control to their own advantage. This placed them in a position of incredible power in the CPs, yet often with inadequate skills, political and administrative commitment, practical policy, strategies, and guidelines crucial to the development and success of CPs.

In relation to the Latin American CPs, the most dominant activities were teaching, research, service provision as determined by academics, services, and managing donors. This tended to relegate the community to recipients and clients, and thus undermined their capacity for partnership fostering. In addition, there was non use of traditional resources due to emphasis on external material inputs and emphasis on excellence as defined by the academic institutions. This situation was made worse by arrogant attitudes which regard community resources and capacities as inferior and undermines the possibility to develop longer term mechanisms by which people might meet their needs, enhance their dignity, and thus strengthen their hand in the CPs. The institutions can therefore be a very weak link because of arrogance and selfish enthusiasm but with neither experience nor appropriate lateral relationship structures and procedures to facilitate partnership building (anon and undated, circa 1995, included in CP quarterly report).

1.4. Community Partnerships

One approach to reorganisation to face the problems of mounting costs, unmet needs, rising expectations and manpower shortages is health planning (Brown, 1972). The WHO addressed that a genuine Partnership between the health system and the community is crucial and has yet to be evolved in many countries. Through its partnership concept, comprehensive health planning has attempted to establish a new kind of functional community process. It has been built on the faith that people really want and should have

an opportunity to participate in the decisions affecting their lives and that an alliance between providers and consumers can bring about necessary changes in community health services. With the provision of consumer participation, the health planning endeavour at the local level suggests in many ways the beginning of a new form of democratic social planning. As early as 1972, Brown (1972) reported that developments in the steady progress toward a participative endeavour was hampered by problems of funding, health planning manpower and the community organization process.

1.4.1. What is a Community Partnership?

A CP is more than identifying and consulting key partners in health in order to ensure compliance with prescriptions and utilization of services. It is not community participation (Cp) induced and directed by one member of the partnership or from any source outside the community. It is a process in which the community invests itself in terms of ideas, experience and skills; takes risks and determines the role of the other partners and the mechanisms for joint decision making and action. In a partnership each member is aware of his or her strengths, weaknesses and limitations and hence the unique contributions they can bring to the partnership. All partners decide on appropriate inputs from each partner, according to the strengths, resources and limitations, and from external sources. They also agree on equitable sharing of benefits and losses. External resources should be used mostly to provide cover and guarantees for risks taken, and should be available for specified period of time. External inputs and skills augment rather than replace the local ones. The greatest benefit should be the ability of the community to have greater control over their lives and situation.

CPs recognize the strengths and resources of all the partners and seeks to facilitate and enhance them. Communities have experience in building partnerships since they have always been involved in their own health care and development initiatives, but within their own context which professional outsiders, the HS and AI may not readily understand or relate to. Their contribution may thus be limited by the limited understanding of the professionals (Anon., circa 1995, included in Partnership quarterly report).

The complexity of each partner needs to be recognized, as each partner is not a homogenous entity. They may not be able to agree quickly on a common course of action (within the entity) necessary for the partnership. Many of them may not see CP as defined in the initiative as a priority. People or departments may therefore not be too anxious to spend their precious time and resources in partnership development activities. One therefore need not assume that people and institutions are ready and waiting to be engaged

in the process. They are fully occupied with their own and, in their own opinion, more relevant activities. This applies equally to all the partners and not just the community (Anon., circa 1995).

Community involvement in the decision-making for community-based education is essential. Students cannot use the community as if it were material in a laboratory. Close collaboration is necessary with community representatives and, whenever feasible, community members. The issue for discussion is how to enlist the community's cooperation in bringing its involvement about (WHO, 1987), and who should participate in educational decision-making. A study of various instances of community involvement (WHO, 1987) showed that, in addition to teachers, administrators, and students, the following may contribute and participate: voluntary organizations; organizations representing different sectors or social classes of the population; youth and religious organizations; industrial and commercial undertakings; community leaders; and, ordinary members of the community such as individuals and families.

The WHO reported that the local community's capacity for organization need not be underestimated. A statement to the effect that local people do not have much experience in managing participatory programmes should be regarded as suspect. It may be true that they do not have the same type of experience as an administration but what experience they do have derives from within their own culture and may be equally or more relevant. If the recognition of local culture and values is not to remain at the level of lip-service, traditional expertise and knowledge must be taken into account. Experience that differs from that of another system is not necessarily worthless. Indeed, the failure of many community development programmes can be traced to neglecting to use local skills and experience. A member of the community often has a much better idea of what needs to be done than an outsider. It is not the lack of education that prevents action from being taken but rather a lack of financial and material resources. The poorer the community the greater the need for resources. This is not to depreciate education but it is not possible to be dogmatic about the exact nature of its importance in development (WHO, 1987).

A wider definition of the meaning of education may be necessary for community involvement. It may have to be interpreted as covering such factors as knowledge regarding organization, cooperative means of solving problems, and methods of acquiring information and skills, rather than sectorally segregated subject matter. The argument that illiteracy implies ignorance and blocks effective community involvement must be challenged. It is not unusual for an illiterate to show greater wisdom than a highly-qualified expert in matters relating to local daily life. It is not necessarily the lack of knowledge that

impedes progress but the lack of assertiveness against assurance of the professionally qualified (WHO, 1987).

Montgomery and Esman (1971) reported that maximum opportunity for participation is enhanced when some programme variables and environmental dimensions are present. The *programme* should be favourable i.e., that it is susceptible to continuous public action; that programme outputs can be arranged to benefit the clientele as a group; that the technology required is locally accessible - relatively simple technology internal to the community is appropriate; and that the projects involved are relatively autonomous. Autonomous projects facilitate participation over a larger range of decisions. The *environment* should also be favourable: that the bureaucracy involved is not so closed; self-protective professional elite, that there are at least some sympathetic interest groups to work with; that political channels are open to client groups; that the political leaders are sympathetic to the programme objectives and to the client groups; that the client groups had achieved viable organisation; and that there is a history of co-operative activity within the client groups. Few cases would actually approach such euphoric perfection. Even under favourable circumstances, participation does not automatically take place.

1.4.2. The power tensions and disparities in Community Partnerships

Addressing community participation (Cp) is in essence involved in addressing conflicting power interests. Those controlling health interventions may have to surrender their dominance, become resources and let the community make decisions (Rifkin, 1986). The struggle for participation is a struggle for the democratisation of political and economic decision-making (Segall, 1983). The power-control shifts are then to be considered in decisions involving people who traditionally have not been included. Considering Cp as programme component rather than change process risks ignoring political issues and endangering potential conflicts (Rifkin, 1986).

Gray (1989) noted that central to the notion of collaboration is the concept of shared power. Stakeholders in a collaboration essentially share the power to define a problem and initiate action to solve it. Power dynamics influence efforts to initiate collaboration. How power is shared during negotiations, and how power shapes the course of implementation needs attention. Even when collaboration is initiated in order to advance a shared vision, stakeholders are anxious to advance their own interests associated with that vision (Dahl, 1982). However, if any of the stakeholders are capable of exerting unilateral control, collaboration does not make sense. It is precisely because stakeholders hold countervailing sources of power and their fates are interwoven that collaboration is made possible.

Collaboration operates on a model of shared power. Problem-solving decisions are eventually taken by a group of stakeholders who have mutually authorized each other to reach a decision. Thus, power to define the problem and to propose a solution is effectively shared among the decision makers. This does not mean that parties to a collaboration are equal in power. It does mean, however, that major inequities in power are a major deterrent to collaboration (Nemeth, 1970). It also means that to achieve collaboration all parties must have some form of countervailing power. Thus the parties must in some ways be dependent on each other (Gray, 1989).

The power dynamics associated with collaboration generally involves a shift from the kind of unequal distribution of power to more participative, equally-shared access to the decision-making arena. Collaboration opens up control over access and agendas to wider participation. This empowers some stakeholders to participate who previously may not have had access directly or indirectly. Stakeholders collectively participate in defining the problems before them. The mechanisms by which power is shared through collaboration are not unproblematic, however, and must themselves often be "negotiated" (Gray, 1989).

People's participation may prove threatening. The fact that CPs lead to people becoming informed partners in determining their own development may be threatening to those in authority since it leads to limited or controlled authority. The community no longer accepts to be merely consulted and asked to comply. The community may also be more interested in rights rather than responsibilities and, on the other hand, Partnership facilitators may not be used to being accountable to the people since their authority, supervision, and support comes from a different source (Anon, circa 1995).

Schumaker (1975) argued that groups in a pluralistic process are all trying to exert influence over decision outcomes. These claimants may extract a range of responses from political authorities. At minimum, a claimant may achieve "access responsiveness." That is, the group gains the ear of a political authority so that their concerns can be aired. A second level of response is "agenda responsiveness", where concerns become the subject of more deliberate review by the authorities. A third level, "policy responsiveness," is achieved if some legislation or administrative action is taken in response to the concerns. Two additional levels of response, "output" and "impact responsiveness," refer to implementation of the policy and elimination of the original grievance.

Montgomery and Esman (1971) defined "participation" not in the passive sense of sharing in government benefits, but in the more active sense of exerting influence on administrative behaviour and on the outputs of official action. Thus, greater participation by the poor and deprived would mean greater influence on decisions and programmes relating to their welfare. They distinguished genuine participation, which implies real influence, from symbolic, manipulated, or controlled participation, which is intended to ratify rather than influence official behaviour.

Hidden agendas among the partners needs attention. It should be obvious that not every member of the community, AI, and HS can be involved in partnership activities at the same time. Each member will consciously and unconsciously have his or her own agenda. The first groups to respond positively are likely to include those who are able and willing to risk involvement in a new initiative for various reasons. Eventually, however, many of them will be disappointed and disappointing. They discover that their real individual concerns are not addressed in the way they assumed they would be. They discover that the opportunities they imagined are unreal and personal gain is limited. They become increasingly demanding and eventually most of them give up. Since they are part of the community, they cannot be ignored. They must be carefully handled but with a clear commitment to the most vulnerable segment. Among the first responders will always be a few people who are truly concerned about the need for change in their situation and who will welcome an opportunity for change. This group could form a starting nucleus source (Anon., circa 1995).

II . Chapter Two

Literature Overview of Partnerships

Chapter one provided the general background of the PHC movement and the need to redirect HPE to be more community responsive, highlighting a strategy that is advocated for by many philanthropic organisations: community partnerships. In addressing the first objective of the study and to identify the factors which contribute to coalition competency, chapter two moves on to dissect and analyse the partnership/ coalition concept in great detail, stripping the notion down to its basic interlacing fabric components, and examining the perspectives of the various definitions and the importance of inter-organizational collaboration. In doing so, a range of structural factors and operational parameters that affect successful partnership functioning, implementation and maintenance are reviewed. These explore issues of formalized roles and procedures; leadership and membership characteristics; degree of reciprocity; motivators; benefits and costs of collaboration; organizational climate; institutionalization sustainability and empowerment and other miscellaneous factors.

2.1 Partnerships / Coalitions

2.1.1. Definitions and importance

Several definitions of coalitions have been suggested in the literature. Broadly defined, coalitions are formal structures of relationships among identifiable groups of individuals, social groupings and/or organizations, all of which are banded together, supposedly, for a common purpose (Kaplan, 1985). Roberts-DeGennaro (1986b) reported that Kelley's (1968) definition was probably the most useful in understanding the behavior of a coalition. He defined a coalition as a group of organizational actors who: (1) agree to pursue a common and articulated goal; (2) pool their relevant resources in pursuit of this goal; (3) engage in conscious communication concerning the goal and the means of obtaining it; and (4) agree on the distribution of the payoff (benefits) received when obtaining the goal. Similarly, Staggenborg (1986) defined a coalition as a group of organizations and individuals who shared some interests and were working toward one or more common goals while maintaining their own agendas. It is the common characteristic of working toward purposive change that identifies a coalition from a loosely coupled group of organizations (Roberts-DeGennaro, 1987). In parallel, Lindsay and Edwards (1988) described coalitions as voluntary confederations of independent agencies participating partially because they are committed to a common cause and partially to protect their own interests, while Butterfoss *et al.* (1993) defined coalitions as formal, multi-purpose and long-term alliances or community organisations of individuals or interest groups to achieve common goals.

"Coalition" and "coalition building" were terms often heard in the 1980s, used by progressives and conservatives alike. Coalitions vary in form and purpose; they can be permanent or ephemeral (although some definitions of "coalition" refer only to temporary structures), they can deal with a single issue or multiple issues (Perlman, 1979), they can be composed of homogenous or heterogeneous elements, they can stimulate social change and the empowerment of people or create stagnation and support oppression of people's needs and desires (Kaplan, 1985). Some collaborations concentrate on advancing a shared vision among stakeholders, some focus on solving mature problems, and others are directed toward resolving a conflict among stakeholders (Gray, 1989).

Coalitions are not new to public health. In the context of the United States, Herman *et al.* (1993) reported that they have existed at the local, state and national levels for several decades. Health coalitions have developed around a wide range of issues including maternal and child health (Arkin, 1986), abortion rights (Staggenborg, 1986), sexually transmitted diseases (Tracy, 1985) and alcohol and tobacco use (Centers for Disease Control, 1990), in response to inadequate state subsidies for family planning initiatives (Herman *et al.*, 1993) or for influencing HPE (El Ansari, 1994). In a like manner, Gray (1989) noted that collaborations induced by shared visions have been designed to address socioeconomic issues such as illiteracy, youth unemployment, housing, or homelessness, which cut across public- and private-sector interests. She also maintained that it should be clear by now that there is no shortage of problems for which collaboration offers a decided advantage over other methods of decision making.

The widespread existence and importance of progressive coalitions, i.e., those coalition endeavours that reflect attempts to improve environmental and social conditions when human needs are not being met by societal institutions, is well documented (Perlman, 1979). Planned social and environmental change in societies as complex as ours usually depends upon effective coalitions. Interorganizational coalitions make up an important part of the "citizen action movement" which, as Miller and Tomaskovic-Devey (1983) noted, is attaining political prominence as an organised force (Kaplan, 1985).

The development of coalitions of community agencies, institutions and citizens to combat chronic health conditions is gaining popularity as an intervention aimed at strengthening the social fabric (Butterfoss *et al.* 1993). Currently, hundreds of millions of dollars are being invested in coalition development as a health promotion intervention. For instance, private foundations like the Robert Wood Johnson Foundation and the Henry J.Kaiser Family Foundation (Tarlov *et al.*, 1987), the W.K. Kellogg Foundation (El Ansari,

1994) are sponsoring local coalitions for community health planning and implementation, or community projects that build community capacity through coalitions and partnerships.

Statements of the importance, potential, and need for increased cooperation among "grassroots" efforts are evident in much of the progressive community development and social movement literatures. Almost unconditional ideological support is found for increased cooperation among organizations and other local community development efforts. The most common theme is "power in numbers;" when individuals and groups join together to address common concerns, they increase their potential to formulate and carry through intervention strategies (Kahn, 1970). The mutual support, increased communication, and interaction among activists in organizations involved in a coalition is likely to decrease personal and organizational isolation and facilitate greater awareness of trends that affect them (Saranson and Lorenz, 1980).

A coalition effort can enable members to engage in activities and accomplish goals beyond the reach of any one organization or individual (Staggenborg, 1986). Coalitions provide a way to maximize the use of scarce resources, to rationalize a fragmented service delivery system across geographical areas and levels of intervention, to increase the "critical mass" behind a project, to build trust and break stereotypes and misconceptions, to enhance professional relationships, to invoke citizen participation in programme planning and to advocate for participants' interests (Brown, 1984; Orthoefer *et al.*, 1988).

Health agencies' desires to combine efforts have given rise to a large number of health coalitions at the national, state and local levels and well-functioning coalitions have successfully generated considerable political power and support for important health initiatives (Lindsay and Edwards 1988). Regardless of the exact purpose, human service organisations do convene in coalitions in the belief that cohesive, coordinated action will be more effective than singular efforts to influence the urban policy agenda (Sink and Stowers 1989). The pileup of problems and inability of organisations to contend with them reflects the turbulence of our environment. Under such conditions organisations become highly interdependent (Trist, 1977). Because of this interdependence, the range of interests associated with any particular problem is wide and usually controversial (Gray, 1989).

Collaboration induced by shared visions are intended to advance the collective good of the stakeholders involved. The partnerships that have sprung up to address deteriorating conditions in U.S. cities are illustrative of collaborative efforts across sectors to advance shared visions. In these partnerships, public

and private interests pool their resources and undertake joint planning to tackle economic development, education, housing, and other protracted problems that have plagued their communities. Successfully advancing a shared vision requires identification and coordination of a diverse set of stakeholders, each of whom holds some but not all the necessary resources. To be successful coordination must be accomplished laterally without the hierarchical authority to which most managers are accustomed. As a result, interorganizational relations must be carefully worked through in order to gain the advantages of such a union (Gray, 1989).

Although the number of funded community health projects that rely on coalitions represent considerable investment of resources, Herman *et al.* (1993) maintained that coalitions were faced with a number of challenges in formation and in working towards an end point(s). A coalition must define and pursue its goals in a way that is consistent with the philosophies, skills, experiences and resources of an often diverse group of members. New coalitions need to clearly define an issue(s), set obtainable goals, recruit an appropriate membership, develop effective communication system and establish a workable division of labour.

Similarly, Butterfoss *et al.* (1993) reported that review of the literature reveals that, in general, coalitions have not been evaluated in an organized and systematic way, and relatively little empirical evidence exists to support their effectiveness. Recognising that many worthy projects and skillful practitioners utilize coalitions as a health promotion strategy, a firmer basis in research is still warranted. A systematic study into the nature, function and potential of coalition work in communities is essential to developing the research base. Coalitions are more useful in some instances than others; and, coalitions, like other health promotion strategies, will be criticized as ineffective and wasteful of resources if used indiscriminately. If coalitions continue to be used without the benefit of improved research, support for coalitions may not withstand future changes in public health administration and policy (Florin and Wandersman, 1990). The Information gained from such research can enhance the efficiency and efficacy of coalitions and partnerships.

While the CP approach is logically appealing, there is little evidence of the effectiveness of community partnerships. Even less information exists on factors contributing to an effective partnership (Kumpfer and Hopkins, 1993). Community psychologists (Heller, 1990) agreed that anecdotal evidence from case studies (Rich, 1986) suggested that some community coalitions are effective. Unfortunately, little empirical research existed on the individual member, team or total coalition characteristics (Chavis and Wandersman,

1990) that contributed to effective outcomes. Roberts-DeGennaro (1987) concluded that studies of the factors relevant to the termination of continuous coalition, or alternatively, what perpetuated them were lacking in the literature. Of particular interest to those who are forming coalitions to address health issues is to identify the salient characteristics which will enable coalitions to fulfill their organizational goals, regardless of the scope, complexity of purpose or method of formation (Sink and Stowers, 1989). For instance, in the context of the Worcester AIDS Consortium, Zapka *et al.* (1992) reported that analyses of coalitions of public health and medical organizations held lessons for managers and researchers concerned with organizational adaptation to an under-funded medical and public health system. Explanations of coalition dynamics, successes and failures also have relevance for public policy since interorganisational relationships are critical to almost all public policy related to prevention and treatment.

2.1.2. Basis and principles

Lindsay and Edwards (1988) maintained that some health coalitions were real while others were artificial. The artificial variety was formed when one agency, with its own agenda, invited other groups to become part of "their" coalition. A coalition formed on this basis creates temporary illusion of broad-based interagency cooperation. This arrangement is a facade that seldom lasts. Eventually people realize when they are serving on a token coalition which was formed as an afterthought by an agency whose members already know where they want to go. Effective health coalitions are the mutual creations of co-equal agencies. When these agencies are involved in the ground floor formation of a coalition, a vital sense of ownership is developed. Without this sense of shared ownership, coalition members will always feel they are working for someone else's agency. A coalition must be genuine and co-owned by its member agencies in order to be effective.

Along a somewhat similar line, Panet-Raymond (1992) also identified two models of collaboration on a continuum from real partnership (*partenariat*) to paternalism (*paternariat*). Real partnership, he maintained, is defined as a relationship, formal or informal, between equal but different partners. They may differ in their origins, nature, mission, objectives, activities, resources, structure and contributions, but they are all considered as mutually essential. A real partnership is founded on mutual recognition and respect of those differences. It is a relationship of interdependence. The object of the partnership can be exchange of services or a joint venture. Community-oriented partnerships should have their objectives defined autonomously, be well-rooted in the community, have strong credibility and a board membership actively involved in a democratic structure. In sum they should have a strong power base which commands respect.

The other model of collaboration is paternalism which is usually planned and imposed (Panet-Raymond, 1992). In this model the contributions of each party are obviously different though often considered as mutually essential. But there is a dominant party, which recognises the community and its groups only as they serve its own agenda and policies. This is not a relationship based on mutual interdependence, but a one way relationship in order to complement the public sector's programmes which it cannot implement by itself. It is a utilitarian relationship, sub-contracting or dumping responsibilities on the community. Budgetary and political motives are obscured by a patronising community that rationalises this form of so-called partnership. Here a key agency/ies may often keep the leadership by imposing their agenda and perspective. Their sensitivity to community dynamics and culture is not great and their acceptance of criticism is very limited. There may be distrust and disregard. There is no real dialogue and therefore, no real partnership.

This is in line with Hord's (1986) observations, who reported:

> "...while there is little argument about the need for or value of collaboration--whether among agencies, institutions, or educational institutions--there is disagreement about what "counts" as collaboration." (p. 22)

Similarly, Brownlea (1987) has pointed out that:

> "...participation may be seen as a way of broadening the range of inputs to a decision, but in fact may represent a kind of tokenism. The input is received, but very quickly discarded as of little or no consequence. The motions have been gone through. The democratic ideal has been observed, but there is little power behind the participants' input." (p. 605)

The expected difference that participation is supposed to achieve might well vary between those drawn into the system to participate and those already in the system and who have ultimate decision-making power. Rather than influencing a decision, participation may provide a platform for the acceptance of a decision made elsewhere in the system. As such, participation may validate or legitimate the *status quo* rather than promote change. Even though they are participants , they may largely be observers; while being in the game they are more reserves rather than players with a lack of real access to the decision arena. Participation is ultimately about moving away from a "them and us" mentality towards a partnership which can be of mutual benefit to all parties (Pietroni and Chase, 1993).

In a similar inquiring spirit to look at the limitations of the concept so that its scope may be reasonably defined, Madan (1987) adopted a sceptical view towards community involvement in health. Community involvement can be debased easily and employed to describe euphemistically the manipulation of people by politicians, bureaucrats and technocrats for purposes which are believed to be for the people's good--and may be well so--but

which are conceived by these others in a manner that infantalizes people. Community involvement thus becomes a part of a social rhetoric, even just a cliché.

Along similar lines, an expert group of the World Health Organization (WHO, 1987) maintained that the principle of community involvement is sometimes thought to be a means manipulating the people. Since Cp is essential to the success of the PHC approach, this misconception must be corrected. Many of the failures of the past were attributable to the control of so-called community programmes by government appointed officials—sometimes resident in the community— but, nevertheless, regarded as outsiders belonging to officialdom. Once a structure has been established by a government it can quickly come to be seen as an extension of government control. To be acceptable, a programme must evolve from the bottom up and not be imposed on the community from above. It must be seen by the community to function successfully. A demand on the community to make it conform to an imposed structure can impede its acceptance by the community it is intended to benefit.

2.1.3. Dynamics and obstacles

In a review of the literature, Schermerhorn (1975, 1981) cited various terms used to describe the general notion of interorganizational cooperation. The most common used term was organizational interdependency. Also included were organizational interdependence (Aiken and Hage, 1975), component interdependence, cooperation, exchange and concerted decision making. Schermerhorn reminded us that this variability in terminology raised a critical question regarding what the underlying concepts hold in common, if anything at all, and suggested that the first goal of any effort of this sort was conceptual clarity.

However, Hord (1986) has queried what "counts" as collaboration. The New England Program in Teacher Education (1973) offers these two definitions: cooperation is when two individuals or organizations reach some mutual agreement, but their work together does not progress beyond this level; collaboration is the development of a model of joint planning, joint implementation, and joint evaluation between individuals or organizations. In a similar spirit, Hoyt (1978) suggested the that cooperation is a term that assumes two or more parties, each with separate and autonomous programmes, agree to work together in making all such programmes more successful. Collaboration, on the other hand was a term that implied the parties involved share responsibility and authority for basic policy decision making.

Gray (1989) defined the general phenomenon of collaboration as "a process of joint decision-making among key stakeholders of a problem domain about the future of that domain". A greater amount of time is required for collaboration than cooperation, since activities are shared rather than allowed (Hord, 1986).

Schindler-Rainman (1981) argued that collaboration is a process that may end in coalition, federation, network, or some other interorganisational entity. One element of collaboration is to get disparate parts of a system or separate systems working together towards some agreed upon goal or purpose, or several agreed upon outcomes. Another element is that in a collaborative process there is a combination of influence and power to make change and/or exert clout towards agreed upon end(s). A third element is that collaboration provides a combination of different human and material resources to impact on the goal(s), and provide better or broader services. Fourthly, the diversity of difference(s) is a source that a collaborative effort heightens, and draws upon.

However, Houston (1979) reported that the paucity of research on collaboration is astounding, and that the literature is filled with case studies and observations describing conditions, designs, and dreams. There seems to be the need for research that would address such complex aspects of collaboration as the structure of collaborative enterprises (organization, governance, management structure), problems of communication at all levels within and between institutions, and support and reward systems for the individuals involved in the group effort.

Collaboration involves a process of joint decision making among key stakeholders of a problem about the future of that domain. Five features are critical to the process: (1) the stakeholders are interdependent; (2) solutions emerge by dealing constructively with differences; (3) joint ownership of decisions is involved; (4) stakeholders assume collective responsibility for the future direction of the domain; and, (5) collaboration is an emergent process. Collaboration establishes a 'give and take attitude' among the stakeholders, designed to produce solutions that none of them working independently could achieve. Therefore, the initial phase usually involves calling attention to the ways in which the stakeholders' concerns are intertwined and the reasons why they need each other to solve the problem. Heightening parties' awareness of their interdependence often kindles renewed willingness to search for trade-offs that could produce a mutually beneficial solution (Gray, 1989).

One outcome of collaboration is a set of agreements governing future interactions among the stakeholders. Trist (1983) referred to this as self-regulation of the domain. During collaboration, a new set of

relationships among the stakeholders is negotiated as they address the problem at hand. The process of collaborating essentially restructures the socially accepted rules for dealing with the problems. Formal and informal contracts about the nature of subsequent exchanges among the stakeholders are forged, and collaboration may lead to increased coordination among the stakeholders, although that is not a necessary outcome of the process.

Collaboration is essentially an emergent process rather than a prescribed state of organization. By viewing collaboration as a process, it becomes possible to describe its origins and development as well as how its organization changes over time. Hence, collaboration can be thought of as a temporary and evolving forum for addressing a problem (Gray, 1989). Typically, collaborations progress from "under-organized systems in which individual stakeholders act independently, if at all, with respect to the problem to more tightly organized relationships characterized by concerted decision making among the stakeholders (Brown, 1980).

Collective interpretations and conversational interactions develop among collaborating parties as they try to define the problem, agree on recommendations, or design action steps. In this way they create a negotiated order. Not all collaborations lead to agreements for action, but when agreements are reached, they are arrived at by consensus. Consensus is achieved when each of the stakeholders agrees they can live with a proposed solution. Collaboration can occur with or without the assistance of a third party who serves as a mediator or facilitator. The task of the third party is not to render a decision but to help structure a dialogue within which the parties can work out their differences.

Realistically, collaboration involves difficult issues that have often eluded simple solutions in the past. Thus, solving complex multi-party problems demands careful attention to the process of making decisions. Successful collaborations are not achieved without considerable effort on the part of the participating stakeholders. Often, parties perceive real risks to collaborating, if only because the process is unfamiliar and the outcomes are uncertain. Unless issues like these and more serious ones such as concerns about co-optation or lack of fairness are dispelled up front, attempts at collaboration will not succeed. Hence, for collaboration to occur, someone must introduce a mind set, a belief in the creative potential of managing differences, and must couple this mind set with a constructive process for designing creative solutions to complex problems (Gray, 1989).

The necessity for clarifying expectations of the participants is of paramount importance--not only the expectations of rewards, but expectations of goals, of commitments from each sector, and of procedures Hord (1986). She suggested ten salient features of the complex collaborative process as opposed to the apparently more simple cooperative process. These features are: (1) Needs and interests are shared, there must be mutual gain; (2) Time must be devoted; (3) Energy: collaboration requires effort needed to initiate and sustain; (4) Communication and frequent interactions at all levels; (5) Resources, rewards, or expected outcomes are shared; (6) Organizational factors, frameworks, and the people within them do the actual work; (7) Control must be shared; (8) Perceptions and willingness to view the world from the standpoint of others; (9) Leadership: strong enthusiastic leaders expressing positive examples; and, (10) Personal traits as simple patience, persistence and a willingness to share.

Along a rather similar path, Panet-Raymond (1992) maintained that there are a number of conditions that can bring about a real partnership rather than a form of paternalism between public institutions and voluntary organisations. Some are political in nature, some are organisational and some are personal.

The *political* context pushing towards a positive community alternative based on grassroots involvement and a less individualistic and bureaucratic approach to people is important. A more flexible, respectful, empowering, developmental and collective approach to servicing need be recognised as a viable option. This approach can open up new avenues for voluntary groups to take charge of new initiatives within a real partnership. In order to do that they need to develop a strong power base through coalitions at local or national levels.

The *organizational* factors that support a real partnership are many. A strong local membership base deeply rooted in the community is necessary for a clear mission statement and objectives that generate support and credibility from the community. The accountability to membership is an added source of power in dealing with a public partner. Clear objectives and expectations from the partners are important to get equity out of a partnership and should give to staff or volunteers involved a clear mandate supported by management. This assures transparency and more involvement from the participating organizations, thus giving more binding weight to the partnership, and protecting the agreement from unilateral and discretionary decisions. A written agreement between the parties confirms the clarity of objectives, mutual responsibilities, means and norms and the duration of the agreement. It usually involves built-in evaluation or at least a time for regular evaluation. Most real partnerships have a regular evaluation which permits adjustments and improvements. Establishment of a clear line of communication between the parties is

equally important, so that any misunderstanding or difficulty will not lead to rampant conflict. Clear understanding and recognition are essential. The understanding must embrace the very different origins and organizational cultures. It is that recognition that voluntary organizations find so difficult to obtain from public institutions and government policy makers. Respect for the other partner's autonomy is fundamental, as well recognition of different views.

The *human* factors that influence partnerships most are open-mindedness, tolerance, patience, respect and sensitivity of the individuals directly involved in the parties. Human qualities such as personal confidence in oneself and oneself's partners are highly valued. These qualities are essential, though not sufficient, to guarantee a real partnership (Panet-Raymond, 1992). The key actors should establish a good relationship and in turn influence their mutual organizations in order to convey the sensitivity and respect that is essential. However many do not have the negotiating skills to deal with their own management and are pressured into difficult situations.

In order to study coalition maintenance, one needs to establish the point at which a coalition moves from formation to maintenance. Within this realm, Roberts-DeGennaro (1987) pointed out that once the organizational actors coalesce around an issue(s), mobilize resources, establish a purpose for the coalition, and a leader, for all practical purposes the coalition has been formed. Thus the coalition maintenance is the process of supporting the life of the coalition, in order to keep it from declining and to sustain it against opposing forces.

Often the critics of collaboration assail it as idealistic and naive. In many instances, however, the outcomes of collaboration have often far exceeded the expectations of any of the parties. For instance, Gray (1989) articulated that despite the compelling incentives to collaborate, there are many reasons why collaborative attempts fall short of the ideal. Old practices do not change overnight, and resistance to changing established practices is a predictable human response (Lorsch, 1986). People resist change for several reasons: they do not like the uncertainty associated with change; they have an investment in the status quo; or they do not understand or agree with consequences of the proposed changes. A critical tool for dealing with resistance is understanding what causes it. Conveners of collaborative endeavors should realistically expect resistance to collaboration and be prepared to cope with the obstacles.

Gray (1989) has shed light on some of the obstacles to collaboration. An important one is the institutional disincentives representing investments in established ways of conducting business that allow stakeholders to satisfy certain interests. Therefore, stakeholders are reluctant to abandon them in favour of the more uncertain outcomes of collaboration. Overcoming these entrenched obstacles may mean delaying initiation of collaboration until stakeholders concerned about the issue are well defined and organized.

Historical and ideological barriers may be another obstacle. Relationships characterized by long-standing bitter adversarial interactions among the parties often create insurmountable obstacles to collaboration. Power disparities and concerns about preserving an institutional power base also pose real obstacles to collaboration. Parties will be reluctant to collaborate if they believe their interest will be deemed secondary to more powerful ones (Gray, 1989).

Similarly, certain societal-level dynamics and characteristics may present restraints to collaboration. For example, cultural norms in the U.S. are rooted in a strong sense of individualism, more so than in most other cultures (Hofstede, 1980). This orientation towards self rather than community encourages people to view collaboration with skepticism, seeing collaboration as a sign of weakness rather than the challenge that it is. Political and institutional cultures within organizations may also pose formidable challenges to the wider acceptance and use of collaboration. Here, the inertial forces of institutional culture come into play. It might be necessary to neutralize these forces and alternatives include: education about the advantages and skills needed and, reward systems that encourage agency officials to participate.

Limited resources are also an issue for many public interest groups since much of their work at the local level is done by volunteers. Participation in collaborative endeavours maybe seen as a drain on time and financial resources. Finally, Gray (1989) maintained that budget cycles also discourage using collaborative approaches because resources need to be projected well in advance. Other impediments are the differing perceptions of risk and, technical complexities.

2.2. Factors Likely To Affect Partnership Success

Butterfoss *et al.* (1993) provided a literature review that suggested how coalitions are typically used, and offered a framework for understanding stages of coalition development from formation to implementation and maintenance to impact. They suggested that the factors that contributed to the implementation and

maintenance of coalitions included: degree of formality; characteristics of leadership and membership; benefits and costs of participation; organizational climate; satisfaction and commitment; skills and training, communication patterns; decision making processes; and, external supports and linkages.

2.2.1. Formalized roles and procedures

Formalisation is the degree to which rules, roles and procedures are defined precisely. Several analyses of interagency relations have noted variation in the extent to which the requirements and characteristics of situations are made explicit (Marrett, 1971). In the intra-organisational context, this dimension has been called the degree of formalisation. Two measures of formalisation were proposed: (1) the extent to which the exchange is given official recognition, and (2) the extent to which an intermediary coordinates the relations. The participation of an intervening unit between two or more given organizations is regarded as a measure of structural formalisation (Marrett, 1971).

Similarly, Partridge (1973) reported that the reason that a health centre's board discussed and reached decisions on a far greater number of topics was that the board was empowered with traditional clear-cut responsibilities for policymaking, broad management supervision, and relations with other organisations. The higher the degree of formalisation the greater the investment of resources and exchanges among agencies (Marrett, 1971), the greater satisfaction with the effort itself (Schermerhorn, 1981), and the more responsible and committed agencies become (Andrews, 1990). Examples of formalisation include: written memoranda of understanding, by-laws, policy and procedures manuals (Andrews, 1990); clearly defined roles; mission statements, goals and objectives (Feighery and Rogers, 1989); and regular reorientation to the purposes, goals and procedures of collaboration (Croan and Lees, 1979). The more routinised operations become, the more likely they will be sustained (Goodman and Steckler, 1989). For instance, Chavis *et al.* (1987) found that organizations that survived for 15 months and longer were more structured and were more likely to have written by-laws and were more likely to use written agendas and minutes to conduct regular and orderly meetings than inactive organizations.

Related to the degree of formalisation is the degree of intensity. Not only do relations differ in the extent of their formality; they diverge, too, on the involvement required, varying from less intense agency "get-togethers" in which the personnel merely become acquainted with one another, to more extreme encounters in which definite operating responsibilities are held among organizations. Interorganisational relations may be avoided because of the uncertainty that the outcome will be successful. Thus unless the success of the

venture has been clearly established, organizations are inclined to choose the less intense situation over that which is highly demanding.

Standardization differed from formalisation. A formal agreement may be broad and sweeping; it need not standardize the exchange relationship. But formalisation of structure, according to Litwak and Hylton (1962), necessitated standardization: an intermediary cannot coordinate when the rules and units are not clearly stated. Thus standardization may be necessary for the structural measure of formalisation, but it is not a sufficient condition. Moreover, standard procedures are somewhat more likely when the exchange relation is formally recognized than when it is informal. Similarly, in the presence of an official agreement there is a greater probability of standardization than when no formal contract exists (Marrett, 1971).

2.2.2. Characteristics Of Leadership And Membership

It is suspected that a critical factor in maintaining a coalition is the need for a strong central leadership within a coalition (Roberts-DeGennaro, 1986b). In his case histories of seven coalitions, Frey (1974) found that a small inner circle of leaders managed the affairs of each coalition. Strong central leadership is an important ingredient in the implementation (O'Sullivan, 1977, Feighery and Rogers, 1989) and the maintenance of coalition activities (Bailey, 1986; Sink and Stowers, 1989; Zapka *et al.*, 1992). Regardless of size, coalitions tended to have a few core leaders who dominate collation activities (Roberts-DeGennaro 1986b).

Qualities of leadership further included: personal resources such as self efficacy, membership in other community organisations; level of education; a high degree of political knowledge, commitment and competence (Rich, 1980; Prestby and Wandersman, 1985); proven administrative skills in order to set agendas, run efficient meetings, garner resources and delegate responsibilities (Feighery and Rogers, 1989); skills in communication and interpersonal relations (Andrews, 1990); and the ability to promote equal status and encourage overall collaboration in the member organizations (Hord, 1986; Lindsay and Edwards, 1988); and, flexibility (Cohen, 1989).

In the CP-HPE context, Knott (1995) articulated the term "transitional leadership" and suggested that for sustainability of a project in a changing environment, it is critical that leaders have a broad understanding of the health care system, including other providers, university education, and community needs. These new leaders must be able to develop strategies to influence and work with these features of the health system.

He reported that as the "seed" funding runs out, new leaders are beginning to emerge from the local project and community. These new entrepreneurs are needed to gain new sources of financial support and sustainable programme development without the Foundation's purse strings and external leadership. These leaders needed to have strong political ties, networking, and linkage abilities to sustain the project and will work at the boundaries between institutions, communities, and other actors, and serve as 'boundary spanners' (Alter and Hage, 1993). "Midwifing" rather than directing change is one of the most effective roles that health care professionals can play in leadership of communities. This type of leadership reflects a merging of vision, power, and concerns. It is collective and acts on behalf of the community interest (Eng *et al.*, 1992). However, the scarcity of knowledgeable, skilled and experienced leadership for CPs has hampered the necessary changes at all levels.

Current and potential leaders at all levels within each partner entity need be identified and developed. This holds true for all partners, not just community people only. A programme should be initiated aimed at mobilising and/or creating a "critical mass" of prime movers, anchor sites structures and agencies in order to generate the collective force necessary for the promotion of sustainable partnership development (Anon., 1995, MUCPP Management Committee Report).

A coalition membership is equally important and is its primary asset. Each member brings a different set of resources and skills to the coalition (Butterfoss *et al.*, 1993). The pooling of member assets is especially significant when participation is voluntary and the coalition has few material resources of its own (Prestby and Wandersman, 1985). Diversity among members enables the coalition to reach and represent a larger constituency. The degree of member participation may also be discerned by the number of active roles that members assume and the amount of time that they contribute to the organisation. Prestby and Wandersman (1985) reported that members of active associations attended more meetings, were more engaged in the organisation and spent more time working for the organisation outside of meetings than did members of inactive block associations. Active participation did not appear to be related to demographic characteristics of members, such as ethnicity, gender or age, but were related to member satisfaction, commitment, expectations about outcomes, skills and training (Prestby and Wandersman, 1985; Wandersman *et al.*, 1987). However, Butterfoss *et al.* (1993) maintained that since most studies have not looked at these correlates before and after participation, it is hard to determine causal direction.

2.2.3. Benefits and costs

Not all interactions are symmetrical: some parties to the exchange may have greater influence in determining the bases and conditions of the activity than have others. This implied that a critical dimension of interorganisational relations among autonomous groups is the degree of reciprocity, or the mutuality of the relationship (Guetzkow, 1966).

The motivating conditions influencing interorganisational cooperation derive from the benefits potentially associated with such activities. Schermerhorn (1975) cited several motivating conditions conducive to cooperation: resource scarcity (Aiken and Hage, 1975), where there is perceived organizational shortages of funds and manpower, scarcities of facilities, services and information; in response to crisis or environmental pressures; or at a more general level to have a potential favorable impact on organizational image or identity. Organizations might be favorably predisposed towards interorganisational cooperation where there is need to gain access to otherwise unavailable resources, free internal resources for alternative use, and/or more efficiently employ existing resources.

Guetzkow (1966) further suggested that the value expectancy, creating the feeling that cooperation is a "good thing to be doing," may tend to pull organizations in the direction of interorganisational cooperative activity. An extra-organizational value inducing the feeling that "cooperation" per se takes a positive value and is intrinsically good thus emerged as another factor which may motivate organizations to move in the direction of interorganisational cooperation. A further point is when a powerful extra-organizational force demands this activity. This makes it additionally important to recognize demands from powerful external sources as potential motivators of "voluntary" interorganisational cooperation. Such demands may stem from sources including government and third party organizations (Schermerhorn, 1975). In the case of this study, the third party was the donor body: the W.K. Kellogg Foundation.

The potential benefits of collaboration cited in the literature included: increased networking, information sharing and access to resources (Kaplan, 1985; Hord, 1986); attaining the desired outcomes for the coalition's efforts (Rich, 1980; Zapka *et al.*, 1992); enjoyment of the coalition's work (Benard, 1989); receiving personal recognition (Bailey, 1986; Benard, 1989; Wandersman and Alderman, 1993); and enhancing one's skills (Rich, 1980; Roberts-DeGennaro 1986b; Wandersman and Alderman, 1993).

Schindler-Rainman (1981) similarly reported that collaborative efforts had several payoffs where overlaps are decreased and new resources are discovered and utilised, and new connections are built. Gray (1989) also cited the increased quality of solutions because solutions were based on a broad, comprehensive analysis of the problem as well as the increased in collective capacity to respond to the problem as stakeholders apply a variety of complementary resources to solving it. Similarly, the potential to discover novel solutions was enhanced, the costs associated with other methods were avoided and the parties retained control during collaboration precisely because they were to be the ones to adopt or reject the final agreement. Participation enhances acceptance of solution and the willingness to implement it.

Along a similar path, Fox and Faver (1986) identified the perceived benefits of collaboration as joining resources and dividing labour, alleviating isolation and sustaining motivation through commitments to the others, and, creating energy through the interpersonal relationships. The positive consequences of collaboration meant increased project size and generating a "collective creativity". On the other hand, Salem (1978) categorized benefits into: (1) personal benefits e.g. instrumental rewards as the development of specific skills from the learning experience and, expressive rewards as the satisfaction of acting in a democratic participatory atmosphere; and, (2) *constituency* benefits which were a function of the representative-constituency relationship. Wandersman *et al.* (1987) also reported that members cited purposive and solidary motives often as reasons for participating, while others (Wandersman *et al.*, 1987; Prestby *et al.*, 1990) identified material or combined social/purposive benefits.

It is assumed that organisations join a coalition with minimal levels of commitment. It is not until the organisational actors interact that they are able to assess the costs and the payoffs from being a member of the coalition (Roberts-DeGennaro, 1986b). As a consequence, the process of forming a coalition may have little influence on what happens after the organisations coalesce. There are costs, however, to organisations from being a member of a coalition. It is assumed that in order for a coalition to survive, the payoffs to the member organisations need to outweigh or at least equal the costs for helping to maintain the coalition (Roberts-DeGennaro, 1986b).

In contrast to payoffs that facilitate participation, members may decline involvement if it is perceived as costly. Costs that are often cited included the devotion of time to the coalition that was taken from other obligations (Rich, 1980; Bailey, 1986); the overcoming of an unfavorable image held by other partners (Schermerhorn, 1975); the lack of direction from the coalition leadership or staff, the perception of a lack of

appreciation, recognition or skills leading to burnt out, and, the feeling of being pressured for additional commitment (Wandersman and Alderman, 1993).

Aiken and Hage, (1975) reported that in shared decision making a cost might be the loss of autonomy and they endorsed a position where constraints developed from "obligations, commitments or contracts with other organizations". Other costs included expending scarce resources of transportation and communication activities. The importance of such costs is that it is the organizations with 'extra' resources which are often best able to link with others. Thus, it may well cost an organization the expenditure of much needed or scarce resources to pursue the potential benefits of interorganizational cooperation.

Maintaining membership in a coalition also involved decision costs (Roberts-DeGennaro, 1986b). For example, there were costs related to collecting and communicating information to the coalition. The payoffs to the organisation in receiving information from the coalition about problems/issues affecting the organisation must be at least equal to the costs involved in collecting and communicating other information to the coalition. What may be considered apathy on the part of a member organisation may represent a rational calculation. The opportunity for leadership may be a payoff to the member organisations in a coalition.

Other researchers identified various kinds of costs: material/personal costs which concerned time, effort and the things people gave up in other parts of their lives in order to participate; solidary costs which included interpersonal conflict and lack of social support; and, purposive/organizational costs which involved elements such as lack of progress and frustration (Roberts-DeGennaro, 1986a; Freidmann *et al.*, 1988; Wandersman *et al.*, 1987). In voluntary organisations, personal costs and social/organisational costs seemed more relevant in limiting participation (Wandersman *et al.*, 1987; Prestby *et al.*, 1990). Some research has also been performed on the ratio of benefits to costs. Freidmann *et al.* (1988) reported that leaders (who tend to be the most active participants) may actually accept a ratio of benefits that is equal to costs, while members (who are less active) may want a higher benefit to cost ratio.

2.2.4. Organizational Climate

The organizational climate is the group members' perceptions of several important organizational characteristics. Giamartino and Wandersman (1983) reported that the organizational climate of a coalition helps in assessing its 'personality'. In relation to partnerships, organisational climate may be characterised by relationships among members, member-staff relationships, communication patterns among members with staff,

and a partnership's decision-making, problem-solving and conflict resolution processes (Butterfoss *et al.*, 1993).

2.2.4.1. Relationships and Communication patterns

Although the current literature is limited in addressing the effect that relationships among coalition members have on the climate of a coalition, it is reasonable to hypothesize that positive relationships among members are likely to produce a productive environment for the coalition (Butterfoss *et al.*, 1993). For example, neighbourhood associations characterized by more cohesion and leader support remained viable and their members were more involved and satisfied with the progress of the group (Giamartino and Wandersman, 1983; Prestby and Wandersman, 1985).

Although not all coalitions have the resources to employ staff, staff can reduce the burdens placed on a coalitions membership. When a coalition employs staff, it is likely to be more harmonious if staff and members are clear about their respective roles, and if staff are given latitude to carry out daily tasks (Brown, 1984). Staff roles should be clarified as soon as a coalition is formed. Feighery and Rogers (1989) believed that in the early stages of the coalition, staff must help educate coalition members to the issues that influence the coalition's mission and strategies, and that staff need to guide members in assuming new roles and responsibilities. Butterfoss *et al.* (1993) similarly indicated that staff effectiveness may be judged by how well they balance their provision of technical assistance to members with the members' ability to make informed decisions. Staff seemed more likely to improve the atmosphere of a coalition when they possessed an appreciation for the voluntary nature of coalitions, and had organizational and interpersonal skills to facilitate the complex, collaborative process (Croan and Lees, 1979). Wandersman and Alderman (1993) found that the relationship between the volunteers and the paid staff is one of negotiation and diplomacy. There are several issues that make this relationship a delicate one. The lack of structure in many volunteer positions often leaves the volunteer unsure of his/her role within the organization, and consequently, this may contribute to the volunteers' perceived lack of commitment to the organization.

Unimpeded internal communication among the membership and staff may be the most essential ingredient for enhancing the climate of a coalition. The quality of communication has been positively related to coordination and negatively related to conflict (Hall *et al.*, 1977). Open communication helped the groups focus on a common purpose, increased trust and sharing of resources, provided information about one another's programmes, and allowed members to express and resolve misgivings about planned activities (Feighery and Rogers, 1989; Andrews, 1990). Durable coalitions often had frequent meetings which

members were encouraged to attend (Hord, 1986; Benard, 1989) and a well developed system of internal communication to keep staff and members informed (Croan and Lees, 1979; Andrews, 1990; Cohen *et al.*, 1990). Chavis *et al.* (1987) reported that active associations used more methods to communicate with members than did inactive associations.

2.2.4.2. Decision-making and community linkages

The climate in which a coalition operates may be enhanced when the leadership shared decision making with the general membership (Zuckerman and Kaluzny, 1990), and when no one individual or organization had more authority or controls more of the coalition's resources than another (Andrews, 1990). Shared decision-making may lead to greater understanding and commitment to the issues confronting a coalition (Brown, 1984). The degree of member input into coalition decisions may range from advice to control (Wandersman, 1981). Encouraging member involvement by formalizing procedures may improve the coalition's ability to sustain itself. The more active members of block associations felt that they had a greater influence in deciding on policies and actions of the group than did inactive members (Prestby and Wandersman, 1985, Chavis *et al.*, 1987).

Butterfoss *et al.* (1993) reported that problem-solving and conflict resolution strategies are less commonly reported as important tools for enhancing the climate of a coalition than are decision-making strategies. Negotiations for reaching a compromise and resolving conflict may be formal or informal, and help improve the climate when they facilitate future interaction among coalition members. A coalition's operational milieu may be enhanced when the process is defined clearly so that the resulting solutions do not conflict with the responsibilities of individual participants (Andrews, 1990). Thus conflict resolution may aid coordination among members especially when member interactions were defined and frequent (Hall *et al.*, 1977).

Mizrahi and Rosenthal (1992) argued that conflict is an inherent characteristic of coalitions. Conflict may arise between the coalition and its targets for social change, among coalitions members and staff, and among coalition partners concerning issues such as leadership, diverse goals, benefits, contributions and representation. Mizrahi and Rosenthal identified four "dynamic tensions" that account for conflict in coalitions, namely the mixed loyalties as well as the diversity of interests of its members to their own organization and to the coalition; the autonomy a coalition requires and the accountability it has to its member organizations; and, the lack of clarity about the coalition's purpose as either a means for specific

change, or a model for sustained inter-organizational cooperation. How a coalition managed these dynamics affected its cohesiveness and effectiveness.

Although coalitions frequently rely on member resources, coalitions may also benefit by linking with resources external to the coalition, especially those concerned with policy, planning and services (Sabatier, 1987). Examples of external resources are elected officials and governmental agencies, religious and civic groups, and neighborhood and community development associations. These resources can provide expertise, facilities for meetings, mailing lists, referrals, additional personnel for special projects, grant funding, loans or donations, equipment and supplies, and co-sponsoring events (Prestby and Wandersman, 1985; Chavis *et al.*, 1987).

Access to local communities is an important link for many coalitions particularly those concerned with health promotion (Roberts-DeGennaro, 1986b). Such coalitions often benefit by linking with individuals and organisations that are active in community affairs. For instance, associations that endured tended to have strong linkages with local community organisers and with other neighbourhood associations (Prestby and Wandersman, 1985). Members of both active and inactive associations linked with community organisations and agencies, but exchange of the needed resources occurred more often in active associations (Chavis *et al.*, 1987). Improved linkages with several other community organisations was reported as an important intermediate outcome by members of a substance abuse task force (Florin *et al.*, 1989), who also reported higher levels of participation, satisfaction, positive expectations and greater intentions of future participation. Roberts-DeGennaro (1986b) similarly pointed out that maintaining a coalition is a dynamic process that develops through their linkages between the member organisations and the coalition. It is the process that supports the life of a coalition, in order to keep it from declining and to sustain it against any opposing forces.

2.2.5. Miscellaneous Factors

2.2.5.1. Satisfaction and Skills

It is not surprising that members who perceived a coalition as beneficial expressed greater satisfaction and often collaborated to a greater extent than members who perceived coalition involvement as costly (Knoke and Wright-Isak, 1982; Cohen, 1989). Organizations with more satisfied members were more cohesive, organized and had more effective leadership (Giamartino and Wandersman, 1983). Prestby and Wandersman (1985) similarly found significant correlations between member satisfaction and increased viability of the

organisation. Yet, other research indicated no significant difference between active and inactive voluntary associations based on member satisfaction (Chavis *et al.*, 1987; Pestby *et al.*, 1990). The general wisdom holds that coalitions tend to remain durable when the commitment of individual members is strong (Benard, 1989; Cohen *et al.*, 1990). Prestby and Wandersman (1985) maintained that member groups have different levels of commitment that result in varied investments of time, effort and resources. As member commitment develops, coalitions activities are likely to increase in scope and effectiveness (D'Aunno and Zuckerman, 1987).

The effective implementation and maintenance of a coalition not only required motivated and involved members, but also required that members have the skills or 'capacity to participate' in order to operate an effective partnership and to be perceived as legitimate (Gray, 1985). In parallel, Schindler-Rainman (1981) suggested some needed competencies for successful collaboration: conflict utilisation skills; appreciation of differences; resource retrieval i.e. how to discover and use available material and resources to do the task decided upon; decreasing turfdom roles, loyalties and defences; learning how to utilise resistance to change as a positive force; competency in recognition and "footnoting" contributions of participants, and; evaluation and feedback competencies.

Some other useful skills were the competencies in multiple dimensional team building; planning and futuring skills; as well as meeting technology skills and involvement competencies. A skills training programme conducted with members of an advocacy coalition resulted in increased reporting of issues by members and overall improved effectiveness of the consumer organization (Balcazar *et al.*, 1990). Skills training need be based on a review of the relevant training literature and the external policies that may affect a coalition's operations (Andrews, 1990; Cohen *et al.*, 1990). Florin *et al.* (1992) illustrated that coalitions often required training and technical assistance, and specified the types of assistance that may be tailored to the different stages of coalition development.

2.2.5.2. Representation and Inclusiveness

Various definitions of what is meant by a community are given in dictionaries and other publications. Some imply homogeneity. For example, "the people living in a particular place or region and usually linked by common interests" (Webster's Third New International Dictionary); "the people of a country (or district) as a whole; the general body to which all alike belong; the public" (Oxford English Dictionary); or " a group of individuals and families living together in a defined geographic area, usually comprising a village, town

or city" (Deuschle and Fulmer, 1962). The report of the International Conference on PHC, Alma Ata, 1978 defined community as "people living together in some form of social organization and cohesion" (World Health Organization, 1978). What emerges is that "Community" is a complex concept. Hillery (1955) identified 94 possible definitions.

Conversely, the definitions of other authorities imply heterogeneity. For example, "many communities are geographic only and have serious conflicts along class or other lines (religious, racial, etc.)" (M. Roemer, personal communication, 1985, cited in WHO, 1978). In some countries each social class, though living in close proximity to the others, has very different health priorities. In some descriptions the heterogeneity of the community is recognized: "the term should not refer to a cohesive, homeostatic association of people but to a stratified arrangement of groups, interests and resources, some of them having more power and status than others. Considerable competition and even conflict is likely to be present in any given community and some change in the internal structure of communities may occur over time" (WHO, 1981). Rifkin *et al.* (1988) reported three broad definitions viz.: geographic; a group of people sharing same basic interests; or, epidemiologically as 'target' or 'at risk' group.

More recent definitions incorporated a social component. For example, "the community is a social space in which the concept of meeting the needs of this group and its internal power will be incorporated for making decisions regarding the solution of its problem" (C. Ordonez, personal communication, 1985, cited in WHO, 1987). The objective was not to provide one standardized definition of the term but to clarify its meaning, all these interpretations should be taken into consideration.

Haynes (1970) argued that although the term "community representation" has become quite popular, no one seemed to know a really satisfactory way of identifying community representatives. He questioned if one is to deal with the official leaders or the natural leaders, with staff of community organizations or with grass-roots support. Who are they and how were they are selected? Similarly, Hochbaum (1969) queried if they should be the more educated and knowledgeable or those who are likely to bring the best understanding of the issues involved to the planning? Can they be selected by the lay population or must they be identified on basis of their qualifications as determined by professionals? Or should these representatives be selected from the very segments of the population. If so, would they not be so uneducated, so naive about health services, and so incompetent as to meaningfully contribute to the planning?

Douglass (1973) cited Murphy's (1954) definition of the *formal* representative: that who has ".....approval by formal vote of his organization...". The two other types, informal and type representatives are derived consequentially from Murphy's definition. The *informal* representative is the person who does not speak for his agency but acts as liaison between it and the deliberating body. A *type* representative is one who is associated with an agency or group only in so far as he personally is a member of that agency or group. He neither speaks for the agency nor acts as liaison. Using these definitions of organizational representation, participants in the community health planning process can be accordingly classified. Douglass concluded that providers who are formal representatives are most likely to yield an orientation in decision making that can be predicted by their organizational affiliation, as opposed to providers who are informal or type representatives and who tended to act in terms of their own self perceptions and attitudes.

Salem (1978) similarly reported that the term "representation" suggests that there is a relationship of some kind between the representatives and their constituents. Many representatives find this relationship non-existent or at best weak. Half the respondents in Salem's study made no attempt to report back to their constituents. Another one third described a haphazard and informal reporting system which consisted mainly of talking to immediate neighbours and others who might be contacted within the context of other activities. Others found no organizational group with which to deal and therefore lacked a mechanism which readily enabled them to convene the residents of the precinct. Thus few representatives were able to either share the information or the power with their constituencies.

One variable in programmes that may determine outcomes is the differential pattern of client participation. In a survey of the members and staff of 61 state mandated coalitions for tobacco control 18 months after formation, Rogers *et al.* (1993) also found that important sectors were not represented. Herman *et al.* (1993), however, have cautioned about how member recruitment that is based largely on pre-existing networks may result in the exclusion of important constituencies and may define the level to which member organizations become involved in a coalition.

Representation may be limited because some people feel they have nothing to gain or contribute given their situation, needs, and history. Often it is a minority, the better off, who are more involved. If the poorer and therefore sicker members of the community are not represented in the partnership, then it is unlikely that their perspective will be presented in the partnership, thus perpetuating inequity. Community partnerships

should ensure that the powerless are not marginalized further in partnership building efforts (Bracht and Tsouros, 1990; Yeo, 1993). Planning needs to be as inclusive and representative as possible, and needs to be supported politically and administratively to function effectively. Even a CP may discriminate against the poor in that they may not be able to afford the time necessary for participation. Although they are the priority target group, they are the least likely to be involved in decisions and actions initiated by professionals and academics. This situation allows the elite in the community to have an upper hand in the collective decision making and other issues of development.

In relation to CP-HPE projects, Knott (1995) reported that the composition of the partnership's board is a factor affecting project sustainability. In some projects, most of the community representatives are health providers. and representation by only local advocacy groups ignores the more mainstream stakeholders in the community, including business, payers, hospitals, and government. A fuller representation of stakeholders in the community on the board would better assure the sustainability of the partnerships.

The CP-HPE risk the same fate of suffering from co-optation of community values into institutional priorities. The Kellogg Foundation gave grants to the universities which have dominated the planning and spending of the funds. In the US context, some CPs had more institutional representatives on the board than community representatives. The universities have held meetings at the campus during working hours. Some of the partnership boards have had community representation only from health providers in the community who shared the same values as university faculty. Knott (1995) reported that these are all signs of co-optation, and that projects that have a majority of community representatives on the board have a more positive view of the project's accomplishments and more favorable attitudes about prospects for the future.

2.2.5.3. Institutionalization and sustainability

Goodman and Steckler (1989) defined institutionalization as the attainment of long-term viability and integration of innovations in organizations. They cited the various synonyms for institutionalization: frozen, stabilized, accepted, sustained, durable, persistent, maintained, incorporated, and continued. Again, such an array of terms underscored the lack of consensus over the components comprising institutionalization. Glaser (1981) used the term "durability" and defined it as continued or sustained use, but institutionalization implies more than use. Miles (1983) characterized it as some sense of "built-in-ness", while Beyer and Trice (1978) described it as "committed use".

Institutionalization is generally considered to be the final stage of a diffusion process, during which programme innovations "settle" into organizations (Beyer and Trice, 1978). It is increasingly recognized that many health promotion programmes will not become institutionalized, regardless of how theoretically sound, well implemented, and effective they may prove to be (Goodman and Steckler, 1987-88). The organizational innovation literature (Berman, 1978; Glaser, 1981; Miles, 1983), and that pertaining to community health development (Simmons, 1976), also illustrate that successful programme implementation did not necessarily assure long-term programme viability. Institutionalization has been a relatively neglected area of research, with the few measures that currently are used for institutionalization lacked precision (Goodman and Steckler, 1989). Until recently, most models stopped at the implementation stage, not considering institutionalization as the logical next step (Goodman and Steckler, 1987-88).

In assessing the degree of institutionalization, Goodman and Steckler (1989) used two dimensions: extensiveness and intensiveness. Institutionalization *extensiveness* referred to the extent of a programme's integration within the subsystems of its host organization. Institutionalization *intensiveness*, on the other hand, is a measure of differing institutionalization intensity, ranging from shallow to deep. For intensiveness they described various degrees: the 'passages' phase, which is the first degree of institutionalization intensity, are highly symbolic events of an innovation's emerging rootedness or stability, tend to occur only once, and establishes "benchmarks" for a programme's stability; the 'routines' phase, which is the next degree of institutionalization intensiveness is characteristic of a programme's increasing permanence, for when a programme is routinized, it no longer stands out as new; and, the 'niche saturation' phase which represents a degree of institutionalization beyond routines and is defined as an institutionalized programme's maximum feasible expansion within the host organization, permeating the organization's subsystems. Related to extensiveness and intensiveness, Goodman and Steckler (1989) also focused on three additional factors: programme renewal, which appears to be an innovative stage beyond institutionalization; diffusion, which extends the programme beyond the host organization where other organizations adopt programmes that are also retained by the originating organization; and, spin-off, which serves as an alternative to institutionalization in the host organization and occurs when the programme shifts location from the originating to adopting organization, and is no longer retained by the former. Spin-off, like outward diffusion, also occurs beyond the boundaries of the originating organization.

Goodman and Steckler (1987-88) illustrated the importance of developing separate but related strategies for programme implementation and long-term programme viability. Implementation was primarily

concerned with allocation of programme resources, such as staff, funds, and support materials. Staff acceptance of programme defined roles was also an important facet of implementation. Institutionalization, on the other hand, entails the modification of values so that programme goals are accepted and internalized by those forces which can help sustain the programme. Whereas implementation tended to focus on more immediate programmatic concerns, institutionalization issues were more politically oriented, such as seeking permanent funding. As Kantor (1983) suggested, "it is when the structures surrounding a change also change to support it that we say that a change is 'institutionalized'. Policy which emphasizes implementation variables, while neglecting those necessary for institutionalization, compromises a programme's ability to survive in the long-term.

In relation to CP-HPE, Knott (1995) argued that to build sustainable projects in large-scale organizations requires changing the organization's rules, incentives, rewards, and culture. It may also require new structures and personnel. Since the CPs that Knott investigated were still receiving Foundation funding, it was too early to tell how significantly the universities had changed. Critical indicators could include: required courses in the curriculum; number of regular faculty involved in the educational programme; merit incentives for the faculty to teach in the programme or to operate practice plans in the partnership sites; and, changed rules for practitioners in the health centre to participate in university departments as community faculty. Cluster evaluation data indicated that required courses and participation of faculty and students appear to be on target but less progress is evident in changing rewards and rules (Knott, 1995).

Demonstration project grants tend to emphasize the development of conceptually sound and well implemented programmes for replication elsewhere. This "multiplier effect" entails first demonstrating implementation effectiveness at the original site, and then disseminating proven programmes to other communities. One irony of this approach, is that after grant termination, programmes worthy of replication can fail to thrive at their original demonstration sites. Thus a policy weighed toward a multiplier effect can cause institutionalization to become a latent concern for the implementing organization (Goodman and Steckler, 1987-88). Accordingly, when local health agencies accept funding for community health development programmes they need to consider the adverse impact that termination might have on communities and agencies alike. Yin (1979) asserted that programme failure is more costly after it is fully implemented since resources have been fully mobilized, career decisions have been made at the expense of other options, and community trust has been extended.

Given the funding restrictions imposed on programmes, Goodman and Steckler (1987-88) suggested that the answer revolves around shared ownership. The emphasis is placed on identification and utilization of diverse perspectives in the diagnosing, planning, implementing, and evaluating processes. Where programme ownership is shared throughout the programme, institutionalization is more likely to occur. When networking is extensive in implementation, but when shared ownership with allied agencies and the community is low, or as a result of ideological constraints, passive instead of active support for programme institutionalization may result. Project ownership may not cross over from the professionals to the community or other agencies. Such a lack of transference of ownership to the community and other social agencies may result in little grassroots support in the community to lobby for project continuance later on.

Knott (1995), cited a study of earlier demonstration projects by Baer *et al.* (1977) and suggested that three factors hinder sustainability: artificiality, non-replicability of the demonstration site, and, co-optation.

Artificiality: referred to the fact that sponsors of demonstration projects did not want them to fail. Generous, multi-year seed funding, technical assistance as well as the sponsoring agency becoming an active and aggressive champion and a disseminator of information about the project to the newsmedia and political and business leaders, characterized the sponsor's support for the projects. While these actions helped the demonstration project to succeed, they created such an artificial set of incentives and other supports that once they were withdrawn the project could not continue on its own. The criteria at the sponsoring agency that did not allow the project to fail, thereby, ironically, increasing the probability of failure in the post-demonstration phase.

Non-replicability: referred to the assumption that funding several demonstration projects and demonstrating their success would cause similar innovations to spread to other communities and organization. Too frequently, this assumption proved to be unwarranted. Other communities did not necessarily possess the same resources, personalities, technology, or organizational culture conducive to the transfer of the innovation. Choosing communities and institutions that had characteristics favourable to project success, thereby limiting the replicability of the project elsewhere.

Co-optation: where community involvement in partnership structures often did not guarantee the kind of change sought by the sponsoring agency. In some cases community representatives consisted entirely of professionals from other agencies who shared the established institutions' goals rather than the more radical

community values. In other cases the established agencies held meetings at times and locations very inconvenient for community representatives. The agencies also used technical jargon and other means to prevent community representatives from having a meaningful voice. The appearance of the partnership thus replaced the reality (Knott, 1995).

Several publications emphasized the need for a coalition to accomplish 'quick wins' and short-term successes to increase motivation and pride and to enhance the credibility of the coalition (Croan and Lees, 1979; Hord 1986). Once a coalition attains a quick win, it may direct its efforts at more complex tasks (Cohen *et al.*, 1990). Short-term successes should not, however, be mistaken for ultimate solutions to chronic health problems and endemic social concerns (Sink and Stowers, 1989). The ultimate indicators of coalition effectiveness reflect a coalition's attainment of its mission, goals and objectives. After all, a well-formed and maintained coalition is not necessarily effective in accomplishing its mission, even if it is effective in generating programmes and activities or member satisfaction and commitment. While these activities and outcomes are important, they are insufficient measures of effective results.

Programme evaluators often discuss two types of programme effects: short-term and long-term. Linney and Wandersman (1991) described short term effects as immediate results of a programme for the recipients of a service or activity. In addition, longer term effects encompassed system changes in service delivery, system reform, cross referrals among agencies and new community linkages (Kagan, 1991). Measurement of long term effects and system change is difficult and few studies address it. If coalitions are to contribute to improved health status, then coalitions must evaluate the degree of impact that they have on improving the social and health status of the communities that they serve.

On the other hand, Knott (1995) addressed outcomes by asking questions about 'what are we trying to sustain?'. The definition of success for the CPs has important implications for whether the institution has coopted the community. Knott (1995) reported that it may be helpful to list these elements as a way of focusing on what the Foundation is trying to sustain. These elements include: the CPs' board and staff, including coordinators; the curriculum for the schools and heath centers; non-hospital instruction in community health centers; non-center experience in the community itself, including schools, nursing homes, and neighborhoods; viable community health centers where instruction can occur; team-based and community-based faculty to teach, mentor and provide experience for the students; and participating students from medicine, nursing, and allied health. Not all these elements of the community partnerships

may be sustained e.g. only students from one of the health professions are participating or out-of-hospital instruction without team-based instruction nor non-centre experiences.

2.2.5.4. Empowerment

Since the late 1970s, the notion of empowerment has appeared with increasing frequency in discussions of preventive social and community intervention. While the idea of empowerment is intuitively appealing, its applicability has been limited by continuing conceptual ambiguity. For instance, Wallerstein (1992) reported that the terms "powerlessness" and "empowerment" have increasingly appeared in the public health literature during the last decade, but reported that the casual use of these terms has led to a lack of theoretical clarity and measurement problems. She maintained that that the health outcomes of powerlessness and empowerment are often unrecognized, despite the considerable research which documents the role of powerlessness in disease causation, and conversely, of empowerment in health promotion.

Although the idea is rooted in the "social action" ideology of the 1960s, and the "self-help" perspectives of the 1970s, empowerment appears with increasing frequency in discussions of strategies for prevention and community intervention. Kieffer (1984) argued that we have yet to define this term with sufficient clarity to establish its utility, and proposes a view of empowerment as a necessarily long-term process of adult learning and development. It is further described as the continuing construction of multi-dimensional participatory competence. This conception encompassed both cognitive and behavioural change.

Wallerstein (1992) reported that in the public health field, empowerment has traditionally been defined, by its absence, as powerlessness. She referred to Rappaport's (1987) and Zimmerman and Rappaport's (1988) definition of empowerment in its broadest sense: a multi-level construct that involves people assuming control and mastery over their lives in the context of their social and political environment. As people perceive their failure to achieve societal promises, they become psychologically damaged and internalize their powerlessness as their own fault, rather as a response to system-wide discrimination (Seeman, 1959).

For Freire (1970), powerlessness results from passive acceptance of oppressive culture "givens", or surrender to a "culture of silence". Empowerment is the process by which the capacity of people is strengthened and vulnerability reduced through effective partnerships. It is an enabling process in which people, especially the labelled, working together to increase their control over events and factors which

influence their well being. It cannot be done for the people, they must do it for themselves. It only happens when the process focuses not only on needs and deficiencies but also on assets, strengths, and capacities of those being empowered. Kieffer (1984) maintained that empowerment is labor intensive, as the significant transformative transition can only grow from long-term engagement. In becoming empowered, he reported, individuals are not merely acquiring new practical skills; they are reconstructing and reorienting deeply engrained personal systems of social relations. As such, it would be frivolous to pretend that there can ever be developed a "short course" in individual empowerment. It is not simply the issue of time, but more importantly the question of practice. Empowerment is not a commodity to be acquired, but a transforming process constructed through action. Individuals must learn to overcome internalized expectations of helplessness, the frustrations of inequities in tactical resources, and the endurance of political intimidation. These capacities evolve only through practice. While empowerment is, at root, an individual demand, it is nurtured by the effects of collective effort. Thus the keyword throughout is "collaboration" (Kieffer, 1984).

2.3.5. Miscellaneous Factors

2.3.5.1. Satisfaction and Commitment

It is not surprising that members who perceived a coalition as beneficial expressed greater satisfaction and often collaborated to a greater extent than members who perceived coalition involvement as costly (Knoke and Wright-Isak, 1982; Cohen, 1989). Giamartino and Wandersman (1983) reported that block organizations with more satisfied members were more cohesive, organized and had more effective leadership. Prestby and Wandersman (1985) similarly found significant correlations between member satisfaction and increased viability of the organisation. Yet, other research indicated no significant difference between active and inactive voluntary associations based on member satisfaction (Chavis *et al.*, 1987; Pestby *et al.*, 1990).

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2.3.5.2. Skills and Training

Partridge (1973) reported that in a health centre board, the official mechanism by which the community members could become involved. The major factors for greater participation included the clarity and nature of the group's mandate, as well as the congruence between the administrative character of the board's role, the administrative tasks it handled, and the administrative abilities of its members. The effective implementation and maintenance of a coalition not only required motivated and involved members, but also required that members have the skills or 'capacity to participate' in order to operate an effective partnership and to be perceived as legitimate (Gray, 1985). Hall *et al.* (1977) also pointed out that the competence and the performance of members were positively related to coordination among participating organizations and negatively related to conflict. In parallel, Schindler-Rainman (1981) suggested some needed competencies for successful collaboration: conflict utilisation skills; appreciation of differences; resource retrieval i.e. how to discover and use available material and resources to do the task decided upon; decreasing turfdom roles, loyalties and defences; learning how to utilise resistance to change as a positive

force; competency in recognition and "footnoting" contributions of participants, and; evaluation and feedback competencies.

Some other useful skills were the competencies in multiple dimensional team building; the use of temporary systems; planning and futuring skills; as well as meeting technology skills and involvement competencies. A skills training programme conducted with members of an advocacy coalition resulted in increased reporting of issues by members and overall improved effectiveness of the consumer organization (Balcazar *et al.*, 1990). Skills training need be based on a review of the relevant training literature and the external policies that may affect a coalition's operations (Andrews, 1990; Cohen *et al.*, 1990). Florin *et al.* (1992) illustrated that coalitions prompted by state legislation for addressing alcohol and other drug abuse often required training and technical assistance, and specified the types of assistance that may be tailored to the different stages of coalition development.

2.3.5.3. Partnership Composition—Representation and Inclusiveness

Various definitions of what is meant by a community are given in dictionaries and other publications. Some imply homogeneity. For example, "the people living in a particular place or region and usually linked by common interests" (Webster's Third New International Dictionary); "the people of a country (or district) as a whole; the general body to which all alike belong; the public" (Oxford English Dictionary); or " a group of individuals and families living together in a defined geographic area, usually comprising a village, town or city" (Deuschle and Fulmer, 1962). The report of the International Conference on PHC, Alma Ata, 1978 defined community as "people living together in some form of social organization and cohesion" (World Health Organization, 1978). What emerges is that "Community" is a complex concept. Hillery (1955) identified 94 possible definitions.

Conversely, the definitions of other authorities imply heterogeneity. For example, "many communities are geographic only and have serious conflicts along class or other lines (religious, racial, etc.)" (M. Roemer, personal communication, 1985, cited in WHO, 1978). In some countries each social class, though living in close proximity to the others, has very different health priorities. In some descriptions the heterogeneity of the community is recognized: "the term should not refer to a cohesive, homeostatic association of people but to a stratified arrangement of groups, interests and resources, some of them having more power and status than others. Considerable competition and even conflict is likely to be present in any given community and some change in the internal structure of communities may occur

over time" (WHO, 1981). Rifkin *et al.* (1988) reported three broad definitions viz.: geographic; a group of people sharing same basic interests; or, epidemiologically as 'target' or 'at risk' group.

More recent definitions incorporated a social component. For example, "the community is a social space in which the concept of meeting the needs of this group and its internal power will be incorporated for making decisions regarding the solution of its problem" (C. Ordonez, personal communication, 1985, cited in WHO, 1987). White (personal communication, 1985; cited in WHO, 1987) on the other hand, favoured the term *population* rather than community. The objective was not to provide one standardized definition of the term but to clarify its meaning, all these interpretations should be taken into consideration.

Haynes (1970) argued that although the term "community representation" has become quite popular, no one seemed to know a really satisfactory way of identifying community representatives. He questioned if one is to deal with the official leaders or the natural leaders, with staff of community organizations or with grass-roots support. Who are they and how were they are selected? Similarly, Hochbaum (1969) queried if they should be the more educated and knowledgeable or those who are likely to bring the best understanding of the issues involved to the planning? Can they be selected by the lay population or must they be identified on basis of their qualifications as determined by professionals? Or should these representatives be selected from the very segments of the population. If so, would they not be so uneducated, so naive about health services, and so incompetent as to meaningfully contribute to the planning?

Douglass (1973) cited Murphy's (1954) definition of the *formal* representative: that who has ".....approval by formal vote of his organization...". The two other types, informal and type representatives are derived consequentially from Murphy's definition. The *informal* representative is the person who does not have approval by vote from the executive bodies or the administrative authorities of his agency. He does not speak for his agency but acts as liaison between it and the deliberating body. A *type* representative is one who is associated with an agency or group only in so far as he personally is a member of that agency or group. He neither speaks for the agency nor acts as liaison. Using these definitions of organizational representation, participants in the community health planning process can be accordingly classified.

In a study of the congruence between a representative's organizational affiliation and health services attitudes, Douglass (1973) concluded that providers who are formal representatives are most likely to yield an orientation in decision making that can be predicted by their organizational affiliation, as opposed to providers who are informal or type representatives and who tended to act in terms of their own self perceptions and attitudes. In contrast, representatives of consumer organizations, on the other hand, were consistently consumer oriented in their perceived roles and attitudes regardless the nature of their representation.

Salem (1978) similarly reported that the term "representation" suggests that there is a relationship of some kind between the representatives and their constituents. Many representatives find this relationship non-existent or at best weak. Half the respondents in Salem's study made no attempt to report back to their constituents. Another one third described a haphazard and informal reporting system which consisted mainly of talking to immediate neighbours and others who might be contacted within the context of other activities. The few representatives who felt that they were communicating with their constituencies were those few who represented areas organized into block clubs. Others found no organizational group with which to deal and therefore lacked a mechanism which readily enabled them to convene the residents of the precinct. Thus few representatives were able to either share the information or the power with their constituencies.

Montgomery and Esman (1971) similarly articulated their concern about programme stability through the establishment and maintenance of means for the peaceful accommodation of adversary interests among parties affected by the administration of the programme. These values were not always mutually compatible in a specific situation. Thus a continuing concern in programme management is to reconcile contradictions among them that emerge in practice. One variable in programmes that may determine outcomes is the differential pattern of client participation. In a survey of the members and staff of 61 state mandated coalitions for tobacco control 18 months after formation, Rogers *et al.* (1993) also found that important sectors were not represented. Herman *et al.* (1993), however, have cautioned about how member recruitment that is based largely on pre-existing networks may result in the exclusion of important constituencies and may define the level to which member organizations become involved in a coalition.

Representation may be limited because some people feel they have nothing to gain or contribute given their situation, needs, and history. Often it is a minority, the better off, who are more involved. If the poorer and therefore sicker members of the community are not represented in the partnership, then it is

unlikely that their perspective will be presented in the partnership, thus perpetuating inequity. Therefore, participation should not be limited to those who already have some power. Community partnerships should ensure that the powerless are not marginalized further in partnership building efforts (Bracht and Tsouros, 1990; Yeo, 1993). Planning needs to be as inclusive and representative as possible, and needs to be supported politically and administratively to function effectively. Even a CP may discriminate against the poor in that they may not be able to afford the time necessary for participation. Although they are the priority target group, they are the least likely to be involved in decisions and actions initiated by professionals and academics. How can their involvement be facilitated when their agenda is already taken up by the struggle to survive from one day to the next. This situation allows the elite in the community to have an upper hand in the collective decision making and other issues of development.

In relation to CP-HPE projects, Knott (1995) reported that the composition of the partnership's board is a factor affecting project sustainability. In some projects, most of the community representatives are health providers. The literature suggested that some community representatives should represent neighbourhood associations and "grass roots" organized interests that have strong advocacy skills and political connections with state and local government officials. However, representation by only local advocacy groups ignores the more mainstream stakeholders in the community, including business, payers, hospitals, and government. A fuller representation of stakeholders in the community on the board would better assure the sustainability of the partnerships.

The CP-HPE risk the same fate of suffering from co-optation of community values into institutional priorities. The Kellogg Foundation gave grants to the universities which have dominated the planning and spending of the funds. In the US context, some CPs had more institutional representatives on the board than community representatives. The universities have held meetings at the campus during working hours. Some of the partnership boards have had community representation only from health providers in the community who shared the same values as university faculty. Knott (1995) reported that these are all signs of co-optation, and that projects that have a majority of community representatives on the board have a more positive view of the project's accomplishments and more favorable attitudes about prospects for the future.

2.3.6. Institutionalization, sustainability and replicability

Goodman and Steckler (1989) defined institutionalization as the attainment of long-term viability and integration of innovations in organizations. They cited the various synonyms for institutionalization: frozen, stabilized, accepted, sustained, durable, persistent, maintained, incorporated, and continued. Again, such an array of terms underscored the lack of consensus over the components comprising institutionalization. Glaser (1981) used the term "durability" and defined it as continued or sustained use, but institutionalization implies more than use. Miles (1983) characterized it as some sense of "built-in-ness", while Beyer and Trice (1978) defined it as a process whereby "attitudinal reactions toward goals occur relative to values held. Values are modified to accept goals. Goals are internalized into modified values". Internalization of goals and modification of values add to the concept of "use", transforming it into "committed use".

Institutionalization is generally considered to be the final stage of a diffusion process, during which programme innovations "settle" into organizations (Beyer and Trice, 1978). It is increasingly recognized that many health promotion programmes will not become institutionalized, regardless of how theoretically sound, well implemented, and effective they may prove to be (Goodman and Steckler, 1987-88). The organizational innovation literature (Berman, 1978; Glaser, 1981; Miles, 1983), and that pertaining to community health development (Simmons, 1976), also illustrate that successful programme implementation did not necessarily assure long-term programme viability.

Goodman and Steckler (1989) reported that institutionalization has been a relatively neglected area of research, with the few measures that currently are used for institutionalization lacked precision. Until recently, most models stopped at the implementation stage, not considering institutionalization as the logical next step (Goodman and Steckler, 1987-88). They also further suggested that institutionalization occurred when a health promotion programme integrates within the subsystems of its host organizations. These five subsystems as defined by Katz and Kahn (1978) were: the production or technical subsystem, concerned with "throughput"; the maintenance subsystem, concerned with personnel, rewarding and sanctioning and assuring continuity throughout the system's operations; the supportive subsystem, which was environmentally directed and established legitimacy and favourable organizational relationships within the larger social environment; the adaptive subsystem, also externally oriented, attempted to adjust the organization's operations to fit the changing environmental demands and conditions; and finally, the managerial subsystem which was the lubricant which controls, coordinates, and directs all the other subsystems' operations.

In assessing the degree of institutionalization, Goodman and Steckler (1989) used two dimensions: extensiveness and intensiveness. Institutionalization *extensiveness* referred to the extent of a programme's integration within the subsystems of its host organization. Yet, subsystems integration, by itself, is insufficient for determining the level of programme institutionalization. Institutionalization *intensiveness*, on the other hand, is a measure of differing institutionalization intensity, ranging from shallow to deep. For intensiveness they described various degrees: the 'passages' phase, which is the first degree of institutionalization intensity, are highly symbolic events of an innovation's emerging rootedness or stability, tend to occur only once, and establishes "benchmarks" for a programme's stability; the 'routines' phase, which is the next degree of institutionalization intensiveness is characteristic of a programme's increasing permanence, for when a programme is routinized, it no longer stands out as new; and, the 'niche saturation' phase which represents a degree of institutionalization beyond routines and is defined as an institutionalized programme's maximum feasible expansion within the host organization, permeating the organization's subsystems. Related to extensiveness and intensiveness, Goodman and Steckler (1989) also focused on three additional factors: programme renewal, which appears to be an innovative stage beyond institutionalization; diffusion, which extends the programme beyond the host organization where other organizations adopt programmes that are also retained by the originating organization; and, spin-off, which serves as an alternative to institutionalization in the host organization and occurs when the programme shifts location from the originating to adopting organization, and is no longer retained by the former. Spin-off, like outward diffusion, also occurs beyond the boundaries of the originating organization.

Goodman and Steckler (1987-88) illustrated the importance of developing separate but related strategies for programme implementation and long-term programme viability, i.e., institutionalization. Implementation was primarily concerned with allocation of programme resources, such as staff, funds, and support materials. Staff acceptance of programme defined roles was also an important facet of implementation. Institutionalization, on the other hand, entails the modification of values so that programme goals are accepted and internalized by those forces which can help sustain the programme. Whereas implementation tended to focus on more immediate programmatic concerns, institutionalization issues were more politically oriented, such as seeking permanent funding. Institutionalization focused on the integration of the programme into the organizational environment through developing an organizational niche for the programme. As Kantor (1983) suggested, "it is when the structures surrounding a change also change to support it that we say that a change is 'institutionalized'– that it is now part of a legitimate and ongoing practice, infused with value and supported by other aspects of the

system". Health educators need to pay particular attention to the differences between implementation and institutionalization. Policy which emphasizes implementation variables, while neglecting those necessary for institutionalization, compromises a programme's ability to survive in the long-term.

In order for an organization innovation to become institutionalized it must find a "home." That is, it must find some sort of organizational niche either in the implementing organization, or in another community agency (i.e., "spin-off"). For such niche to occur, there must be mutual adaptation between the organization and the innovation. Both change and adapt to accommodate each other as the innovation finds its place within the organization.

In relation to CP-HPE, Knott (1995) argued that to build sustainable projects in large-scale organizations requires changing the organization's rules, incentives, rewards, and culture. It may also require new structures and personnel. Since the CPs that Knott investigated were still receiving Foundation funding, it was too early to tell how significantly the universities had changed. Critical indicators could include: required courses in the curriculum; number of regular faculty involved in the educational programme; merit incentives for the faculty to teach in the programme or to operate practice plans in the partnership sites; changed rules for practitioners in the health centre to participate in university departments as community faculty; new hiring resources allocated to primary care community teaching areas; and, on-load teaching for community participation by regular faculty. While these changes are not meant to be exhaustive, they do represent the kinds of changes that schools will need to undertake for the institution to value the partnerships over time. Cluster evaluation data indicated that required courses and participation of faculty and students appear to be on target but less progress is evident in changing rewards and rules (Knott, 1995).

Demonstration project grants tend to emphasize the development of conceptually sound and well implemented programmes for replication elsewhere. This "multiplier effect" entails first demonstrating implementation effectiveness at the original site, and then disseminating proven programmes to other communities. One irony of this approach, is that after grant termination, programmes worthy of replication can fail to thrive at their original demonstration sites. Thus a policy weighed toward a multiplier effect can cause institutionalization to become a latent concern for the implementing organization. That is, long-term survival is less important than effective programme implementation. Focus on deep implementation with no attempt to build a political constituency for a programme could hinder further institutionalization (Goodman and Steckler, 1987-88). Accordingly, when local health

agencies accept funding for community health development programmes they need to consider the adverse impact that termination might have on communities and agencies alike. Yin (1979) asserted that programme failure is more costly after it is fully implemented since resources have been fully mobilized, career decisions have been made at the expense of other options, and community trust has been extended.

Knott (1995) maintained that building sustainable CPs involved more than implementing successful individual projects. As history has shown, these individual projects grew with artificial supports from an external funder and in difficult-to-replicate settings chosen for their favourable conditions. If CPs are to continue to expand and spread to other communities and organizations, the CPs must fit well into broader institutional, policy and market systems. Most of these system features and changes extend beyond the CPs' and Foundation's control. Yet developing strategies for accommodating and enhancing these changes raise the likelihood of sustainable CPs. In the cost containment, managed care environment of health care, the partnerships might just offer an especially attractive option for providing education to professionals in low-cost, community and team-based settings. The challenge is to convince institutional leaders, policy makers, and business of the value and benefits of this unique opportunity to change the system

Given the funding restrictions imposed on programmes, Goodman and Steckler (1987-88) suggested that the answer lies in other approaches to resource development, beyond the governmental or foundation grants typically used. Funding limitations, after all, are a commonplace in community health development efforts, and therefore need to be at the heart of community development policy and planning. A foundation for the modification of values so that programme goals and objectives are accepted and internalized by those forces which can help sustain the programme is needed. It is comprised of clusters of interlocking programme dimensions which revolve around shared ownership. The connecting fiber among its elements is the emphasis placed on identification and utilization of diverse perspectives in the diagnosing, planning, implementing, and evaluating processes. Where programme ownership is shared throughout the programme, institutionalization is more likely to occur. When networking is extensive in implementation, but when shared ownership with allied agencies and the community is low, or as a result of ideological constraints, passive instead of active support for programme institutionalization may result. Although a basic tenet of community health development is that community involvement is a necessary prerequisite for community based programme advocacy and institutionalization, and that community support for the programme's activities need be high, project ownership may not cross over from the professionals to the community or other agencies. Such a lack of

transference of ownership to the community and other social agencies may result in little grassroots support in the community to lobby for project continuance later on.

As regards sustainability, since the 1960s, foundations and government agencies have funded numerous demonstration projects in education, social welfare, economic development, health, and many other areas. The logic of demonstration projects as opposed to wholesale programmes rested on the notion of providing experimental settings and "seed funding" for innovative approaches. The goal of most demonstration projects was not only to sustain the original project but to spread these new approaches to other areas of the country. Knott (1995), however, was concerned with sustaining the Kellogg community-university partnerships once the Foundation's funding and programme support discontinues. He argued that past experiences suggested that many demonstration projects failed to continue once the sponsoring agency withdrew initial funding and other support, and proposes that building sustainable partnerships depends on much more than producing successful individual projects. The public policy, institutional, and economic systems within which the partnerships operate will determine if the CPs eventually succeed at their ultimate goal of providing more PHC professionals working together in communities.

Knott (1995), cited a study of earlier demonstration projects by Baer *et al.* (1977) and suggested that three factors hinder sustainability: artificiality, non-replicability of the demonstration site, and, co-optation.

Artificiality: referred to the fact that sponsors of demonstration projects did not want them to fail. Generous, multi-year seed funding, technical assistance as well as the sponsoring agency becoming an active and aggressive champion and advocate for the new project and as disseminator of information about the project to the newsmedia and political and business leaders, characterized the sponsor's support for the projects. While these actions helped the demonstration project to succeed, they created such an artificial set of incentives and other supports that once they were withdrawn the project could not continue on its own. This dynamic occurred in part because of performance criteria at the sponsoring agency that did not allow the project to fail, thereby, ironically, increasing the probability of failure in the post-demonstration phase.

Non-replicability: referred to the assumption that funding several demonstration projects and demonstrating their success would cause similar innovations to spread to other communities and

organization. Too frequently, this assumption proved to be unwarranted. Other communities did not necessarily possess the same resources, personalities, technology, or organizational culture conducive to the transfer of the innovation. Again, the sponsors of demonstrations often chose communities and institutions that had characteristics favourable to project success, thereby limiting the replicability of the project elsewhere.

Co-optation: where community involvement in partnership structures often did not guarantee the kind of change sought by the sponsoring agency. In some cases community representatives consisted entirely of professionals from other agencies who shared the established institutions' goals rather than the more radical community values. In other cases the established agencies held meetings at times and locations very inconvenient for community representatives. The agencies also used technical jargon and other means to prevent community representatives from having a meaningful voice. The appearance of the partnership thus replaced the reality (Knott, 1995).

Knott (1995) also reported that there are important lessons to be learnt from demonstration projects. The perspective from earlier studies limited the analysis to the project or the community level, with little attention to system or institutional influences on the success of the partnerships. In particular, the literature on demonstrations failed to incorporate three variables: institutional change, public policy, and market forces.

Institutional change: the literature on demonstration partnerships omitted any reference to institutional change. Studies often focus instead on change in the community itself and ignored the agencies who served as the original targets for innovation. Yet, without the institution adapting new standard operating procedures, incentives, and reward structures--characteristics that determine the definitions of reality and set of values for the institution--change could not last.

Market forces: demonstration projects take place within a broader set of relationships and structures. Of particular importance are the set of relationships determined by the interactions of the private market. In the longer-run, the incentives created by market interactions turned out to be much more powerful than seed funding or the reputation of the demonstration project (Knott and Wildavsky, 1980).

Public policy: government actions comprised the other system-level influence on demonstration projects. Public policy influenced the projects directly as well as shaped the relationships and structures formed by market interactions.

Knott (1995) suggested that incorporating these additional variables into the analysis produces a more holistic, system-level picture of the factors affecting sustainability of partnerships. The relationships between local institutions, the partnerships, and the community comprise one important subsystem, and the relationships between market forces and public policy comprise another important subsystem. How these two subsystems function and interact with each other forms the set of influences on the sustainability of the partnerships.

2.3.7. Empowerment

Since the late 1970s, the notion of empowerment has appeared with increasing frequency in discussions of preventive social and community intervention. While the idea of empowerment is intuitively appealing, its applicability has been limited by continuing conceptual ambiguity. For instance, Wallerstein (1992) reported that the terms "powerlessness" and "empowerment" have increasingly appeared in the public health literature during the last decade, but reported that the casual use of these terms has led to a lack of theoretical clarity and measurement problems. She maintained that that the health outcomes of powerlessness and empowerment are often unrecognized, despite the considerable research which documents the role of powerlessness in disease causation, and conversely, of empowerment in health promotion.

Although the idea is rooted in the "social action" ideology of the 1960s, and the "self-help" perspectives of the 1970s, empowerment appears with increasing frequency in discussions of strategies for prevention and community intervention. Kieffer (1984) argues that we have yet to define this term with sufficient clarity to establish its utility, and proposes a view of empowerment as a necessarily long-term process of adult learning and development. It is further described as the continuing construction of multi-dimensional participatory competence. This conception encompasses both cognitive and behavioural change.

Seeman (1959) early defined powerlessness as a subjective or perceived phenomenon: the expectancy or belief that an individual cannot determine the occurrence of outcomes. As people perceive their failure to

achieve societal promises, they become psychologically damaged and internalize their powerlessness as their own fault, rather as a response to system-wide discrimination.

Wallerstein (1992) reported that in the public health field, empowerment has traditionally been defined, by its absence, as powerlessness. She referred to Rappaport's (1987) and Zimmerman and Rappaport's (1988) definition of empowerment in its broadest sense: a multi-level construct that involves people assuming control and mastery over their lives in the context of their social and political environment.

Kieffer (1984) maintained that understanding empowerment demands that we first clarify a conception of the condition from which it evolves. He reported that in this frame, Seeman's (1959) view of powerlessness is most useful. While not seen as unilaterally imposed on the individual by his/her environment, powerlessness is viewed as an experience embedded in and reinforced by the fabric of social institutions (Stokols, 1975). However, for Freire (1970), powerlessness results from passive acceptance of oppressive culture "givens", or surrender to a "culture of silence".

Empowerment is the process by which the capacity of people is strengthened and vulnerability reduced through effective partnerships. It is an enabling process in which people, especially the labelled, working together to increase their control over events and factors which influence their well being. It cannot be done for the people, they must do it for themselves. It only happens when the process focuses not only on needs and deficiencies but also on assets, strengths, and capacities of those being empowered. Kieffer (1984) maintained that empowerment is labor intensive, as the significant transformative transition can only grow from long-term engagement. In becoming empowered, he reported, individuals are not merely acquiring new practical skills; they are reconstructing and reorienting deeply engrained personal systems of social relations. As such, it would be frivolous to pretend that there can ever be developed a "short course" in individual empowerment. It is not simply the issue of time, but more importantly the question of practice. Empowerment is not a commodity to be acquired, but a transforming process constructed through action. Individuals must learn to overcome internalized expectations of helplessness, the frustrations of inequities in tactical resources, and the endurance of political intimidation. These capacities evolve only through practice. While empowerment is, at root, an individual demand, it is nurtured by the effects of collective effort. Thus the keyword throughout is "collaboration" (Kieffer, 1984)

Rappaport's (1981) exploration of the ideology of emphasis on rights and abilities rather than deficits and needs are crucial in this direction. All partners must be committed to investing themselves and their resources in the effort and to strengthen existing capacity to cope with basic needs in order to grow and develop in all dimensions as individuals, families and communities.

People are powerless because their knowledge, skills, experiences, and opinions are ignored or by-passed as inappropriate. When inappropriate solutions and technologies are imposed on them, they may lack skills or resources to bring about expected change. Furthermore, acceptance of this sense of powerlessness is assumed to be manifest in consistent trends of declining voter participation, particularly among lower income and economically displaced population. It is also seen as evidenced in the decline of society's "mediating structures" and the pervasive "erosion of social competence". The goal of empowerment therefore is to enable communities to analyze their situation and reality and to efficiently address root causes of their situation to become less dependent on outside resources, personnel, services and regulations.

Kieffer (1984) reported that many individuals who are living in the most oppressive social and economic conditions evolve as active and effective citizen-leaders nonetheless This seeming paradox of emergence of citizen activism in the midst of more general apathy and hopelessness deviates the thinking from a focus on conditions of powerlessness to unraveling the phenomenon of emergence of formerly politically ineffectual individuals and the manner in which they reconstruct their personal and social realities to become assertive and committed grassroots activists.

2.3.8. Coalition Outcomes

Several publications emphasized the need for a coalition to accomplish 'quick wins' and short-term successes to increase motivation and pride and to enhance the credibility of the coalition (Croan and Lees, 1979; Hord 1986). Once a coalition attains a quick win, it may direct its efforts at more complex tasks (Cohen *et al.*, 1990). Short-term successes should not, however, be mistaken for ultimate solutions to chronic health problems and endemic social concerns (Sink and Stowers, 1989). The ultimate indicators of coalition effectiveness reflect a coalition's attainment of its mission, goals and objectives. For instance, in health promotion oriented coalitions directed at reducing alcohol and other drug (AOD) abuse, the ultimate indicators of effectiveness may be reduction of AOD-related arrests, admissions to emergency rooms, or absences from work or school (Wandersman and Goodman, 1991). Buterrfoss *et al.* (1993), however, are concerned by the lack of systematic study devoted to factors that influence the

attainment of such outcomes. After all, a well-formed and maintained coalition is not necessarily effective in accomplishing its mission, even if it is effective in generating programmes and activities or member satisfaction and commitment. While these activities and outcomes are important, they are insufficient measures of effective results.

Thorough evaluation is one mechanism that is frequently cited for improving outcome effectiveness (Bailey, 1986: Cohen 1989: Feighery and Rogers, 1989: Wandersman and Goodman, 1991). Programme evaluators often discuss two types of programme effects: short-term and long-term. Linney and Wandersman (1991) describe short tern effects as immediate results of a programme for the recipients of a service or activity. A short-term effect in a drug prevention programme may be the degree to which a drug information programme actually increased knowledge of drugs and the perceived risk of taking drugs. Long term effects often extend from short-term effects and may include reduction in overall drug use and a decrease in driving-under-the-influence arrests. In addition, long term effects also encompassed system changes in service delivery, system reform, cross referrals among agencies and new community linkages (Kagan, 1991). Measurement of long term effects and system change is difficult and few studies address it. If coalitions are to contribute to improved health status, then coalitions must evaluate the degree of impact that they have on improving the social and health status of the communities that they serve.

Rogers *et al.* (1993) found that staff and members had different perceptions of the role of the coalitions and that these differences could effect coalition operations and outcomes. In a somewhat similar vein, Kumpfer *et al.* (1993) find that the perceptions of members regarding the coalition's functioning and leadership characteristics were predictive of the coalition's production of a community plan of action. Gottlieb *et al.* (1993), in examining issues related to coalition implementation reported that structural and functional characteristics of the coalitions are predictive of the perceived effectiveness of the coalitions and the perceived level of activities that results.

On the one hand, Smith *et al.*, (1995) argued that more research is needed on the outcomes of cooperation and suggested that researchers expand the set of outcomes considered. Most previous research has linked cooperation to outcomes focused on performance variables and individual satisfaction variables. This focus is consistent with the conceptualization of cooperation as a dynamic process: cooperation will not continue if its benefits do not equal or exceed its costs. Thus the benefits are typically defined in terms of performance and satisfaction. However, many of the benefits of

cooperation, at least to an organization, can be defined in non-economic terms; benefits may include improved and high quality decision making, improved competitiveness, and so on. These dimensions can be seen as intervening variables that help to explain why cooperation might enhance performance and satisfaction. Nonetheless, researchers would benefit from examining a broader and more proximal set of outcome variables.

On the other hand, Knott (1995) addressed outcomes by asking questions about 'what are we trying to sustain?'. The definition of success for the CPs has important implications for whether the institution has coopted the community. Knott (1995) reported that it may be helpful to list these elements as a way of focusing on what the Foundation is trying to sustain. These elements include: the CPs' board and staff, including coordinators; the curriculum for the schools and heath centers; non-hospital instruction in community health centers; non-center experience in the community itself, including schools, nursing homes, and neighborhoods; viable community health centers where instruction can occur; team-based and community-based faculty to teach, mentor and provide experience for the students; and participating students from medicine, nursing, and allied health. Not all these elements of the community partnerships may be sustained e.g. only students from one of the health professions are participating or out-of-hospital instruction without team-based instruction nor non-centre experiences.

III . Chapter Three

Design & Methods

In accomplishing the first objective of the study in understanding how coalitions operate and identifying the factors which contribute to coalition competency, chapter one has provided the general background of the PHC movement and the need to redirect HPE to be more community responsive, highlighting the strategy of community partnerships. Chapter two moved on to an in-depth review and analysis of the intricacies and details of the partnership/ coalition concept. Chapter three describes the methods employed in this research. It is comprised of two subsections. First, the study setting: a broad overview of South Africa's heath indices and health policy concerns, which then narrows down to a review of the main focus of the study - the cluster of five SA CPs-HPE sponsored by the philanthropic organisation, the W.K. Kellogg Foundation. Second, is the section on the study design: the rationale for the use of mixed-methods in this cluster evaluation, the underpinning theoretical and conceptual framework/s, methodological issues pertaining to details of the quantitative and qualitative research instruments that were employed in the survey and the interviews, as well as the strategy for the analyses of both types of data.

3.1. Study Setting & Partnership Activities [Map - Annex (1)]

3.1.1. Overview of the Study Setting: South Africa

Political history, socio-economic and basic health indices, and health policy concerns

Apartheid has systematically underdeveloped and deprived people and left inequities. Apartheid made SA unique, where racial discrimination was legalised and executed to perfection. The health system has been fragmented for ideological reasons, with hierarchical fragmentation between national, provincial and local authorities. Until recently, there were 14 departments of health and four provincial administrations planning and executing independently (National Progressive Primary Health Care Network, circa 1994). Centrally there were four departments of health, one for each racial group, later combined reducing the total to eleven (National Progressive Primary Health Care Network, undated, circa 1993). As Kale (1995) described it: "the artificial paradox of the best of First World medicine and the worst of the Third World medicine within a few miles of each other resulted in extreme inequity in the health profile of the country". After the 1994 democratic elections, one unified department of health servicing the whole nation was formed.

In the history of struggle, Zabala (1992) suggested three 'epochs': African self-help era from 1960s to 1970s, with micro-enterprise initiatives; self-reliance/ community development through the 1970s, using

local resources for upliftment; and community participation in the 80s, characterised by politicisation and growth of organisations.

The prevailing socio-economic and political conditions gave rise to a range of institutions. Towards the end of the 1960s, the Black Consciousness Movement and black self-reliance occurred and after initial economic growth (Callinicos, 1993), by 1973 the apartheid economy was failing out. The 1970s threw up prototypes of labour, community and development organisations. In the 1980s resistance against state governance, assisted by international media exposure support, resulted in politicisation of organisations with state resistance everywhere in the society (Wolfe, 1992). With Mandela's release and the African National Congress's (ANC) unban in 1990, came a movement away from resistance to development. Major reorientation was thus required as negotiations about political and developmental priorities started (Narosoo, 1993).

Due to past oppression, people and community were frequently organised through party machineries against the state. Now they are expected to join forces and participate with the state, an unfamiliar situation needing time, effort and trust. Past oppression is sometimes seen as an obstacle; people are sceptical and doubtful of new projects. They have been used and do not know about outcomes. Some have used this to achieve financial gain and never put the money back in the community. Now they are being asked to participate–this requires time and energy.

South Africa is an upper middle-income economy. A population estimate of South Africa (SA) is 39 millions, 60% urban and 39 % under 15 years of age (The World Bank, 1993). Average annual growth is 2.2 %. About 300 000 illegal "back street" abortions are estimated each year (National Progressive Primary Health Care Network, circa 1993), 12 % of babies are low birth weight and infant and perinatal mortality rates are 54 and 23.3 per 1000 live births (The World Bank, 1993). Roughly 40 % of births are properly supervised, around 65 % of under-two's fully immunised (National Progressive Primary Health Care Network, circa 1993). About 16 % of newborns are low birth weight and malnutrition is common, present in 30 % of children (Department of Health, 1995a;1995b;1996). Three quarters of the population is black, three quarters of whom live in rural areas. Basic health indices compare poorly with other upper middle-income countries.

Constituting half the population, women's poor status is reflected in educational discrimination, violence, and exclusion from decision making (The ANC Health Department, with the support and technical

assistance of WHO and UNICEF, 1994) . Maternal mortality rate varied from 8 to 58 per 100 000 live births (Department of National Health and Population Development, 1992), estimates suspected to be lower than true rates. Half the total population were living below the poverty line in 1991 (Patel, 1993), and male-controlled decision making has ignored the circumstances and problems of women in a male dominated society (National Progressive Primary Health Care Network, circa 1993).

South Africa spends around 6.4 % of its Gross Domestic Product on health, comparing favourably with WHO's 5% target. However, real public sector expenditure on about 80% of population is 3.2% (National Progressive Primary Health Care Network, circa 1993). Financial allocative skew resulted from the provinces having higher per capita expenditure than the Homelands, and tertiary care more than primary (The ANC Health Department, with the support and technical assistance of WHO and UNICEF, 1994).

Kale (1995) reported that the general mood of the people of SA was a complex mixture of disbelief in the realisation of a dream, hope for a utopian future, and fear that the prevailing peace was a passing phase in their long history of violence and repression. Health policy was developed by the ANC and the Medical Association of South Africa even before the 1994 elections. Everyone had a vision. All the main players were speaking the same sort of language about a comprehensive health service not based on race.

The major challenge for a current "Government of National Unity" will be to redress the gross inequities in the current health system. It will need to investigate possible ways of resolving the maldistribution of resources between the public and private sectors, to reduce geographical and "racial" disparities in health service provision, and to address the financial barriers to obtaining health care for lower income groups. Alternative sources of financing are currently being investigated. These included excise duties on tobacco and alcohol products, increased user-fees at public sector hospitals for patients with medical insurance cover, and a possible implementation of a National Health Insurance system. There are unlikely to be any easy or short-term solutions to the many problems confronting the South African health system. However, if the political will to achieve a just and equitable health system is sustained, significant gains can be made during this transitional period. Another line of thought that is also being debated was the role of traditional healers and traditional medicine.

The established domination of the medical profession by white males is changing. The number of non-white students admitted to medical colleges has increased in the last few years (Kale, 1995). However the distribution of doctors is skewed in favour of urban areas and particular provinces. The distribution of

SA's large body of trained nurses, competent pharmacists and other health professionals is also skewed. By First world standards, SA needs more doctors. But it needs them in the right places: mostly in rural SA or black townships. It is feared that better salaries and working conditions in SA might cause a threat to the health of other already impoverished neighbouring African countries due to migration of doctors. Incentives for attracting doctors to rural areas are being studied, and concern for increasing numbers of general practitioners willing to serve in underserved areas is being aired. Downsizing of academic and tertiary care services, together with an academic system that would function differently are seen as possibilities.

Kale (1995) reported that plans for the future include medical schools setting up "bridging courses" to upgrade the entry qualifications of otherwise talented black students from poor schools. This is expected to correct the skewed racial distribution of doctors. This however must be viewed in the light that academic institutions are already facing cuts in their budgets as funds are required for primary health care, which has been grossly neglected so far.

3.1.2. <u>The WKK Foundation and South African CPs-HPE</u>

3.1.2.1. <u>The WKKF Initiative: developments, criteria, selection and challenges</u>

The WKKF started programming in Africa since 1986. In a matter of 5 years the Foundation was to support the development of a major initiative - the Community Partnerships in Health Personnel Education. This initiative was patterned after similar efforts begun in the USA in 1990, and Latin America in 1992. The main purpose of this initiative was to improve health care for communities by re-orienting the education of HP, through a CP between health professionals and communities in order to reach a broad understanding of health issues within a specific social context.

The CPs-HPE came to SA at a critical time in her political history. As the pillars of apartheid crumbled and as the membership of the African National Congress (ANC) and other political parties became legal with the historic release of Mandela and others from years of imprisonment, the WKKF was concluding discussions with community members (recommended by progressive health groups) and representatives from the major health science teaching centres. At this stage it was evident that in order to address the health needs of the majority of people in a future post-apartheid SA, it was imperative that the training of HP be re- structured. The CPs-HPE were thus very important and appropriate for the health development in SA.

A ten member group of community representatives and health professionals, which came to be known as the SA Advisory Group (SAAG), helped formulate the SA CPs-HPE following an orientation visit to the USA programmes. The SAAG developed and circulated informational materials throughout the country. They held meetings and provided further information. Out of this process 65 proposals were submitted by organisations in the country that were interested in redirecting their HPE through the CPs initiative. Thirteen of these were selected to participate in an 18 month development process. At the end of the 18 months, all 13 had developed proposals and subsequently site visits were made by staff from the WKKF, SA consultants to the WKKF, and the SAAG members.

The criteria of the SA CPs-HPE were as follows:

(1) CPs: Demonstrated through joint participation of communities and health professionals in determining priority health issues, planning educational bases, and in student selection.

(2) Community based programmes: Establishment of educational bases in communities were envisaged not only to ensure the recognition of PHC practitioners, but also to ensure their adequate socialisation within communities. It also called for sensitivity to the prevailing dynamics, strengths and weaknesses within a given community and an awareness among the people of available resources and shortcomings.

(3) A Comprehensive PHC emphasis with attention to the needs of the underserved: The main focus here was on basic causes of ill health which health professionals need to learn to address. These were recognised as the underlying socio-economic determinants of health.

(4) Academic rigour in HPE: The challenge here was to ensure that the education of health personnel within community bases can surpass that conducted within the confines of conventional teaching hospitals.

(5) Skills development: The focus here was on developing an increased understanding of group dynamics, community decision making process, and leadership.

(6) Inter - disciplinary learning: Here the emphasis was on teams learning together in order to function efficiently.

(7) Student selection: This was to be based on potential rather than achievement and the selection was to be from within the community to be served by CPs-HPE initiative.

The process of selection into the CPs-HPE initiative passed through the several phases: following the first round of site visits, in September 1992, three sites were selected into the CPs-HPE. These three CPs were all included in this study. Four other CPs were encouraged to further develop their plans over the following year. Two projects from this group were also included in the study. In January/February 1994, a second round of reviews was undertaken, and all the seven projects were henceforth included in the partnership.

Within slightly more than a year later, the South African Network of CPs in HPE was formed by representatives from the seven CPs, with the duty of networking between the seven sister CPs to inform and facilitate their development. The aim of the network was to share lessons and successes, to avoid pitfalls and to identify innovative ways of monitoring and evaluation of the various facets of the partnerships. Critical sphere of investigation by the network were the areas of educational and service transformation, community-based academic/service primary health care sites, community empowerment, and policy changes. Towards the end of 1995, a joint monitoring and evaluation task force had been set up and had conducted a survey of the various evaluation activities within the seven projects (South African Network of Community Partnerships in Health Personnel Education, 1995). The vision was that this task force would generate information which could inform and impact upon national, regional and local health policy and planning initiatives, as well as information which could assist in the process of negotiating the further sustainability of these South African CPs. At the time of the study (between 1995 - 1996), most of CPs were all moving from initiation to implementation, had all developed strategic plans albeit to various extents and had a variety of programmes running.

This study examines five out of the seven projects. The sixth project did not respond to the invitations to participate in the study for reasons unknown to the researcher, although at a later unplanned meeting between the project's coordinator and the researcher at an international conference, it was expressed that this could have been due to a communication breakdown between the project and the researcher in the preparatory stage of the study. The seventh project was examined in an earlier study by the researcher while undertaking a health policy report for the degree of Masters in Public Health Medicine (El Ansari, 1994).

A list of challenges confronted the SA CPs-HPE:

(1) Due to the legacy of apartheid, there were inherent inequalities in this initiative, where the communities were greatly disadvantaged.

(2) In most of the institutions the students undergoing training were not from the communities that were partners in the initiative, nor did they come from the same cultural backgrounds.

(3) The leadership in some of the projects was made up of people from a different cultural background to that of the community/ies involved in the CP.

(4) Some institution leaders were convinced that the community based focus would lead to "lowering of standards".

(5) There were no similar CP models in Africa to learn from. For models people had to look to the West.

(6) During the recent months prior to the study, the projects had lost many of their leaders to jobs in government institutions and the NGO sector.

3.1.2.2. Executive summaries of the participating SA CPs-HPE

South Africa required a broad range of health personnel to address the overwhelming needs of the majority of people. This was clearly demonstrated by the differing emphasis in programme activities of each CP. A brief executive summary of the SA CP-HPE participating in this study is given below (Househam, 1993, Lazarus *et al.,* 1998). Annexes (1-4) show the geographical localities of the CPs, the stakeholders involved in each, as well as the programmes and major activities of the CPs-HPE under study.

North Eastern Transvaal Health Workers & Community Education Project (NETHWORC)

(Partnership No. 1 in the study, linked to the University of the Witwatersrand, Johannesburg).

A consortium of the Witwatersrand University and its projects in the area viz. the Health Services Development Unit (HSDU) and the Wits Rural Facility, the Bushbuckridge community in the

Mpumalanga (former Eastern Transvaal) region, and the local health services both at Mapulaneng and at Tintswalo hospitals. As such, the NETHWORC project had a solid foundation in the community and in the institutions in the area.

The focus in this project was on the development of a Community College. It was envisaged that the Community College will serve to bridge the gap between secondary and tertiary education including adult literacy training, and programmes for health workers. Project activities included bridging programmes, vocational training, and health worker programmes.

The community seemed the strongest partner in this project. Through local civic and traditional systems the CP has been able to set up successful management systems that link the community with the health services. Stronger links with the university were yet to be established.

University of Transkei Community Partnership Project (UNITRA-CPP)

(Partnership No. 2 in the study, linked to the University of the Transkei, Umtata, Eastern Cape province, formerly the Transkei)

Transkei has a population of circa four million. It is 95 % rural with lack of infrastructure including water, sanitation, roads and health facilities due to the apartheid regime. The university was inaugurated in 1985 and in the inaugural address, the Founding Dean announced that unlike the traditional medical schools in SA, the UNITRA Medical School would be community-based. From its inception it has been mandated to implement a community based curriculum for medical training.

The partnership was between UNITRA as the AI partner, the Dept. of Health and the Municipality as service providers and four local communities. The plan of action included the establishment of academic community-based PHC centres where medical, nursing and health education students would be taught and CHWs would be trained. It also included the establishment of the Dept. of HPE at UNITRA whose role included the whole medical school programme in addition to the activities of the CP as these were inseparable. Further activities included community development activities.

The CP initiative enabled the university to expand its vision to include a cross section of health professionals, thus in addition to medical students being trained, nursing and health education students were also trained. The main focus of the CP was improving the health status and the quality of life of the

under-served communities in the Transkei through appropriate training of HP and community health development, through initiating water and sanitation projects.

The CP activities included the development of academic community-based centres. Through the initiative there was a move towards developing comprehensive health services, which were not previously available in the Transkei. The health service component is stronger in this project than in any other partnership projects. The greatest need of the university was the strengthening of professional teaching staff.

Border Institute of Primary Health (BIPH)

(Partnership No. 3 in the study, linked to the Frere Nursing College, the Ciskei Nursing College and the Fort Hare University- Nursing Science Dept)

The Border Institute of Primary Health brings together three partners, namely: the community, health services and training institutions. The beneficiary community in the Newlands locality were approached through the Newlands Resident's Association. The HS providers, who were individually approached, consisted of the Cape Provincial Administration Health Services which ran the heath care center in Newlands, the Ciskei Dept. of Health and the Dept. of National Health.

The objectives were to prepare the partners for participation and, through developmental workshops, to strengthen the CP management by having 50 % of the members from the community partner. In parallel, other goals were to choose one community for the development of a PHC Teaching and Research Center, and to become involved in the training of community-based health workers.

The partners were approached by the CP. The development of the PHC Training Centre was accepted by the community and a steering committee was formed. The health service partners in the area were individually approached for their involvement. They responded by appointing representatives to serve on the steering committee. Two of the training institutions in the area send their students for community-based experiences at the beneficiary community where the health centre was started. Lecturers from these institutions were on the management committee of the BIPH.

Mangaung- University of the Orange Free State Community Partnership Project: (MUCPP) (Partnership No. 4 in the study, linked to the University of the Orange Free State)

Bloemfontein Mangaung is a city with an estimated population of 300,000 people. The "black" population living in Mangaung (the township) had significantly lower living standards than their "white" counterparts in Bloemfontein. Standards of health and health care in the "black" community similarly were less acceptable.

Formerly a "whites only" university, in this CP the university had made the commitment to initiate affirmative action in student selection and in increasing admission of these students, as well as a bridging programme and developing support systems for disadvantaged students at the university. A further priority was the development of relevant training for CHWs, and to promote more effective community-oriented training for the HP.

Existing inequalities between the "black" and the "white" communities, as exemplified by the severe lack of infrastructure, needed to be rectified. As a result, a multi-purpose center which was underway and was going to be strategically placed in the Mangaung community. This was going to provide a PHC service component, a PHC training component, and would have a PHC development unit for income generating activities, as well as serving as a community resource center. The CP aimed, by a process of consultation and networking with the existing HS that were currently provided by the municipality of Bloemfontein, to improve the primary level health services of the people of Mangaung. The CP aimed further to increase the awareness of health and in particular PHC in the community.

The local HS (the Provincial Administration of the OFS) had pledged several million Rands towards the development of a part of the community center. There was wide community support for the construction of the proposed center and it was decided to approach governmental and non-governmental sources for funding of this component of the partnership. It was felt both, that this was beyond the resources of the local government, and that at that time, the CP wished to maintain a measure of independence from existing government structures.

In view of the disadvantaged nature of the community, it was not possible to engage the community in a project that addresses only PHC. The community perceived their urgent needs to be wider and of a higher priority than health care. It was envisaged that the community health center would serve as a focus for

the community to move to deal with these priorities themselves. Outside the field of health care, the university was a valuable source of expertise. Activities at the center would facilitate the transfer of skills to the community.

In this CP, all three partners were fully committed to the initiative, and were highly respectful of each other. Since the initiative was started there has been an increase in the number of "black" students admitted into this once - "whites only", Afrikaans University. Students now have a choice of receiving instruction in either English or Afrikaans; first language Afrikaans faculty members are taking English courses, and there were a number of "blacks" on the university faculty.

Western Cape Community Partnership Project (WCCPP)

(Partnership No. 5 in the study, linked to the University of the Western Cape and the Peninsula Technikon).

The CP here had, as its mission statement, the promotion of improved health care and health status of their disadvantaged communities through developing a model of HPE which is community-based. This was to be achieved through a partnership between the communities, the AI and the HS.

There were three communities participating in the CP. These communities were the most disadvantaged communities in the area. They were isolated, lacked infrastructure, were underdeveloped and had high levels of poverty and unemployment. The AI partner consisted of a wide array of training institutions: the health sector at the University of the Western Cape which encompassed community health sciences, nursing, social work, psychology, physiotherapy, occupational therapy, child guidance, dietetics, human ecology, student counseling, dentistry. Another participating educational institution was the Peninsula Technikon with its Dept. of Public Health, Dept. of Paramedical Services and Dept. of Dental Services. The HS partner consisted of the Regional Services Council and the Cape Provincial Administration.

The CP recognized and accepted that different models of CBE would be developed at different sites and identified appropriate entry points into their target communities e.g. the Mfuleni Community Health Center as an entry point into the Mfuleni Community. The next step was a process of engaging the structures in the community sites with the goal of community-based interdisciplinary learning. Several academic Depts. were already active in the area and it was envisaged that the local Community Health Center could be transformed into an Academic PHC Center.

The HS providers at all levels had been very supportive of the CP. Front line workers had been actively involved in management of the CP, training/supervision of students in the field, research (planning and implementation of community surveys) and teaching at the university.

3.2. The Quantitative/Qualitative Design

Rationale

> "*Analysis (chemical): the decomposition of compound substances by chemical processes into their constituent elements, or into simpler compounds, in order to identify the substances present (qualitative analysis) and to estimate their quantities by weight or volume (quantitative analysis)*" (Dictionary of the history of science, Macmillan, 1981).
>
> ...[let] *"a hundred flowers bloom and a hundred schools of thought contend...."* (Mao, 1967:302).
>
> *"When qualitative methods are clearly established in our research repertoire, the advance of medical knowledge will be greatly accelerated"* (Holman, 1993).

The research design incorporates some of the most important methodological decisions that a researcher makes in conducting a research study (Polit and Hungler, 1995). There are a number of essential steps when planning research (Kirk-Smith, 1996), the first of which is to decide on the method to be used to collect the data and answer the research questions. When considering research design, the main aim need be to select the instruments which will provide reliable answers to the research question. It need also minimize bias that could distort the study findings (Polit and Hungler, 1995). The quantitative approach is deductive and collects hard data by means of structured questionnaires. On the other hand the qualitative research approach is inductive, because it gathers all available information in order to look for a pattern or theory which fits. Selection of data collection methods is also influenced by constraints in resources and time (Pearson, 1995). What emerges from the literature is that a multi-method research approach is more capable of disclosing the diverse dimensions of CPs. Data generated by the qualitative methods will supplement and complement the understandings revealed by the quantitative methods and will also act as a fertile source of hypotheses for future inquiries of both types.

As Strong (1992) advised, the current range of qualitative methods is wide. This includes: unstructured interviews with individuals (to avoid the group effects on what people say); audio recording to examine the minutiae, and participant observation, where the researcher lives among those he or she is studying, taking part in exactly the same daily routines, seeking to capture the mundane reality of the distinct little worlds in which we live via systematic participation and notation rather than through what (selectively)

gets recalled or written. In the qualitative mode of this study, the researcher sets out to employ various qualitative data gathering techniques: interviews, participant observation and scrutiny of documents and reports.

Strong (1992) reported that qualitative methods exist in all sciences, but in the natural sciences they have long since been out-stripped by quantitative methods. For the social sciences, the stumbling block has proved to be the sheer complexity of human behaviour; a complexity due to our unique possession of language. Trostle (1986) for example, highlighted the close relationship between anthropology (which tended to emphasize qualitative methods) and epidemiology (which tended to emphasize quantitative methods) that existed from 1840 to 1870 (cited in Yach, 1992). Kroeger (1983) also commented that many of the problems of studies in developing countries are exacerbated by the speed, cost and budgets demanded by rapid methods. "Communicative field research (as a qualitative, descriptive and analytic tool) and quantitative interview studies should be used together since they complement each other". He adds that in reality this is often ignored.

Strong (1992) reported that measuring is sometimes a task of quite extraordinary difficulty. It can certainly be done on some occasions, and needs to be done wherever it can. But measurement alone cannot provide adequate answers to many of the central questions posed. For example, if one wanted to know the complex things that staff and community members think when given a chance to speak at length rather than answering pre-digested questions, and if one wanted to know what these informant groups do as opposed to what they say, then one would need qualitative as well as quantitative methods. Given the much greater complexity of social as compared with chemical forms, qualitative analysis plays a correspondingly large part in the social sciences (Strong, 1992).

Similarly, Black (1994) reported that health services research was dominated by quantitative methods: research tended to be considered real and serious only when it used these approaches. He contended that we clearly needed and could benefit enormously from the quantification of many aspects of the physical, social, and psychological worlds. Indeed, it is the undeniable importance of quantitative inquiry that makes the need for improvements in its conduct so crucial. These could be achieved in three ways. Firstly, by the development of more sophisticated statistical methods for handling quantitative data. Secondly, by using quantitative methods in combination with qualitative methods. And thirdly, by acknowledging that some situations are inevitably beyond the scope of quantitative methods but could be investigated more appropriately by qualitative ones.

Likewise, Patton (1980) noted that evaluation research was dominated by the largely unquestioned natural science paradigm with its quantitative emphasis, taken to be the epitome of "good" science. The hypothetico-deductive, natural science paradigm aims at prediction of social phenomena; the holistic-inductive, anthropological paradigm aims at understanding of social phenomena. He argued that the label "research" has come to mean the equivalent of employing the "scientific method," of working within the dominant natural science paradigm and advocated for a new paradigm– "a paradigm of choices" –which recognises that different methods are appropriate for different situations". Patton (1980) supported the use of multiple methods, both quantitative and qualitative, wherever possible.

In a similar vein, Yach (1992) argued that one of the reasons for the split between qualitative and quantitative methods related to the continued dominance of the medical profession in many aspects of public health. This has tended to mean that the disciplines given priority within medical schools e.g. clinical epidemiology, which tend to almost emphasise quantitative methods were favoured. Again, this study, although designed by a researcher belonging to the medical profession, purposively and productively counters such observations.

The debate within the evaluation arena has shifted to questions about the complementarity of the alternative methods of investigation and the degree of cross-perspective integration possible (Greene and McClintock, 1985). This shift signaled a greater acceptance of the naturalistic perspective–or at least of qualitative methods–within the evaluation community. The consensus about the neutrality of methods (Bednarz, 1983; Patton, 1980; Reichardt and Cook, 1979), along with the widespread acceptance of qualitative methods, has afforded the vastly increased repertoire of methodological tools and has renewed the interest in the time-honoured methodological strategy of triangulation (Denzin, 1978; Jick, 1983; Webb *et al.,* 1966 and 1980).

Since qualitative research values subjectivity, emphasises the meaningfulness of findings achieved by reducing the distance between investigator and subject and by eliminating artificial lines between subjective and objective reality, Sandelowski (1986) called that there was a special need for qualitative researchers from developing countries to conduct their own research. Similarly, Yach (1992) reported the importance of cultural competence, defined as the ability of a researcher to immediately understand and have rapport with the local population or community under investigation. Such competence would usually be derived from living with and among that community or having spent a considerable amount of time understanding the underlying cultural dynamics. To the first point raised by Sandelowski (1986) and

as spin off to this study, the researcher trained several local community individuals in qualitative research in each of the CPs-HPE participating in the study. To the second point raised by Yach (1992) the researcher was actually residing, working, and physically living with the community under investigation in each of the CPs-HPE for a period between 2 to 4 months. Furthermore, the researcher had conducted previous research in the same setting (SA) during the elections in 1994 (El Ansari, 1994), a point increasing his awareness of and offering insight into the various environmental and political contexts of the study setting.

In the study setting of the post-apartheid new SA where the notion of CPs between the universities, health service providers and the communities they serve was a relatively new concept to all partners, qualitative data generated by interviews, participant observation and scrutiny of the CPs' published reports and documents was used to put practices into their historical and socio-cultural contexts and to help identify explanatory variables.

3.3. Quantitative methods

3.3.1. Theoretical and Conceptual framework/s

Following Bednarz's (1983) suggestions, this study was informed by multiple conceptual frameworks (Rogers *et al.*, 1993; Gottlieb *et al.*, 1993) and theories. Many of the guidelines informing this study were also based upon assumptions derived from the extant literature on community health promotion coalitions (Brown, 1984; Roberts-DeGennaro 1986a and b; Lindsay and Edwards, 1988; Feighery and Rogers, 1990). Two related conceptual models were merged and collectively employed:

Annex (5) shows the first conceptual model used to develop the survey instrument and guide analysis of part of the quantitative data. This model, based on an earlier study in the context of tobacco control coalitions (Rogers *et al.*, 1993), was developed through a review of the literature, especially the work of Wandersman (1984), Prestby and Wandersman (1985), Goodman and Steckler (1989a, 1989b), Prestby *et al.*, (1990) and Florin *et al.*, (1992). It utilised several assumptions regarding characteristics and participant perceptions. This study was informed by these assumptions. It is assumed, for example, that:

(a) that coalitions/ CPs would serve as effective vehicles for broad-based community participation, especially by members of culturally diverse, undeserved or high risk populations;

(b) that high levels of coalition participation would lead to more effective control interventions designed, implemented, and widely disseminated in and accepted by the community;

(c) that certain structural characteristics, such as development of mission, by-laws, and clearly defined member roles and responsibilities, must be present in these coalitions in order for them to function effectively; and

(d) that attention to operational parameters (e.g. leadership and management skills, communication, decision making processes) were central to coalition viability.

Thus, these guidelines addressed issues of membership, resources and support, organisational structure, function, and roles. Several annual reports from the SA CPs-HPE regarding their aims, objectives, functions, processes and structure were also reviewed, and it seemed reasonable to believe that these assumptions as well as the conceptual framework were appropriate to this study. The model suggested that certain members, staff and organisational variables are predictive of participant satisfaction with the coalition and their sense of outcome efficacy, and the degree of member organisation commitment to the coalition effort. Thus this study represents the results of a cross sectional look at the perceived internal, organisational features of several SA CPs-HPE.

Annex (6) shows the second conceptual model used to develop the survey instrument and guide analysis of part of the quantitative data. This framework was based on a study by Gottlieb *et al.* (1993) in their survey of fifty state and local coalitions in the USA. The model addressed the four types of barriers that must be addressed by every coalition: barriers of organisation, of attitude, of vision and of ignorance (Hagebak, 1982; Allensworth and Patton, 1990):

(a) barriers of organisation: included those imposed by agency structures and systems, existing reporting systems, limited funding, time constraint, and personal turnover

(b) barriers of attitude: included political considerations, turf guarding, personality conflicts and negative past experiences

(c) barriers of vision: history and tradition, agency priorities, absence of clear directives and inadequate models

(d) barriers of ignorance: lack of awareness of problems, potential solutions and the benefits of interagency collaboration

The explanatory variables address the structure and functioning of the coalitions. The relationship between these selected structure and process variables and the intermediary measures of coalition accomplishment and impact would indicate what factors were associated with the success of coalitions.

3.3.2. The quantitative tool: The Questionnaire

The study tool was a self-administered questionnaire compiled by the amalgamation of two surveys constructed, developed, validated and used by Rogers *et al.* (1993) in their survey of tobacco control coalitions in California, USA and by Gottlieb *et al.* (1993) in their survey of fifty state and local coalitions also in the USA. Several items were adapted from Prestby *et al.* (1990), and from the Minnesota Department of Health (1990). Some sections were adapted from questionnaires used by the donor body (WKKF, 1994) for evaluation of the CP-HPE in the USA (Michigan State University, Survey Research Division of the Institute for Public Policy and Social Research, 1994; made available through Harris D, pers communication). Several sets of items were slightly modified to fit the aims and objectives of the SA CPs-HPE under study.

To the best of the researcher's knowledge the original questionnaires had not been used or tested in developing countries settings before (Gottlieb, pers communication, 1994). This represented a challenge to the researcher in the administration of the questionnaires, their simplification and the question of if the questionnaire needed to be translated. After several inquiries by the researcher and assurance from the SA CPs-HPE that most of the CM can speak and comprehend English, it was decided that the questionnaire need not be translated into the local language. However, given the lay community involvement in such CPs, critical revision of several items of the questionnaire was undertaken to keep its language as simple and as comprehensible as possible to the layman participant, without effecting its content. This was done together with the inputs of the coordinator of one of the CPs-HPE under investigation (Nicola, pers communication, 1994). Three independent reviewers with expertise in CPs read and commented on the questionnaire, where it was collectively agreed that the items were clear and that most the domains and elements of CPs fostering and maintenance were well represented, suggesting content validity of the final draft (Gulick and Escobar-

Florez, 1995). The identical version of this simplified questionnaire with the exact wording was administered to all respondents from the various stakeholder groups.

3.3.2.1. The long version of the questionnaire

Appendix (1) shows the long version of the questionnaire.

The variables under study were (arranged in the order of the questionnaire):

Structural features

Staff respondents were asked factual information about the CPs, such as the number and frequency of meetings, committee structure, number of coalition members, and staffing issues.

Management capabilities

The extent to which staff managed the CPs in ways that led to smooth efficient operations rated by members on 22 seven-point items (e.g. 'Routine matters are handled quickly;' 'Everyone participates in discussions, not just a few'). Items were adapted from Minnesota Department of Health (1990) and were rated on a 1-7 scale from 'Strongly Disagree' to 'Strongly Agree'.

Formalised rules and procedures

(Formality of Partnership Structure)

Nine items rated on a 1 = 'Yes', 2 = 'No' and 3 = 'Don't Know' scale about the operational systems of the CPs (e.g. 'Does your Partnership have a written mission statement?' and 'Does your Partnership have written by laws/ operating principles?'). Eight items were adapted from Rogers *et al.*, (1993); two items were adapted from Gottlieb *et al.*, (1993).

Operational Understanding

Knowledge about CPs mission, structure and operations answered through five yes/no items (e.g. 'Do you know how members are appointed?' and 'How committees and task forces are formed?').

Experience

The number of months worked in this or other similar CPs in the past.

Involvement

Respondents were asked in a yes/no format about seven activities they could have engaged in over the last 12 months, such as recruiting new members to the coalition and serving as an officer or chairperson. They also reported on their degree of involvement in their CPs and approximately how many hours per month they had spent over the last 12 months in coalition activities, such as regular meetings and CPs co-sponsored activities. Respondents also reported on their the authority to make decisions on behalf of the organization they represented at CPs meetings. Some items were adapted from Prestby *et al.* (1990).

Community representation

Two items. The first item measured the degree to which respondents believed that the CPs were representative of the people in their community, rated as 1 = 'Not at all representative' to 7 = 'Very representative'. The second item inquired about the various groups which the respondents perceived to be not well represented on the Partnership and that needed greater representation.

Staff-community member communication

The quality of communication between the CPs professional staff and community members and among community members themselves rated on five, seven-point semantic differential scales (i.e. good-poor; frequent-infrequent; good at giving information-bad at giving information; comfortable-uncomfortable; and effective-ineffective).

Community member-member communication

The quality of communication between Partnership community members themselves rated on five, seven-point semantic differential scales.

Contributions

Respondents rated four items on a seven-point scales about the extent to which they and their organisations made various contributions to the Partnership (e.g. 'Time of yourself and of others'; and, 'Facilitate access to special populations').

Benefits of participation

Each set of respondents also rated on a seven-point scale 11 items relating to the benefits of participation in the Partnership (e.g. 'Getting to know other agencies and their staff' and 'Building my own skills in partnership work'). 'Benefits' items were rated on a 1-7 scale from 'Not at All' to 'Quite a Lot'.

Costs of participation

Respondents rated 5 items about the costs (difficulties) associated with their participation in the CPs (e.g. 'Time spent on the CPs keeps me from doing my work' and 'Being involved is a problem'. 'Costs' items were rated from a 1 = 'Strongly Disagree' to 7 = 'Strongly Agree'. Some items were adapted from Prestby *et al.*, (1990).

Role Clarity

Four items related to the type of role (i.e. no role, advice only, develop, recommend or approve) that the respondents had in the CPs in setting the budget, designing programme goals and objectives, selecting local contractors and developing the CPs' comprehensive plans.

Satisfaction with the Partnership

Community members and professional staff rated on a 1 = 'Strongly Disagree' and 7 = 'Strongly Agree' scale their agreement with five items regarding satisfaction with the internal operations and perceived accomplishments of the CPs (e.g. 'I am satisfied with how the Partnership operates'; 'The work accomplished by the Partnership has met my expectations'; and, 'I am satisfied with what is accomplished by the Partnership').

Ownership

Degree of agreement with four items regarding feelings of ownership in the CPs (e.g. 'I feel a sense of pride in what the Partnership accomplishes' and 'I feel I have a voice'), with 1 = 'Strongly Disagree' and 7 = 'Strongly Agree'.

Member organisation commitment

Respondents rated four items addressing the extent to which the organisation they represented had endorsed or adopted the mission of the CPs, carried out activities in the name of the CPs, and publicly agreed on CPs activities; items were rated from 1 = 'Not at all' to 7 = 'Very much' (e.g. 'To what extent has your organisation agreed on or adopted the mission and goals of the Partnership'; and, 'To what extent does your organization participate in Partnership sponsored activities?').

Leadership skills

Eleven items (adapted from Prestby *et al.*, 1990) asked in a yes/no format about a number of incentive management skills that the leadership of the Partnership employs (e.g. 'Makes me feel welcome at meetings'; 'Gives praise/ recognition at meetings').

Communication mechanisms

Eight yes/no items on methods of communication used in the CPs(e.g. 'Regularly published newsletters')

Expertise

The abilities of the professional staff and the abilities of the community members were rated separately on 11 seven-point items (e.g. 'Implement educational activities', 'Community organising' and 'Reaching target populations'), with 1 = 'Low Ability' and 7 = 'High Ability'.

Resource allocation satisfaction

Single item indicating the degree of satisfaction respondents had with the allocation and use of CPs funds in the community or local jurisdiction, with 1 = 'Not at all satisfied' and 7 = 'Very satisfied'.

Participation benefits to difficulties ratio

In addition, all respondent classes indicated on a five-point scale whether they thought were more benefits or difficulties associated with their participation on the CPs, with 1 = 'Many more difficulties than benefits' and 5 = 'Many more benefits than difficulties'.

Partnership Activities

(A section on advocacy activities was dropped after piloting, only educational activities are included)

Perceived activity relating to policy/advocacy (2 items) and educational work (2 items) by the CPs; Community members and staff responded to this four items rating the perceptions about policy/advocacy and educational activities by the CPs. The first item of both sets ('How much has your Partnership engaged in policy/advocacy work (educational activities?') was rated on a 1-7 scale from 'Not At All' to 'A great deal'. The second and third items ('To what extent were the partners involved and effective in their work?') was rated from 1 = 'Not At All' to 7 = 'Very much'. A fourth item asked about the contributions that the respondent made to the CPs educational activities. These items were adapted from Rogers *et al.*, (1993).

Interaction

Respondents rated seven items indicating the degree of interactions, conflict resolution, differences and control among the partners on seven point scales with 1 = 'Strongly Disagree' and 7 = 'Strongly Agree' (e.g. 'There are established ways to settle most differences that arise in the Partnership'; 'Conflict is handled effectively in the Partnership'; and 'The Partnership team is tolerant of differences or disagreements'). Some items were adapted from: WKKF (1994) HPE and CP Study (Michigan State University, Survey Research Division of the Institute for Public Policy and Social Research, 1994; made available through Harris D, pers communication).

Decision Making

Nine items were adapted from the WKKF (1994) HPE and CP Study, measuring the attitudes and beliefs related to participation in decision making in the CPs were rated by respondents from 1 = 'Strongly Disagree' to 7 = 'Strongly Agree' (e.g. 'It is easy to get my ideas across to the project leadership if I have a suggestion'; 'I feel I have many opportunities for participation in the Partnership'; and 'Decisions are made only by a small group of leaders').

Flow of Information

The extent to which the amount, accuracy, timing and relevance of information were managed in the CPs were measured by five items adapted from the WKKF (1994) HPE and CP Study. Respondents rated the responses on seven point scales with 1 = 'Strongly Disagree' and 7 = 'Strongly Agree' (e.g. 'Far too little information on important topics is shared among the partners'; 'The information I receive about the Partnership is accurate'; and 'The information I receive about the Partnership is relevant to my needs').

Outcome efficacy

Community members and professional staff rated sixteen seven-point (1 = 'Not at all certain' and 7 = 'Totally certain') items soliciting their degree of confidence and certainty that their CPs efforts would influence HPE and PHC, (e.g. 'How certain are you that the Partnership's activities and changes that are planned will actually increase the number of medical, nursing, and other health professions students who will practice in underserved areas once they finish their training'; and, 'How certain are you that the Partnership's activities will increase community involvement in health care reforms?'). These items were adapted from the WKKF (1994) HPE and CP Study.

Organisational Barriers

Community members and staff responded to seventeen three-point (1 = 'A major problem' and 3 = 'Not a problem') items rating the extent to which each of these organisational barriers presented a problem in how their CPs functions. This scale included barriers imposed by agency structure and systems, limited funding, turf guarding attitudes, and lack of common vision (e.g. 'Competing priorities among partners'; 'Differences in partners' financial years'; 'Coordination of activities among partners'; and, 'Differences in partners' philosophies'). These items were adapted from Gottlieb *et al.*, (1993).

Personnel Barriers

Community members and staff responded on a 1 (= 'A major problem') to 3 (= 'Not a problem') scale their agreement with nine items rating the extent to which each of these personnel barriers presents a problem in how their Partnership functions. Personnel barriers included staff and volunteer expertise, priorities, interest, availability, and turnover. (e.g. 'Interest in Partnership activities'; and, 'Volunteer changing'). These items were adapted from Gottlieb *et al.*, (1993).

Perceived Effectiveness

All informants responded to fifteen items on a four-point scale (1 = 'Extremely Effective' and 4 = 'Extremely Ineffective') scale rating how effective their CPs functioning was in each of the areas of communication, decisions, coordination and improved services (e.g. 'Communication between partners'; 'Making decisions'; 'Focus on Primary Health Care'; 'Training Community Health Workers'). Some of the items were adapted from Gottlieb *et al.*, (1993), with some items adapted from the WKKF (1994) HPE and CP Study.

Perceived Activity

Overall level of perceived activity. All informants responded to two items on a four-point scale (1 = 'Very Active' and 4 = 'Very Inactive') rating their assessment of the level of CPs activity over 1994, and over 1995 until the study reached their Partnership. These items were adapted from Gottlieb *et al.*, (1993).

3.3.2.2. <u>The short version of the questionnaire</u>

Appendix (2) shows the SV of the questionnaire.

A short version of the questionnaire was constructed for re-administration to every sixth respondent. The items were selected to represent and cover most of the different sections (except the sections on communication and expertise) of the long version questionnaire.

Annex (7) lists the variables under study grouped into descriptive, predictive and intermediary measures. Predictive measures included staff and community member predictor items and organisational predictor items. These were used as predictors of the intermediary measures: satisfaction, outcome efficacy and member organisation commitment, effectiveness and educational activities. Annex (7) also lists the number of items in each questionnaire section measure in the long and short versions of the questionnaire.

3.3.3. <u>Reliability</u>

Two types of reliability were computed:

(1) Cronbach's Alpha reliability coefficient: To indicate the degree of internal consistency within the multi-items measures, Cronbach's test of reliability (Cronbach, 1951; Rogers *et al.*, 1993) was computed for every section of the questionnaire comprising of more than one item. For the sections under staff and member predictors, it was also computed separately for the professional staff and community members groups, while for the common organisational predictors it was computed for the whole data sample.

(2) Test- Retest Reliability: every sixth respondent of the long version questionnaire also completed a short version questionnaire, for comparison of responses on two separate occasions, several days to two weeks apart (Piccinelli *et al.*, 1993; Stucki *et al.*, 1995; Brener *et al.*, 1995; Poulter *et al.*, 1996).

3.3.4. Piloting & Data Entry

Annex (8) illustrates how the survey's responses were checked, along with the computer entry of the quantitative data.

The questionnaire was field tested in South Africa in October 1995. The section on CP activities was divided into policy/advocacy actions and educational activities. The section tapping information relating to policy/advocacy actions undertaken by the partners and the CPs was dropped as the piloting indicated that it created considerable and consistent confusion as to what counts as a 'policy action' as opposed to an 'educational activity'. Several other questions manifested some difficulty in understanding. Those latter ones were not dropped but rather special attention was always given to further explain them. Respondents were encouraged to leave any questions that they could not answer or did not clearly understand. Upon collection of the questionnaire more light was shed on the unanswered questions and the respondents were encouraged to answer more if they could and wished. This proved very useful in improving the partial responses to the survey. The main bulk of the data was then collected between November 1995 and September 1996.

3.4. Qualitative Methods

3.4.1. Theoretical framework guiding the interviews and data analysis.

In order to consider how the CP-HPE experiences compared with principles of organisational behaviour, the interview questions and subsequent analysis were guided by published theory and empirical work. Zapka *et al.* (1992) asserted that formal theory concerning coalition behaviour has been developed independently by game theorists, psychologists and political scientists, with limited effort to synthesizing perspectives. Murnighan (1978) recommended, however, that more applied investigation of actual coalitions be undertaken and suggested that all three perspectives had useful aspects to consider. He noted that the game theorists' emphasis on a coalition's payoffs (outcome achievement), social psychologists' emphasis on resources and political scientists' emphasis on importance of ideology similarity among coalition members were all appropriate variables to include in studies of coalition behaviour.

Schmidt and Kochan (1977) argued that interorganisational relationships should be conceptualised as mixed-motive situations in which organisations behave in accordance with their own self-interests. The two foci were the exchange perspective (White, 1974) and the power dependency approach (Guetzkow, 1966).

According to the *exchange perspective*, two or more organisations formed relations when each perceived that by working with others it would be better able to attain its goals than by remaining autonomous. Such relationships formed in periods of scarce or declining resources (Aiken and Hage, 1975). Guetzkow (1966) observed that the interactions between organisations can be characterised by co-operation and problem solving as compared with conflict and bargaining.

On the other hand, the *power dependency approach* implied that the motivation to form relations was asymmetrical–one party was motivated. The inter-organisational relationship was formed when the motivated party was strong enough to induce others to interact. Therefore bargaining and conflict characterise interactions rather than co-operation and problem solving (Guetzkow, 1966).

Building on the work of McCann (1982), Gray (1985) viewed the development of inter-organisational relationships as having three sequential phases: *problem setting, direction setting* and *structuring.* Each phase focused on distinct processes. For example, recognition of legitimate stakeholders and presence of a skilled convener were necessary to the mutual acknowledgment of issues during the *problem setting* phase of coalition formation; coincidence of values and dispersion of power would affect the *direction setting* phase of coalition formation; and ongoing independence negotiation and external mandates impact on structural decisions as well as coalition maintenance. D'Aunno and Zuckerman (1987) emphasised the factors that influenced the transition between phases of mutli-organisational collaboration and itemised several key maintenance factors which were relevant beyond the structuring phases which Gray (1985) stressed on. These stressed the importance of *critical crossroads* in understanding coalition behaviour.

This eclectic array of theories and frameworks suggested questions to the researcher, early in semi-structuring the interviews, as well as later in the synthesis and analyses of the data. For instance, the importance of recognised interdependence (Gray, 1985) prompted questions about collaborative experiences among the organisations. Concern about power dependency (Guetzkow, 1966), the need for mutually acceptable regulative framework (Gray, 1985) and the importance of critical crossroads (D' Aunno and Zuckerman, 1987) prompted questions about problems and tensions which are important variables to discuss when reporting 'consortium processes and maintenance'.

3.4.2. Data sources

Data for the qualitative component of the study were obtained primarily from interviews with the different partners in each of the participating CPs-HPE. The bulk of the data was obtained from the interviews with an informed convenience sample of the CPs representatives. For this study, convenience sampling, a form of non-probability sampling was used. This involved using the respondents who are both strategically placed in the CPs' fabric and who are conveniently available. The general categories of informants included formal leadership, representatives of the CPs participants, apparent spokespersons of agencies servicing the community and the CPs under study, staff from the various medical/ nursing teaching institutions, health services providers and administrators, and, community leaders and individuals.

In addition to the interviews, data were also collected from each of the CPs-HPE archives. Archival data included annual and situation analyses reports from the AI/universities, department of health, funding donor and community advocacy groups as well as workshops and conference papers. Similarly, the SA CPs-HPE Network documents and miscellaneous reports from participating agencies and organisations. Several abstracts and manuscripts also provided important information and were scrutinized (WKKF, 1992; Househam, 1993; El Ansari, 1994; Knott, 1995).

The interviews were one to one, semi-structured, tape recorded, conducted on site (or at the interviewee's duty station or home). They were about 30 minutes in length. When needed and feasible, subsequent brief telephone conversations with interviewees clarified information. Interviewees were assured that their names would not be associated with any specific comment or quotation in the report. Data were collected by the researcher during a 15 month interval (1996 - 1997). Though the interviews were sufficiently structured to include exploration of key issues, they were also sufficiently flexible and conducted in an informal atmosphere in order to maximise the opportunity for respondents to express their own perceptions and experiences.

3.4.3. The qualitative tool: in-depth semi-structured interviewing

Primarily open-ended questions.

Purpose and Preparation

An interest in understanding the experience of people working jointly and the meaning they made of that experience. The major task was to build upon and explore the participants' responses to the questions. The interviewing method used was essentially open-ended, so preparation, planning and structure were crucial. Thoughtful structure was required to decrease any chance of distorting what the researcher learned from the participants. Both, the interviewer and the participants took nothing for granted.

Access and Contact

Access was sought through the legitimate gatekeepers viz. the CPs-HPE administrators, coordinators and directors. Caution was exercised so that the sense of official sponsorship to the study was avoided in order that the equity of the relationship between the researcher and participants could be maintained. The researcher maintained status as someone outside the hierarchy rather than someone in it. When feasible, a short separate contact visit was made to the potential participant, otherwise this contact was via the telephone. Qualitative data collection in each of the participating CPs-HPE started usually towards the end of quantitative data collection phase in the same CP, with the intervening period being capitalised upon to identify key pivotal personnel, build rapport, explain the aims of the study, and assure anonymity and confidentiality in the feeding back of the collected information. This preliminary contact was also used to build a participant pool (collect simple participant information), confirm participant's interest in participating and scheduling a convenient date and time for the interview.

Number and Selection of interviews

One interview was undertaken per participant and about two or three key participants per respondent group per CP (eight to ten participants per CP). In addition, there was also provision to allow for a "snowballing" approach to the selection of potential participants, where each informant was asked about who was sitting next to him/her in the last meeting attended at the CP. The goal was to sample the widest variation of people from the participating sites, within the limits of the study. Attention was given not to only sample the CPs' more active strata e.g., board members and community leaders, but to cast the sampling net far out to reach the individual layperson and community members who were either at the functional periphery of the CPs or were geographically distant and relatively isolated from their CPs

physical site. Two interviewees could not speak fluent English. Those were interviewed via a third party who undertook the task of the two-way interpretation: translation of the researcher's questions to the Khosa language and interpretation of the interviewee's Khosa responses to English. The third party was usually a CP member who the non English speaking interviewee felt at ease with and who have had already completed a questionnaire or had been interviewed i.e. a person who has gained insight into the focus of the study. However, the interpreter was repeatedly cautioned to limit her/his role only to the interpretation process without any incenuations, additions or suggestions both to the interviewee and to the researcher.

Length and Spacing

It was sometimes difficult to strictly stick to the 30 minute time limit previously agreed upon, and in many cases the interviews were extended until the respondent's concerns were felt to be exhausted. Spacing of the interviews was about 3 days apart. This time was used to review and study the previous interview, capturing on both, any shortcomings in technique or emergent points/issues that warranted more attention. Attempts were made to conduct a number of interviews, study and analyse them, re-visit promising avenues of inquiry and then conduct more interviews.

Technique and Managing the Data

The general attitude of the researcher was to listen more and talk less. Listening to what the participant was saying, and concentrating on the substance to make sure that the researcher understood it. Later questioning stemmed from this earlier listening. Participants were given and explained the interview guide, and granted some time to list the topics of their concern using the guide. Informants were also encouraged to air any other concerns they had. The questions were simple and gave considerable freedom to the informants: "what do you not like about your Partnership?". At the end of each concern and before moving to the next, the second question was: "what are your recommendations to remedy this concern?" This was hoped to produce a set of issues and concerns that the CPs-HPE staff and members perceived, and a corresponding set of potential solutions and recommendations to remedy them. The audio-tapes were accurately labelled and the extensive files developed while working with the transcripts were cautiously managed. One goal was to be able to trace the interview data to its original source on the interview tape. Transcription of the interviews was time consuming but was provided for. Analysis and interpretation including studying and reducing the text, marking what is of interest and making thematic connections was facilitated by NUD*IST (Non-numerical Unstructured Data Indexing, Searching and Theorising) (Richards and Richards 1991 and 1994). The English computer files were the starting point of the analysis process.

3.4.4. Interview Guide

Annexes (9-10) show the Interview Guides that were used.

In accomplishing the first and second objectives of the study, the focus of the qualitative component of the investigation was to identify the respondents' perceptions of the particular strengths of what makes a successful collaborative effort, and in contrast, the shortcomings that could contribute to unsuccessful collaboration between various health agencies. These could have been simply anything.

The study was guided by multiple frameworks. As the factors contributing to success or failure of the collaborating process were multiple and diverse, the study therefore seeked to keep an open flexible approach so as to include all incoming opinions. In this way, and by not adopting a rigid approach to the variables under investigation, it was envisaged that respondents' opinions would be picked up by the study. Furthermore, emerging issues that were not foreseen at the beginning of the study were thus allowed to surface and further investigated. The attempt was to cast the research and data collection net in order to pick up as many concerns as deemed necessary. This was accomplished by giving respondents maximum flexibility. To summarize, the respondents spoke about anything they liked, but the primary focus was not a detailed description of who is collaborating with who in doing what. That information was collected via scrutiny of documentary data and subsequently it was used to put the emerging findings in their appropriate contexts.

3.5. Analyses

This survey, assessed the CPs-HPE from more than one distinctive point of view: the community members who voluntarily serve as members of the coalitions, the staff from the health department's and health services' various units and the staff from numerous local university/teaching and training institutions all of which are involved in the CPs, and finally the core staff who were full-time paid workers employed by the CPs.

3.5.1. Quantitative Analysis

Annexes (11-12) show the flow of analyses.

Statistical analysis

Data was analyzed using respondent groups as the unit of analysis. The statistical analysis of the dataset was undertaken using the statistical package SPSS for Windows version 6.1. (Norusis, 1990) on a IBM compatible lap-top computer. Depending on whether the scores were continuous or categorical, the stakeholders' responses to the questions were compared employing the appropriate statistical tests.

(1) Cronbach's Alpha reliability coefficient (Cronbach, 1951) was computed for the various sections for each of the comparison groups to indicate the degree of internal consistency within the multi-items measures (Wijkstra *et al.*, 1994). Reliability was estimated on the observed correlations of the items with each other expressed as Cronbach's Alpha (Politi *et al.*, 1994). Cronbach's α is appropriate for assessing the stability of the subscales (Eisen *et al.*, 1994; Pomerleau *et al.*, 1994) and values > 0.7 were taken as reliable (Nunnally, 1978).

(2) Test-Retest reliability coefficients were computed for the sub-sample who completed both the long and short versions questionnaire to test if responses were significantly different. Accordingly, For dimensions with continuous Likert scales, paired samples (repeated measures) t-tests were undertaken (Pomerleau *et al.*, 1994), while for dimensions with dichotomous or polycotomous categorical scales two tests were undertaken: first was the percent agreement, i.e. the ratio of the number of agreements on a particular issue rating to the number of possible agreements (Main and Pace, 1991). Although this measure is useful as a descriptive indicator of agreement and is particularly appropriate when items have no variability, the technique does not take into account the possibility that agreement on particular item could be due to chance alone. Kappa is the method that statistically corrects for chance agreement when determining the reliability of an instrument (Cohen, 1960). It is an appropriate estimate of agreement giving equal weight to the relative seriousness of disagreements (Main and Pace, 1991; Gloth *et al.*, 1995). Accordingly, in this investigation, the chance adjusted agreement between the first and second administration were further estimated by Cohen's Kappa index (Rogot, 1966) which takes in account random chance of a matched response (Brener *et al.*, 1995; Boult *et al.*, 1995). Kappa values < 0.4 were considered as 'poor' agreement, values 0.4–0.75 as 'moderate to good' agreement, and values > 0.75 as 'excellent agreement' (Fliess, 1981). Similarly, Landis and Koch (1977) reported that Kappa values greater than 0.75 denotes excellent reproducibility, a kappa between 0.4 and 0.75 denotes good reproducibility and a kappa between 0 and 0.4 denotes marginal reproducibility.

(3) Descriptions of coalitions and basic descriptions of member and staff responses on the various variables was undertaken. This included percentages of coalitions reporting problems related to organisational barriers and to personnel barriers.

(4) Comparisons between the respondent groups regarding clarity on coalition roles were then computed. To statistically test if any significant discrepancies existed between the groups. Chi-squared tests were applied to various CPs' dimensions with categorical scales, while multiple analysis of variance (MANOVA) were computed for dimensions with continuous Likert type scales (Rogers *et al.*, 1993).

(5) Predictor analyses followed, where key member staff & organisational factors will be correlated with the intermediary measures of satisfaction with the coalition, outcome efficacy and member organisation commitments (Gottlieb *et al.*, 1993).

(6) For each of the five intermediary measures of accomplishment and impact Chi-squared or MANOVA staff - member comparisons were undertaken.

(7) Correlates of coalition performance

a) Bivariate correlation analysis (Pearson product - moment correlations) to determine statistically significant relationships between pairs of predictor and intermediary variables for coalition members and staff.

b) Multiple stepwise regression with hierarchical entry to examine the contributions of the predictor variables to the intermediary measures of satisfaction; commitment; outcome efficacy; effectiveness; activity; and, educational activities. This is to assist in the process of identifying a 'best' set of independent variables while addressing the problems caused by collinearity (Neter and Wasserman, 1974).

(8) The question of "how much of the variance in each of the six intermediary measures is explained by the combinations of which independent variables" was attempted for both professional staff and member respondents.

3.5.2. Qualitative Analysis

Yin (1984) cautioned that if the overall analytic decisions was made prior to data collection, i.e. that a framework guided the data collected, then this would result in a pattern-matching logic approach. In this study, as data collection proceeded, data reduction proceeded, i.e. pulling out themes and making clusters and lists. Narrative data display was also guided by the framework and clusters of information deemed important in theories related to coalition behaviour. After the transcription process, the various sections of the interviews were coded to reflect the ideas embedded in their content. This was undertaken across all the interviews. The second step pulled together all sections with similar codes into overarching broader themes. The next step involved arranging the themes in a logical narrative pattern to aid in the examination of the emerging messages. However, as the interviewees were left ample space and room for their own particular areas of concern, without imposing boundaries, similarly, the proliferation of divergent or alternative explanations was left flexible based upon the different information until there was enough evidence to support a particular view. The final report then incorporated the findings of the analyses and converted these into policy recommendations for the CPs-HPE participating in the study.

3.6. Validity

The questionnaire component reflects an intent to derive prescription for change from a deductive analysis of responses on a predetermined set of specific variables (Greene and McClintok, 1985). Here, criteria of technical rigour guided questionnaire development (e.g., piloting, minimum measurement error, designing a short version questionnaire), data collection (e.g., maximum response rate for complete and partial responses), and analysis (e.g., statistical significance, measuring Cronbach's alpha reliability coefficients and test-retest reliability) toward a reductionistic prioritising of major findings.

In contrast, the nature of the interview component was reflected in its intent to describe and understand inductively the domain of inquiry from the multiple perspective of respondents. Criteria of relevance guided the development of the interview component (e.g., open ended/semi-structured), data collection (e.g., on-site), and analysis (e.g., inductive, thematic) toward an expansionist, holistic description of patterns of meaning in context.

Qualitative data is sometimes assailed as "miniature" and therefore less generalisable. Nevertheless, the content validity of such qualitative data is accurate because the responses are more saturated with details

elucidating the variables of the SA CPs-HPE model under study, where the focus was the domain of interrelations among providers, consumers and the larger community. And, following the recommendations set by Lincoln and Guba (1985) in order to minimise the biases of retrospective recall, the interviews were long enough to establish an element of rapport, to learn the context of the interviewee's participation, and to allow time for clarification, yet short enough to guard against undue respondent burden. At each Partnership rapport was also established during the quantitative data collection phase which was just prior to the interviews.

As is well documented in the literature on qualitative methodology, data from retrospective interviews have inherent biases due to faulty recall, selective perception, and social desirability. This investigation employed several of Denzin's (1978) suggestions: multiple frameworks guided the questions; frequent feedback and clarifications was used to permit debriefing; numerous people were interviewed; and supplemental archival data were used whenever possible to confirm impressions. Tendencies to oversimplify or escalate vivid anecdotes (Miles and Huberman, 1984) were moderated by 'inter-subjective consensus' among the researcher and informant feedback and by additional discussions.

The notion of triangulation, put forth by Denzin (1978), involves bringing a variety of data and methods to bear upon the same problem. In this way, sounder explanations can be produced. Broadly defined, triangulation is "the multiple employment of sources of data, observers, methods, or theories" (Bednarz, 1983) in investigation of the same phenomenon. The goal of triangulating methods is to strengthen validity of the overall findings through congruence and/or complementarity of the results from each method. Congruence here means similarity, consistency, or convergence of results, whereas complementarity refers to one set of results enriching, expanding upon, clarifying, or illustrating the other (Greene and McClintock, 1985). Indeed, the capacity to implement a strategy of triangulation means evaluators must include in their repertoire the ability to use qualitative methods. (Patton, 1980)

Analysis of qualitative data collected by various methods may produce an explanation that cannot be reconciled immediately with one based upon quantitative data drawn from the same study. Here, Trend (1978) has cautioned about the notion that using multiple methods will lead to sounder explanations in an easy, additive fashion. Indeed, the neat dovetailing of the pieces of a research puzzle should be cause for suspicion. When "hard" and "soft" show an unbrushable lack of congruence, this should guide the researcher to dig more deeply to find out where the problem lay. Early harmony may prevent any additional

searching, since nothing would have needed explaining (Trend, 1978). Within this realm, this study's approach is the concurrent use of survey and interview methods by the same researcher.

IV . Chapter Four

Findings

4.1. Quantitative Findings

After two literature reviews in chapters one and two, and the description of the methods and tools of the study in chapter three, this chapter depicts the findings of the investigation. First, the quantitative findings that were related to the structural factors and operational parameters that were indicated in chapter two are shown. These comprise of reliability issues and descriptive, comparative and predictive results for each of the stakeholder groups involved in this collaborative effort, as well as for the whole sample. Second, the qualitative findings emerging from the study are reviewed, clustered under common overarching themes that captured their common essence. The themes included clarity; representation; communication; ownership issues; power deferentials and consultative decision making; capacity building; and, sustainability factors.

4.1.1. Response Rates

The questionnaire was field tested in SA in October 1995. One section collecting information relating to policy actions undertaken by the partners and the CPs was dropped as it produced a great deal of confusion as to what counts as a "policy action" as opposed to an educational activity. Several other questions were difficult to understand. Those latter ones were not dropped but rather special attention was given to further explain them. Respondents were encouraged to leave any questions that they could not answer or did not understand. Upon collection of the questionnaire more light was shed on the questions and the respondents were encouraged to answer more if they wished. This proved very useful in improving the partial responses to the survey. The main bulk of the data was then collected between November 1995 and March 1997. Annex (8) illustrates the data collection and entry procedures

It was difficult to compute the response rates for the survey for several reasons:

First, not all those working in any particular department whether from the academic institutions or health services were involved with the CP in their area. Many individuals who at first appeared to be 'potential' respondents apologized as they did not have the necessary information or did not attend enough meetings. Such a group would return the questionnaire unfilled and were safely excluded. Secondly, other individuals who, by definition, should have been able to contribute information (e.g. university professors sitting on the steering committees of the CPs) also apologized stating that they were not that involved in their CPs. The apology in it self, however, reflected the level of their actual involvement in

their CPs. Third, according to the CP, any number of individuals who could have contributed information but were not satisfied with their CPs for some reason were reluctant to join the survey. A wide review of literature indicated parallel cases. For instance, in most instances of collective action, only a fraction of people or organisations with shared grievances or interests become involved in the effort (Olson, 1965; Mcarthy and Zald, 1977). Moreover, most of those who do get involved do so at a relatively minor level, such as simply belonging to an organisation and paying dues (Rothenberg, 1992).

It is this latter group, who were reluctant to join the survey, that would have been important to air their views and perceptions of the CPs under investigation. This is because they possessed such information but were 'boycotting' the survey due to present or past differences with the CPs' management or leadership. In several attempts to ease the situation, the researcher thoroughly explained that he was neither from the CPs nor from the funding body, that responding to the survey might be a way to air their concerns and express their views, and that the data collected was anonymous and confidential. This did not seem to help much in improving responses. Accordingly, in one of the CPs, one community did not wish to participate, and in another CP, some staff from a teaching college also did not return the questionnaires despite numerous telephone reminders.

As a result of the above characteristics, there was a degree of uncertanity when calculating the denominator for the various groups. This caused constant tensions in computing the response rates. Only for the CS group was it feasible to know how many persons were actually engaged in the partnership, as they are paid employees in the partnerships, so for this group, response rates were close to 100 %. As for the academic departments and the HS providers, the observation was that usually one or two representatives of the department were those who were actively participating in the CPs meetings/activities.

The technique of 'snowballing' derived from the qualitative research domain was used. Every respondent was asked if he/she knew any other colleague that was actively participating, and they were also asked about who was sitting next to them in the most recent CP meeting. The researcher would then go to that next potential respondent, hand her a questionnaire and repeat the cycle. This technique proved helpful but time consuming.

Any individual who was ready to inform the study and complete a questionnaire was reached. To that end one can testify that the response rate was definitely above 90 % or more. Stevens *et al.* (1993) suggested

that a response rate of 60 % was considered acceptable for questionnaires. Several respondents who had recently left the CPs or were not there at the time of data collection were mailed the questionnaires. Six respondents could not speak fluent English and filled their questionnaires in with the help of another respondent who had completed the questionnaire and thus had gained insight into the questions. The researcher was always present during such sessions to ensure that there was no guiding in the responses, only explaining and clarifying the questions i.e. the integrity of the data collection process.

The criteria for inclusion in the survey was that the potential respondent was informed about the CPs or would have attended at least one meeting. These narrow criteria opened a wide window of eligibility. Any informant who satisfied these criteria was included in the survey and carefully followed up. This is supported by the study's finding that about 70 % of the sample reported to be either not very or moderately involved in their CPs. The implication of this is that the survey reached a variety of participants and CPs members of various levels of activity, and not solely the top strata, which is frequently the active group comprising steering groups, committee and task force members, and partnership core staff. The findings are thus reflective of the activities and interactions that were actually happening 'on the ground'.

4.1.2. Reliability of the Questionnaire

4.1.2.1. Long Version; Cronbach's Alpha

Cronbach's Alpha reliability coefficient was computed for each section of the questionnaire and the standardised item Alpha is reported. For the professional staff variables and the community members variables, Alpha was computed separately for each groups selecting only the professionals or the community members respondents respectively. For the rest of the variables e.g. organisational variables and intermediary measures) Alpha was computed using the whole sample. Table (1) and Figure (1) show the reliability coefficients for the various sections.

For most sections Cronbach's Alpha reliability coefficient was above 0.7 (75 % of questionnaire sections), with few sections lying between the 0.65 and 0.7 level. However, two points were worth noting:

1) The reliability coefficients for the professional staff (PS) and community members variables [Figure (1)], the left-most and right-most curves of the Figure]. For both the PS & CM, the sections displayed a W shaped curve of reliability i.e. the sections exhibited the same pattern of reliability for both the PS & CM groups (the same variable were used separately for each group). The two curves were fairly similar except for the CM the curve was shifted slightly down i.e. the questions were exhibiting slightly less reliability with the CM group than with the PS. This similarity of pattern had two implications. First, that the questions were well understood by the respondents from the two separate groups. Second, that the depression (low reliability) in the curves could have been a function of the questions in that particular section itself as they caused a dip in the reliability curve of each of the two groups separately.

2) The reliability of the section on perceived activity was not very high (0.66). Nunnally (1978) suggested values greater than 0.7 as reliable. The implications of sections with low reliability is that caution and awareness needed be exercised in the interpretation and generalizability of the study's findings.

4.1.2.2. Long & Short Versions; Test- Retest Reliability

The short version of the questionnaire was re-administered to every sixth respondent in the sample. Ninety three respondents out of 668 completed the long and short versions. Figures (2-3) show the spread of the re-admission and composition sample across four CPs and stakeholder groups. Two points were worth considering. First, the decision to undertake re-admissions was taken and the short version questionnaire

prepared only after the data collection from Partnership No. 1 was completed i.e. after the piloting stage. Accordingly, Partnership No. 1 was not included in the re-admission procedure. Secondly, the community group was slightly under-represented in the re-admission sample (about 9 % of the re-admission sample) as it was not always feasible to request hard-pressed CM to complete a short version of the questionnaire after they had already completed the long version.

The mean scores of the re-admission sample in the short version were compared to their scores in the long version. Paired samples (repeated measures) t-tests for equality of means were computed for the sections with continuous Likert type scales while Chi-squared tests were computed for the sections with categorical scales. Significant differences were highlighted.

For the variables with continuous scales, Table (2) and Figure (4) show the mean scores of the same sample for the sections with continuous scales for the long and short versions of the questionnaire as well as their corresponding significance level of the differences. Out of 20 questions covering 14 different aspects of the Partnership that were repeated, five of the questions displayed a significant difference between the mean scores of the same sample which completed the long and short versions. These questions were related to contributions to and benefits of the CPs, as well as general and resource allocation satisfaction (e.g., "I am satisfied with how the Partnership operates").

For the variables with categorical scales, Table (3) and Figures (5-6) show the Kappa values and extent of agreement between admission of the long and re-admission of the short version of the questionnaire. Out of 15 questions covering 11 different aspects of the CPs, 80 % of questions showed a Kappa Statistic of > 0.45 indicating good reliability, out of which 4 questions were > 0.7. Fliess (1981) suggested that Kappa values < 0.4 were considered as 'poor' agreement, values between 0.4 – 0.75 as 'moderate to good' agreement, and values > 0.75 as 'excellent agreement'. Similarly, Landis and Koch (1977) reported that Kappa values greater than 0.75 denotes excellent reproducibility, a kappa between 0.4 and 0.75 denoted good reproducibility and a kappa between 0 and 0.4 denotes marginal reproducibility.

Table (1). Reliability Coefficients For Long Version Questionnaire Sections

Variable	Number of Items	Number of Cases		Standardised Item Alpha	
		PS	CM	PS	CM
Professional Staff & Community Member Variables					
Operational Understanding	5	283	352	.77	.69
Participation Benefits	11	283	346	.92	.88
Participation Costs	5	279	349	.69	.65
Role Clarity	4	272	326	.82	.75
Sense of Ownership	4	295	358	.82	.69
Staff opinions on staff expertise	11	259	311	.91	.89
Staff opinions on community expertise	11	237	304	.91	.87
Contributions	4	286	356	.74	.70
Resource Allocation satisfaction	1	-	-	-	-
Costs/Benefits Ratio	1	-	-	-	-
Organisational Variables					
Management Capabilities	22	563		.92	
Rules and Procedures	9	624		.78	
Community Representation	1	-		-	
Staff-Community Communication	5	599		.91	
Community Members Communication	5	569		.92	
Leadership Skills	11	558		.79	
Communication Mechanisms	7	558		.68	
Partnership Interaction	7	607		.81	
Decision Making	9	597		.67	
Flow of Information	5	629		.68	
Intermediary Measures					
Satisfaction with Partnership	5	640		.84	
Member organization Commitment	4	603		.79	
Outcome Efficacy	16	563		.93	
Organizational Barriers	17	379		.88	
Personnel Barriers	9	536		.85	
Perceived Effectiveness	15	493		.91	
Perceived Activity	2	553		.66	
Partnership Educational Activities	3	604		.80	

Figure (1). Reliability Coefficients of Long Version Questionnaire: Questionnaire Section, Variable Type & Number of Respondents

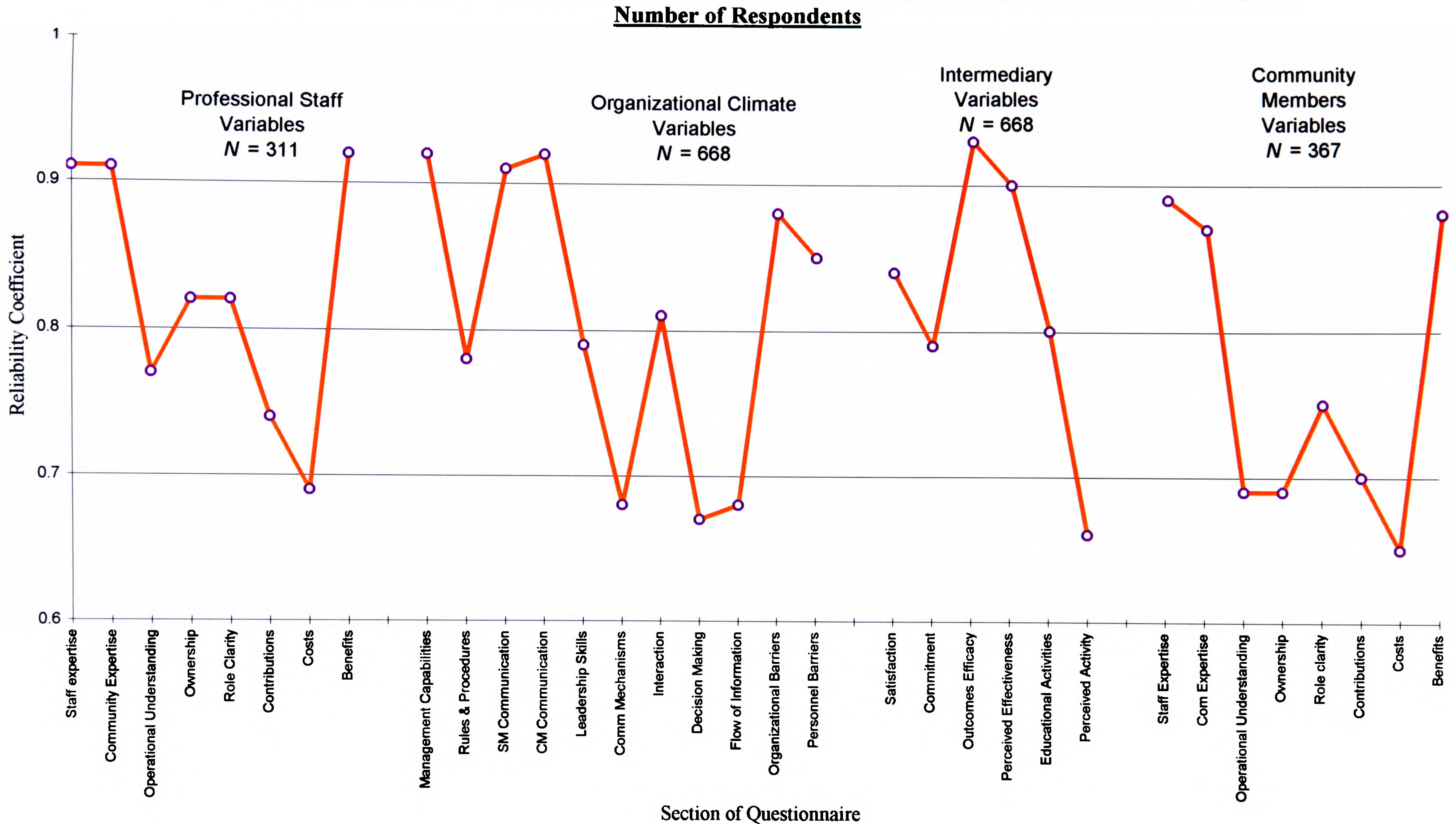


Figure (2). Test- Retest Reliability: Composition of Re-admission Sample
(N = 93)

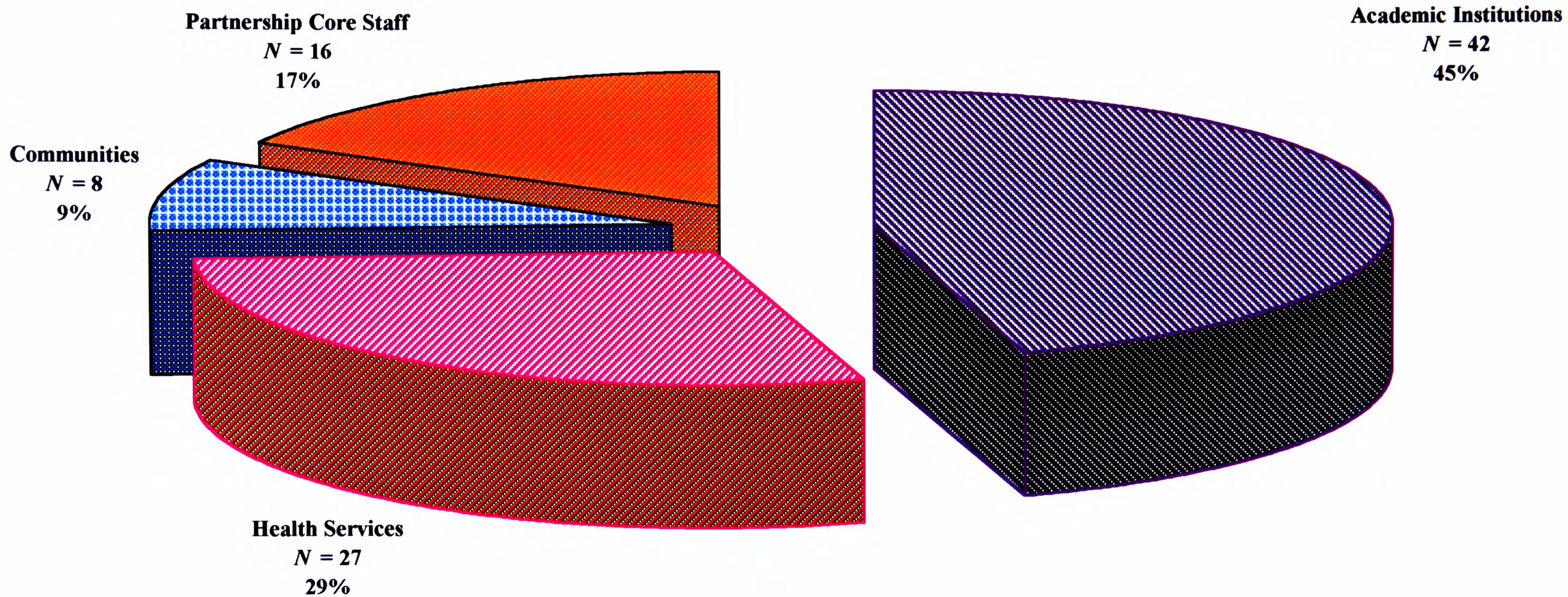


Figure (3). Test- Retest Reliability: Spread of Sample Across Partnerships (N = 93)

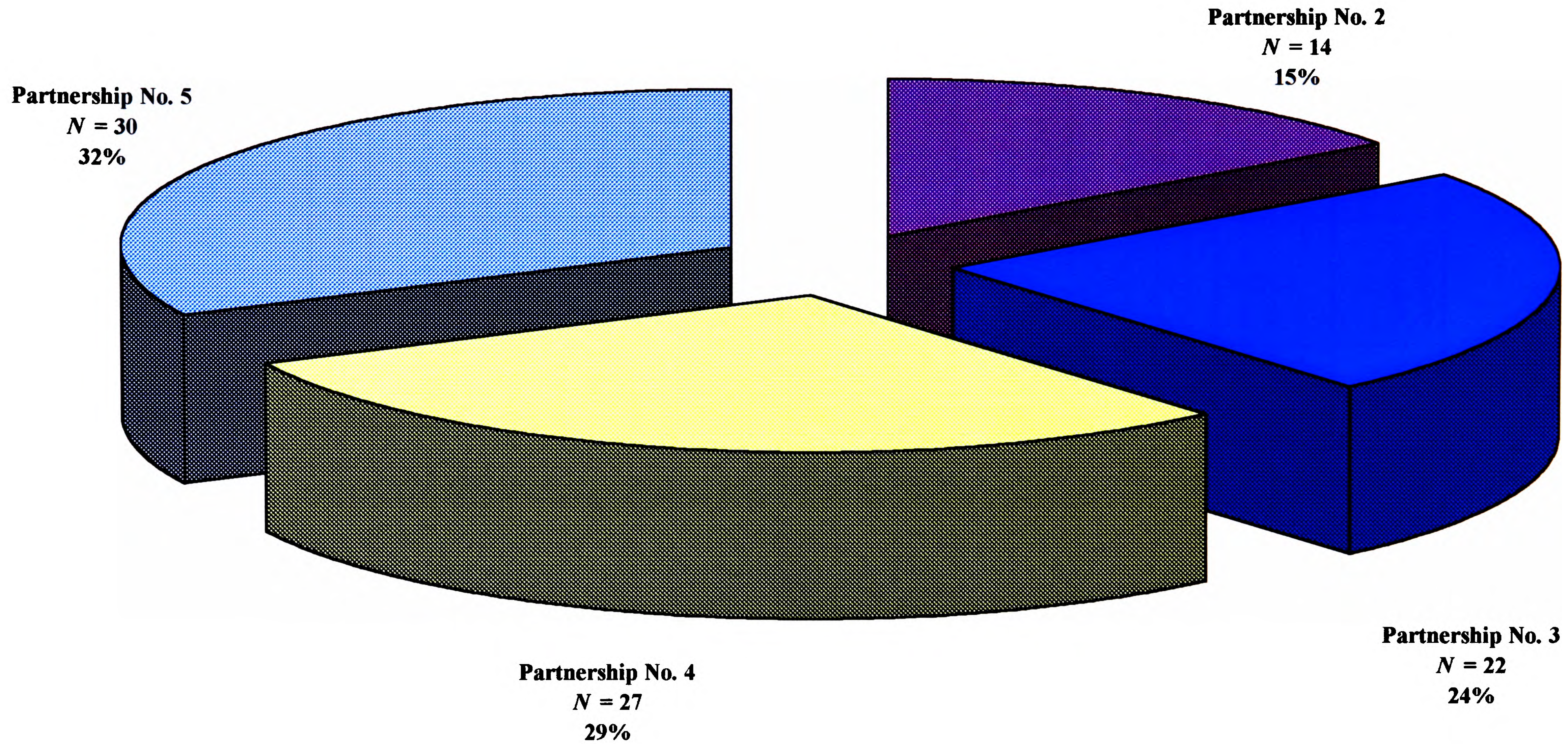


Table (2). Test-Retest Reliability: Short & Long Versions; Variables with Continuous Scales; Comparison Of Mean Scores of Paired samples ; Fourteen Aspects of Partnership Functioning

Variable	Number of pairs	Mean Score		*P* Level & Significance of Paired samples *t*-test
		Long version	Short version	
Management Capabilities (Q 9)	91	4.47	4.53	0.75 (NS)
Management Capabilities (Q 10)	92	4.43	4.78	0.07 (NS)
Management Capabilities (Q 22)	91	5.46	5.18	0.08 (NS)
Community representation (Q 1)	93	4.81	4.65	0.27 (NS)
Contributions (Q 1)	92	5.10	5.14	0.84 (NS)
Contributions (Q 2)	91	2.40	2.85	0.04*
Benefits (Q 1)	93	5.13	5.11	0.89 (NS)
Benefits (Q 11)	93	5.21	4.90	0.02*
Costs (Q 2)	90	2.65	2.82	0.36 (NS)
Satisfaction (Q 2)	92	3.97	4.65	0.000*
Satisfaction (Q 3)	92	5.70	5.53	0.07 (NS)
Ownership (Q 1)	88	5.40	5.36	0.72 (NS)
Commitment (Q 3)	81	4.91	4.60	0.07 (NS)
Resource allocation satisfaction	87	4.21	4.48	0.04*
Educational activities (Q 1)	91	5.53	5.46	0.49 (NS)
Interaction (Q 2)	89	4.61	4.62	0.92 (NS)
Decision making (Q 6)	93	4.01	3.91	0.61 (NS)
Information flow (Q 4)	92	4.20	4.26	0.73 (NS)
Outcome Efficacy (Q 5)	91	5.20	4.90	0.01*
Outcome Efficacy (Q 6)	90	3.97	3.91	0.62 (NS)

* Significant

Figure (4). **Test- Retest Reliability: Long & Short Versions of Questionnaire. Paired Samples; Variables with Continous Scales**

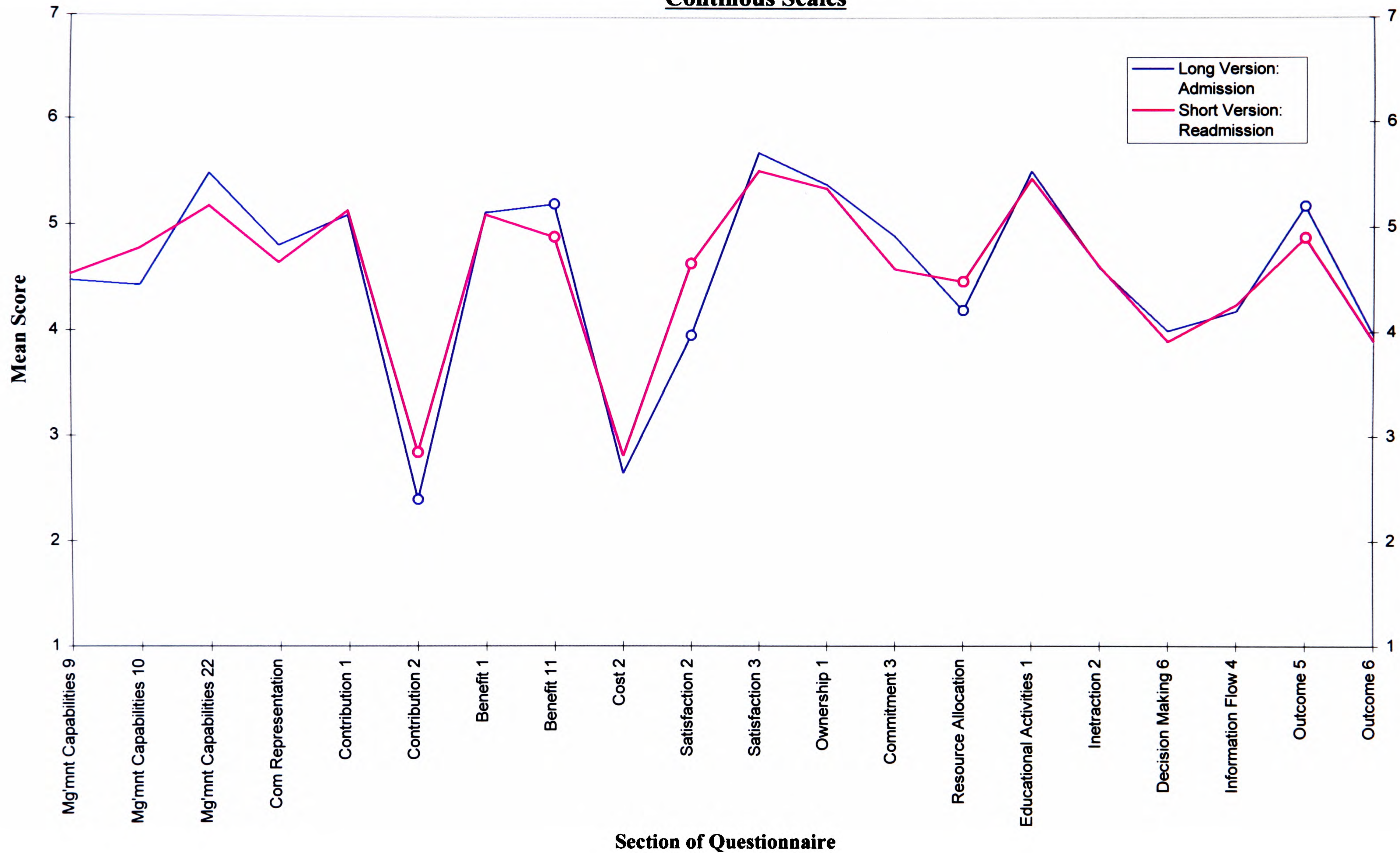


Table (3). Test-Retest Reliability: Long & Short Versions; Variables with Categorical Scales; Comparison of Respondents' Scores on Admission and Re-admission; Kappa Statistic; Eleven Aspects of Partnership Functioning

Variable	Number of Respondents	Kappa Value	Extent of Agreement (%)
Rules and Procedures (Q 1)	92	0.87	97.8
Operational Understanding (Q 1)	91	0.75	87.9
Involvement (Q 1)	90	0.54	73.3
Role Clarity (Q 4)	89	0.47	59.5
Leadership Skills (Q 1)	91	0.72	87.9
Communication Mechanisms (Q 1)	91	0.81	91.2
Costs/Benefits ratio (Q 4)	90	0.61	71.1
Organizational Barriers (Q 1)	88	0.49	68.1
Organizational Barriers (Q 8)	88	0.31	55.6
Personnel Barriers (Q 8)	88	0.47	69.3
Perceived Effectiveness (Q 2)	89	0.49	77.5
Perceived Effectiveness (Q 3)	90	0.41	72.2
Perceived Effectiveness (Q 10)	86	0.33	61.6
Perceived Activity (Q 1)	75	0.56	76.0
Perceived Activity (Q 2)	90	0.54	74.4

Figure (5). Test- Retest Reliability: Long & Short Versions of Questionnaire. Comparison of Respondents' Scores on Admission and Re-admission; Variables with Categorical Scales

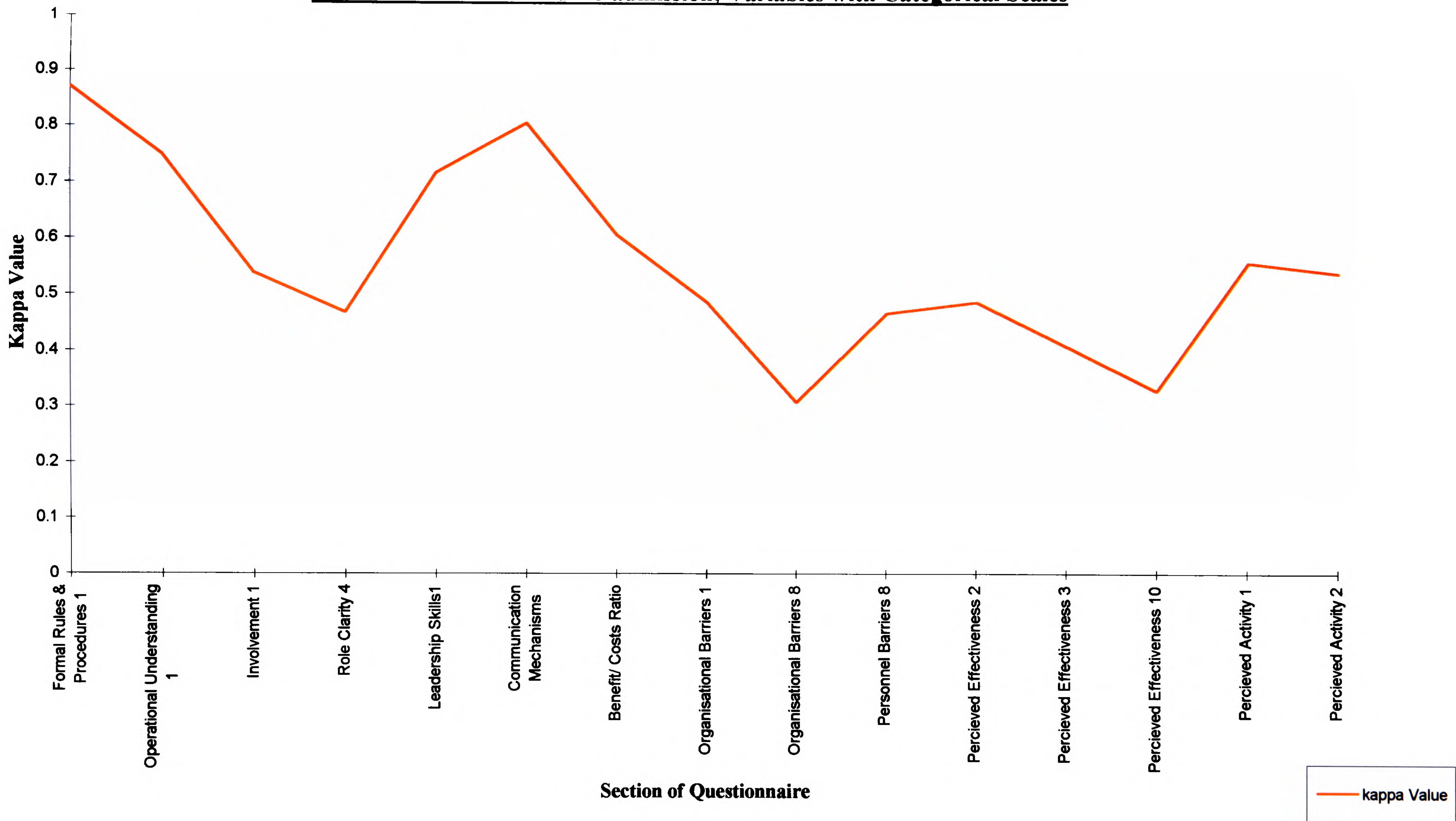
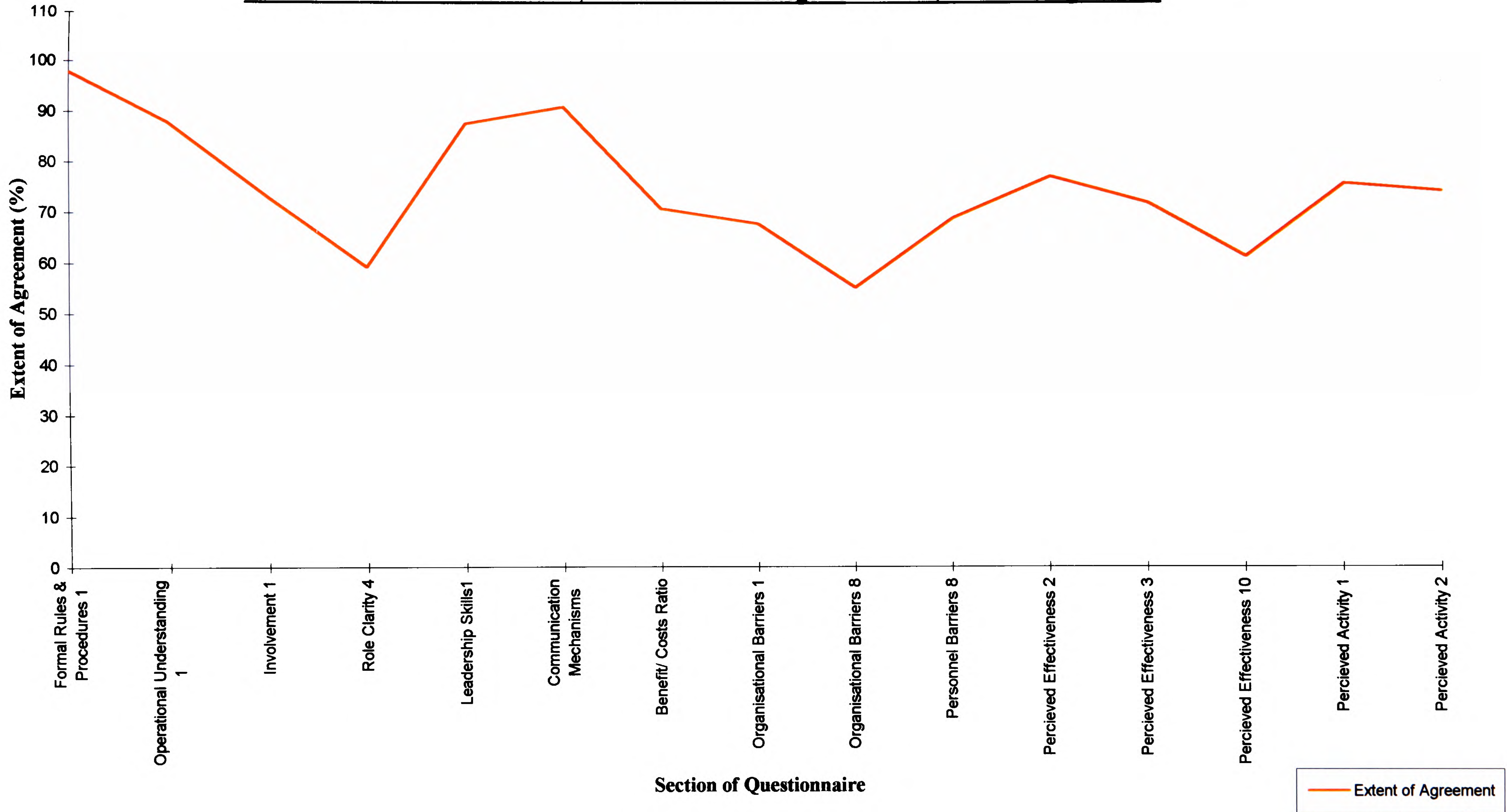


Figure (6). **Test- Retest Reliability: Long & Short Versions of Questionnaire. Comparison of Respondents' Scores on Admission and Re-admission; Variables with Categorical Scales; Extent of Agreement**



4.1.3. Descriptive Findings

In South Africa, the process started by an invitation from the W. K. Kellogg Foundation to South African universities to submit proposals aiming at reforming the way health, nursing and allied health professions were trained. A pre-requisite from the Foundation was the involvement of and wide consultation with the local communities in every step of the process (WKKF., 1995). From a large number of initial proposals, seven were selected, but not all of them were granted full funding immediately. Although the process of selecting the seven locations started as early as 1991-1992, several of the localities were given mini-grants as well as more time, support and assistance from the Foundation to be able to develop more appropriate and comprehensive proposals. This process required around an extra year. Ultimately, the seven were granted full funding to start their health and health promotion programmes.

Within slightly more than a year later, the South African Network of CPs in HPE was formed by representatives from the seven partnerships, with the duty of networking between the seven sister partnerships to inform and facilitate their development. The aim of the network was to share lessons and successes, to avoid pitfalls and to identify innovative ways of monitoring and evaluation of the various facets of the partnerships. Critical sphere of investigation by the network were the areas of educational and service transformation, community-based academic/service primary health care sites, community empowerment, and policy changes. Towards the end of 1995, a joint monitoring and evaluation task force had been set up and had conducted a survey of the various evaluation activities within the seven projects (South African Network of Community Partnerships in Health Personnel Education, 1995). The vision was that this task force would generate information which could inform and impact upon national, regional and local health policy and planning initiatives, as well as information which could assist in the process of negotiating the further sustainability of these SA CPs. At the time of the study (between 1995 - 1996), most of CPs were all moving from initiation to implementation, had all developed strategic plans albeit to various extents and had a variety of programmes running.

This study was initiated in response to the mutual recognition that there were no local South African models that these young CPs could draw upon, and imported models may need subsequent adjustments in order to be useful in the new settings where they were to be replicated.

Background Descriptions

All the CPs under investigation were funded through grants obtained by the same external agency: the W. K. Kellogg Foundation. The overall goals and timetables for the CPs were near identical. Each had a an executive board or steering committee composed of 50 % CM, 25 % AI and another 25 % HS providers. All had clear mission statements, but at the time of the study three CPs were in process of taking steps to develop and sign a formal constitution between the partner groups. The five CPs under investigation were, however, located in different localities and had separate academics, service providers, community leadership and local staff. All had been active for a period of between 3 to 4 years. Their target populations were the local communities in the vicinity, most of which had been previously disadvantaged and underserved before the 1994 democratic elections in SA. The population size of the participating communities ranged from 35,000–300,000. Surveys of community needs had identified poverty, water, sanitation, sewage disposal, housing, lack of recreational facilities, lack of early learning opportunities, adult illiteracy, substance abuse, teenage pregnancies, unavailability and inaccessibility of health services and insensitivity of health care personnel as the major factors contributing towards ill-health (Lazarus *et al.*, 1998). The activities of each CP were somewhat unique but with a degree of arching overlap. The programmes stretched from educational health workers training programmes and health sciences students training programme, community college, bridging programmes, school education and bursaries, and youth health desks to local government facilitation and vocational training and skills programmes e.g. brick laying, community gardening and sewing [Annex (4)].

The academic institutions staff that were participating (20 % of the sample) came from a broad range of disciplines. These included respondents from the mainstream university departments or their peripheral units such as the Health Systems Development Unit, the Community Rehabilitation Workers Training Program, or the university's Rural Facilities and Primary Health Care Research Unit. Mainstream university departments included the classical academic departments such as microbiology, anatomy, physiology and medical chemistry or the clinical departments of internal medicine, psychiatry, pediatrics and nursing science. Other departments that were also participating were community health, family medicine, health personnel education and health education. Moreover, participation and contributions were not narrowly limited to the medical and nursing faculties but extended to the other faculties such as the faculty of arts, faculty of education and college of agriculture represented by departments such as social works, psychology, adult literacy and home economics.

Similarly, health services respondents (17 % of the sample) represented a diverse group of hospital and day hospital staff as well as staff from the health centers, health posts and municipal clinics. Hospital staff represented departments such as maternity ward, operating theatre and dentistry nurses, psychiatric, rehabilitation and physiotherapy units' staff, as well as personnel from environmental and primary health, nursing school and the department of health. Respondents varied from a regional director and chief medical superintendent to community and planning matrons, to nurses and nurse managers of all administrative grades.

The community representatives (55 % of the sample) were from civic organizations, youth and women's groups, crèche and church assemblies, teachers organisations, a priest, a headmaster, a businessman, a lawyer, several civil servants, members of non-governmental organisations, community-based organisations and voluntary agencies, community health workers, tribal authorities or 'solo' community members. Finally, the core staff employed by the CPs (8 % of the sample) were the partnerships' directors, programme coordinators and facilitators, community development workers and supporting administrative staff

Given this diversity of participants, the findings indicate that the stakeholder groups agreed as regards the above average representativeness of their CPs of the various stakeholders in their localities (M for the whole sample = 4.78 on a seven point scale). However, about 10-20 % of the stakeholders reported that certain constituencies could benefit from more representation on the CPs e.g. specific workgroups; rural population; community based organisations; worksites/ businesses; medical community; the elderly; the media; schools (teachers, students); and the youth.

Demographic characteristics of sample

The sample of respondents was spread evenly across the five participating CPs, averaging about 130 respondents per partnership, with a range 100 respondents in the smaller CPs to 195 respondents in the larger ones. When the spread of the sample is examined across the stakeholder groups, about 50 % of the sample were comprised of community members either representing community and civic organisations attending, or attending on their own behalf. The other 50% of respondents were comprised of the academic institutions, health services and core staff. Figures (7 - 9) show the composition of respondents by partnership and stakeholder group.

The mean age of respondents was 40 years and ranged from 18 to 78 years of age. The age distribution exhibited a slight skewness to the right indicating that more of the respondents were from the older age groups. About 90 % of the sample were above the 25 years old age bracket [Figure (10)]. Furthermore, Figures (11 - 12) indicate that there were no significant differences between the mean ages of respondents across the CPs or participant group.

There were more females than males in this sample, a ratio of 65:35 [Figure (13)]. The numbers of females were more than the males for all CPs except one [Figure (14)].There were no significant differences between the ages of respondents for males and females across the CPs [Figure (15)]. Figure (16) confirms that females were more represented in each of the four stakeholder groups. There were twice as many females as males in the AI and CS groups, and about four times as many in the HS group. This needed to be viewed in the light that this latter group consisted mostly of nurse managers, senior and junior enrolled nurses, nurse assistants and other hospital staff/ health center staff, who in these CPs, perhaps as in many parts of SA, were mostly females.

The data collection phase of this study was shortly after the 1994 historical elections in SA, where people had a sense of bitterness from the long established Groups Act that segregated South Africans according to their ethnicity. The single question asking information about respondents' ethnicity was not answered by about 15 % of the sample. However, taking that in consideration, Figure (17) showed that about three quarters of the sample had classified themselves as "black" South Africans, while the proportion of "white" participants in these CPs was a small 10 % of respondents. This need not be hastily taken as face value that the "white "ethnic groups were not being involved in the CPs, but rather, these CPs were all located in previously underserved and under-privileged areas, mostly of which have a "black" population. In this study, the "white" respondents represented, in most instances, academic staff to which the CPs were linked for academic support, or health services staff.

Only 10 % of participants had any previous experience in CPs or other forms of collaborative efforts or joint working arrangements [Figure (18)], and as Figure (19) depicted, at the time of the study the average respondent had been participating for about slightly less than 2 years (95 % CI: 6 - 38 months). These findings were consistent with the fact that CPs were a relatively new concept in SA, reflected in that only 10 % of the sample reported to have had any previous experience with CPs, coalitions or joint working activity. At the time of the study, the average participant reported to have attended about 50 % (95 % CI: 19 % - 85 %) of their CP's meeting that they should have attended over the past 12 months.

Since joining the partnership, the average participant had recruited a mean of 10 new members to the partnership, served a mean of 10 times as a spokesperson for and worked a mean of 11 times on implementing educational or cultural activities or events sponsored by the CPs. In parallel, the average respondent had served a mean of 8 times as a representative of the CPs to other groups.

As regards the authority to make decisions on behalf the organisations, departments or agencies that the participants represented, some members did not represent any organisations but were attending on their own behalf (5 %), while for those representing their agencies, about one quarter of the sample reported that they had full authority while another quarter reported that they had no authority whatsoever to make decisions on behalf their organisations. The rest of the sample had to first negotiate with their individual agencies before making a decision, in the form of approval of other staff (35 %) or of the boards of their organisations (10 %).

Figure (7). <u>Number of Respondents by Partnership</u>
(N = 668)

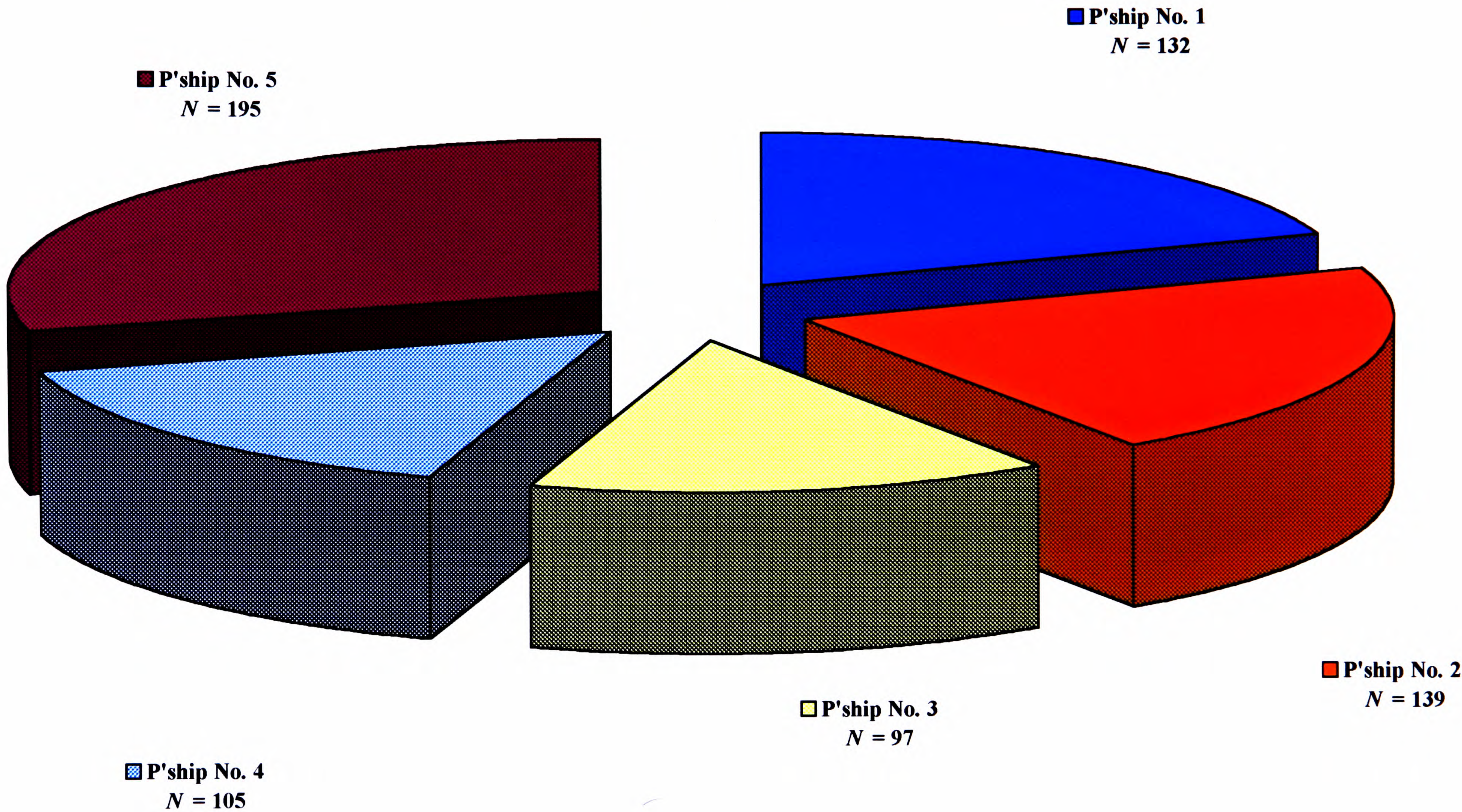


Figure (8). Number of Respondents by Stakeholder Group
($N = 668$)

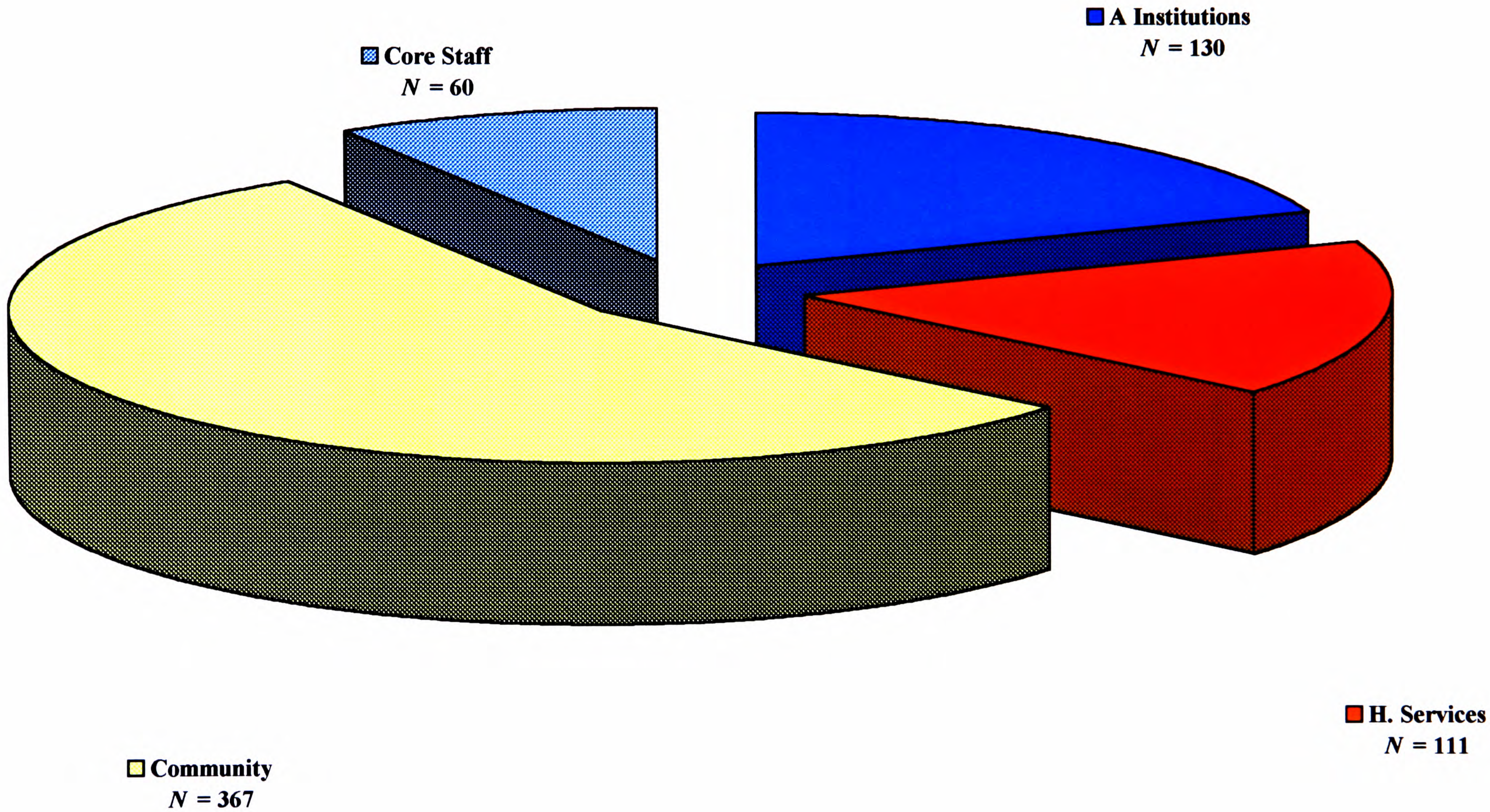


Figure (9). Percentages of Respondents by Partnership and Stakeholder Group (N = 668)

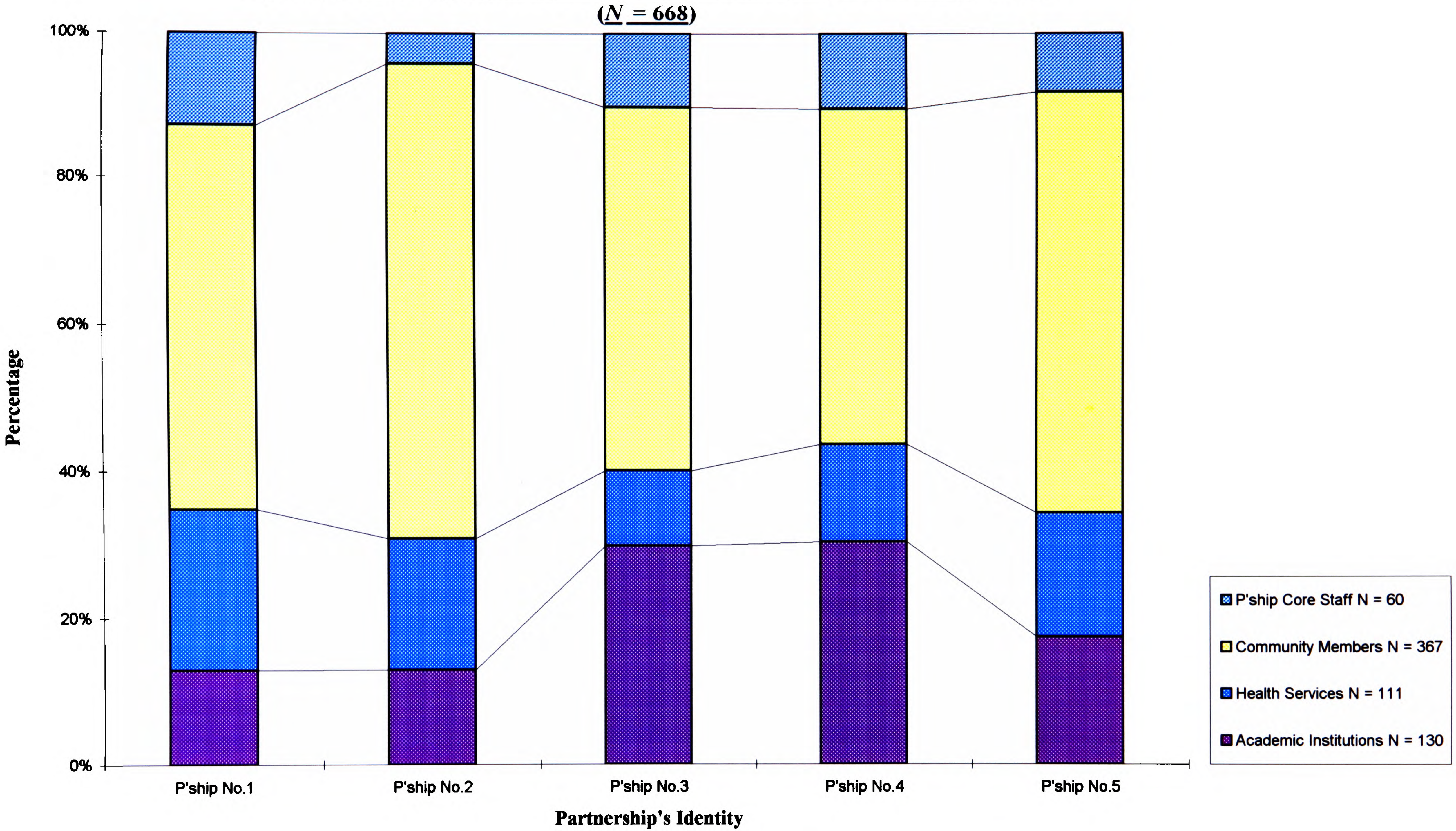


Figure (10). Age Distribution of Respondents

(N = 636)

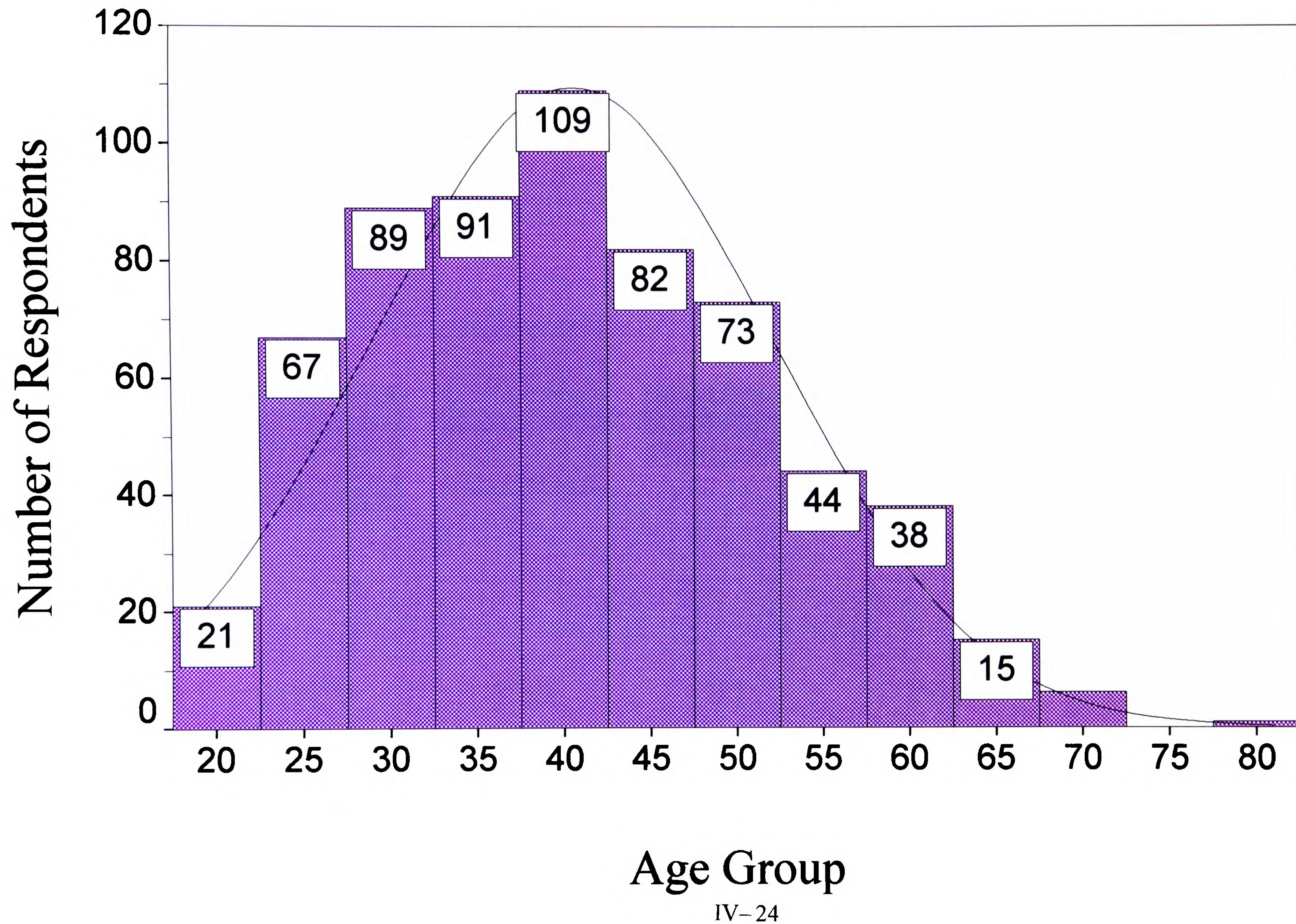


Figure (11). Age of Respondents by Partnership

(N = 636)

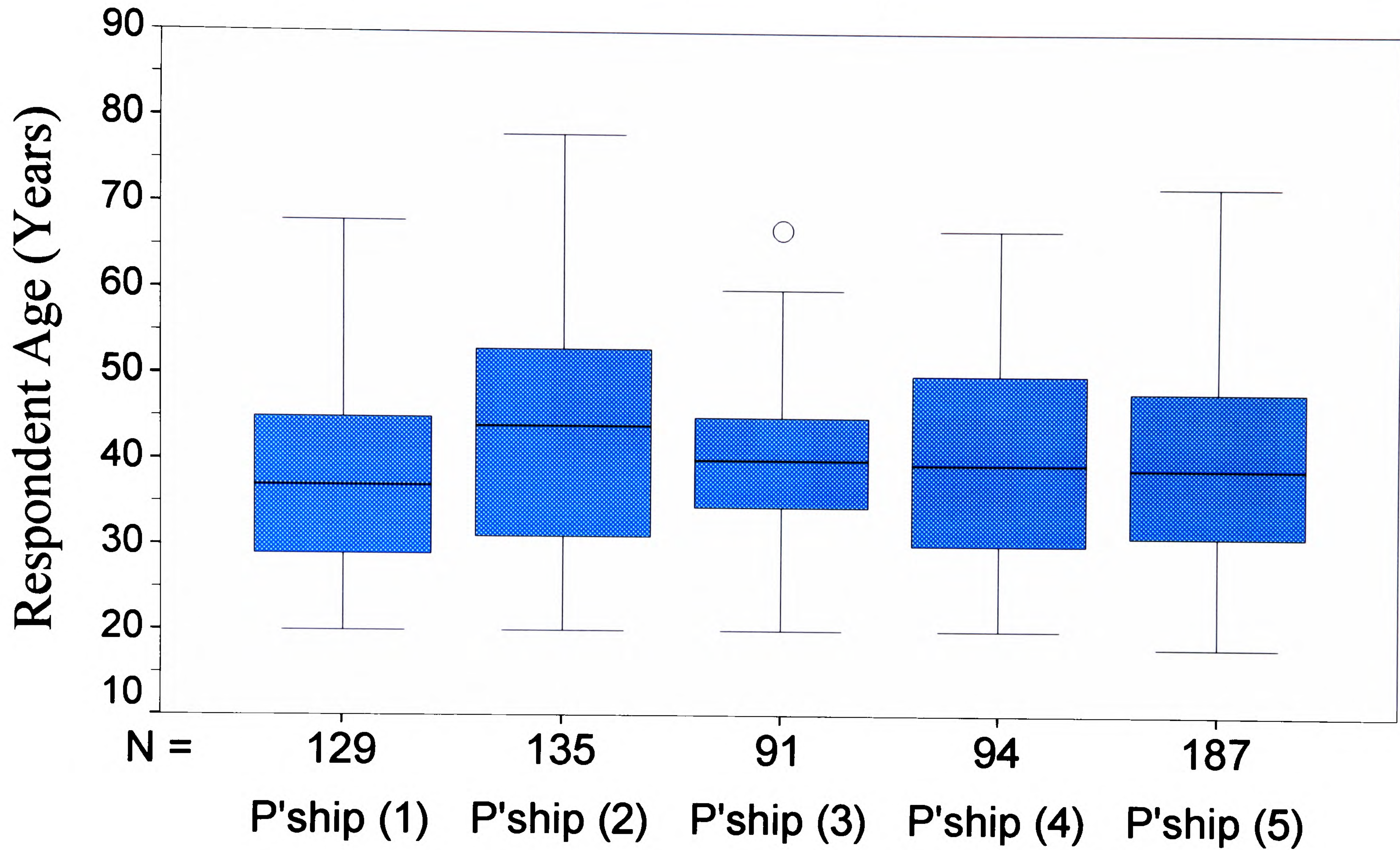


Figure (12). Age of Respondents by Participant Group

(N = 636)

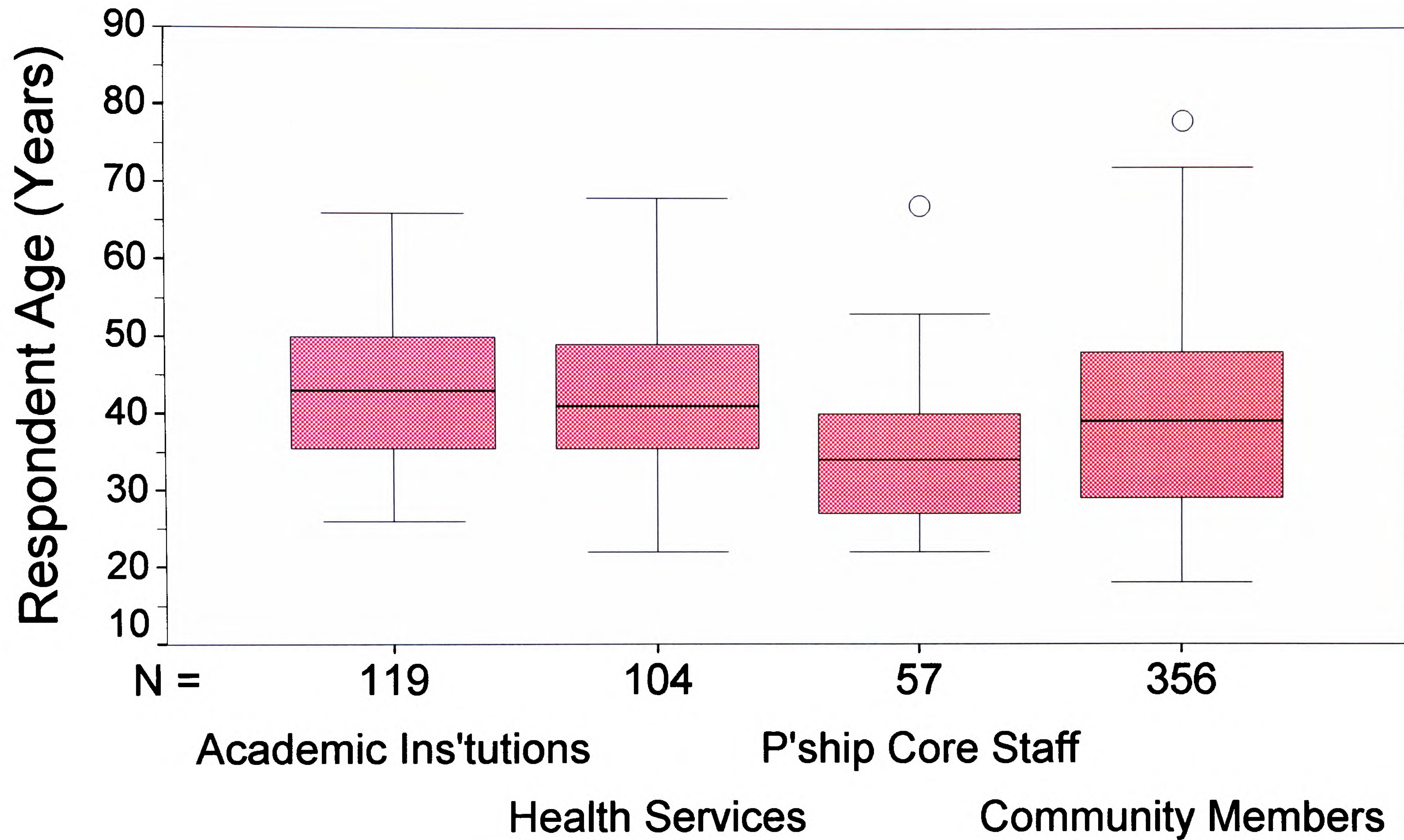


Figure (13). **Gender Distribution of Respondents**
(N = 664)

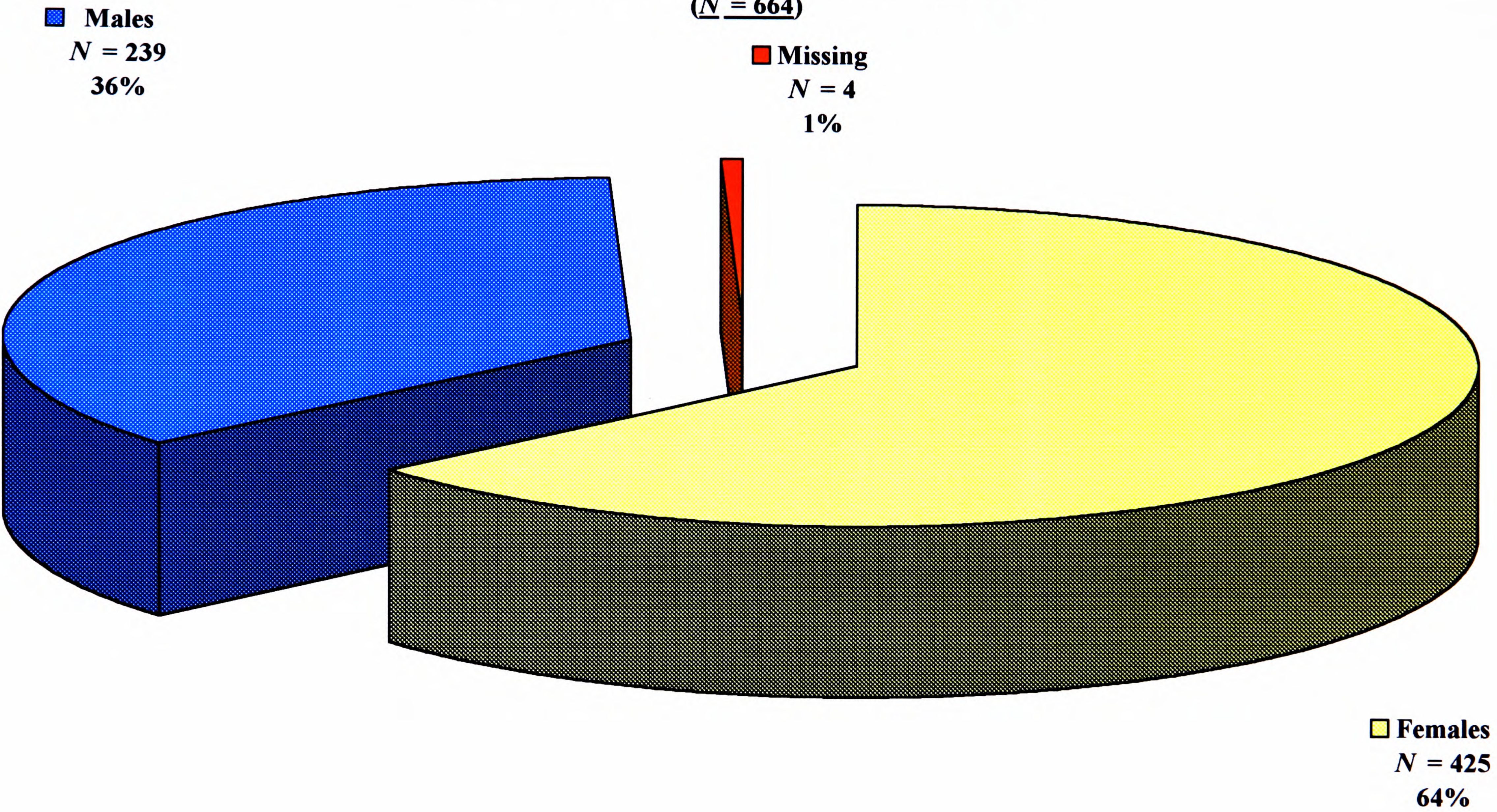


Figure (14). Gender of Respondents by Partnership

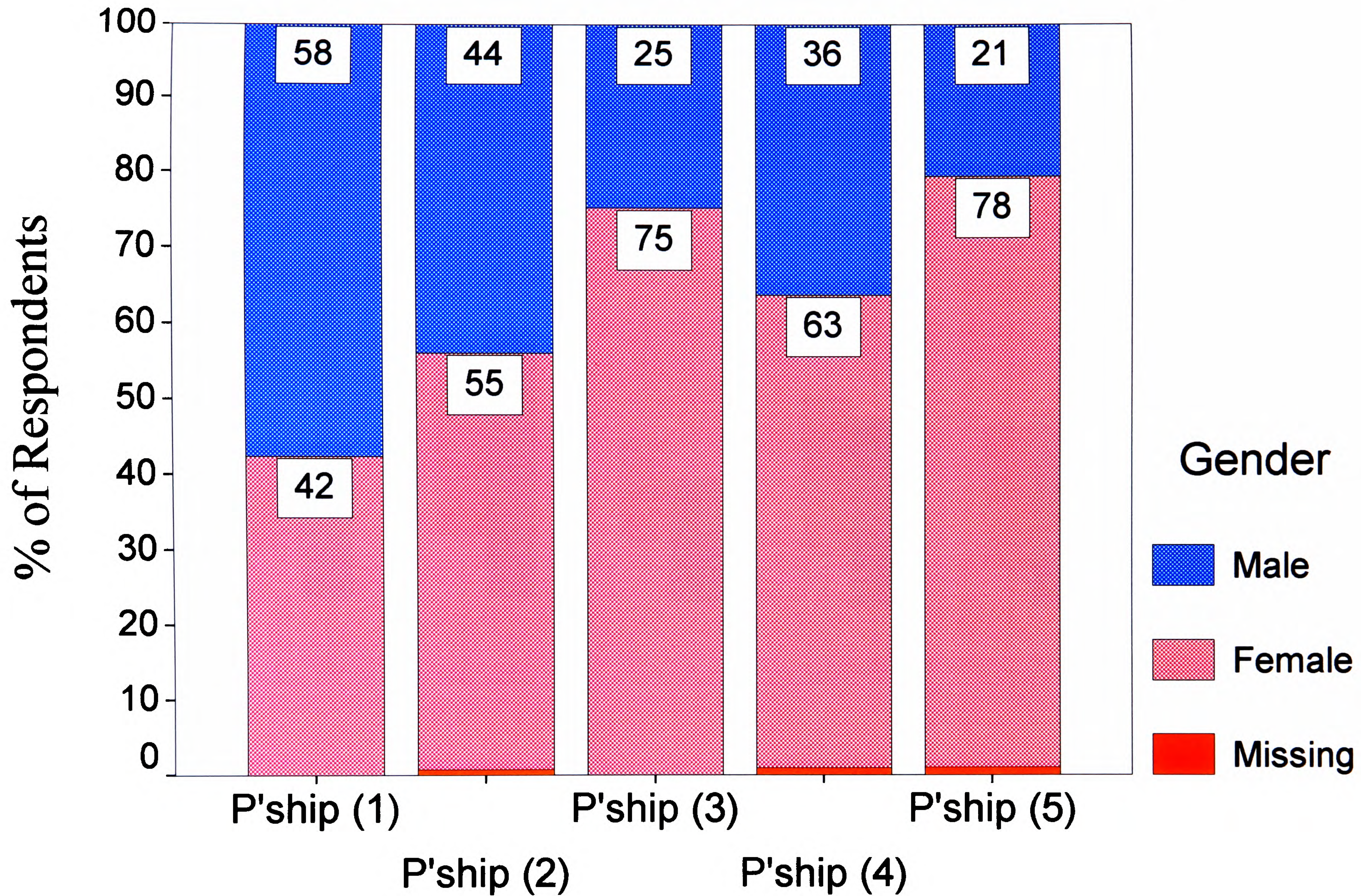


Figure (15). Age of Respondents by Gender

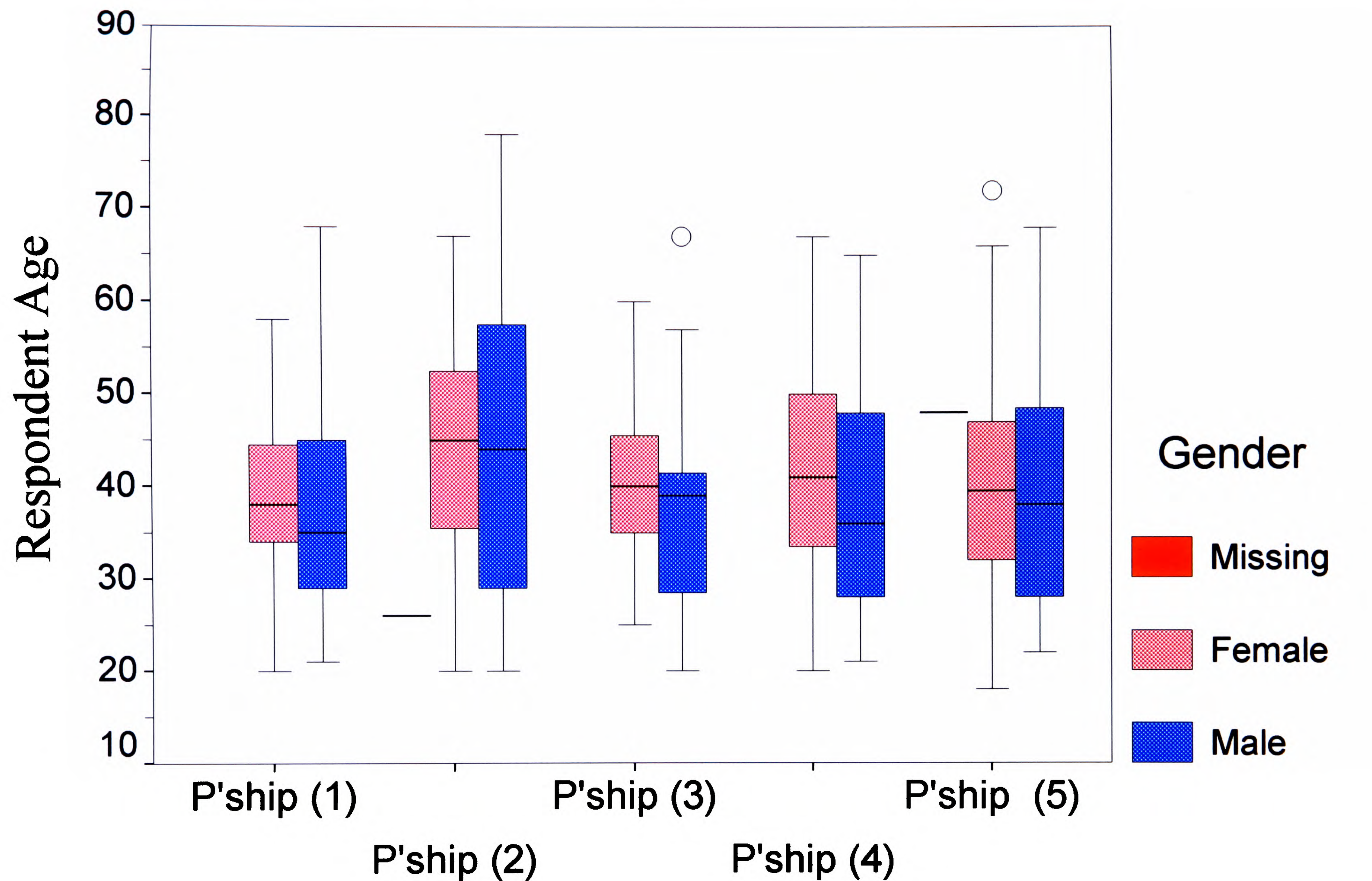


Figure (16). Gender of Respondents by Stakeholder Group

(N = 664)

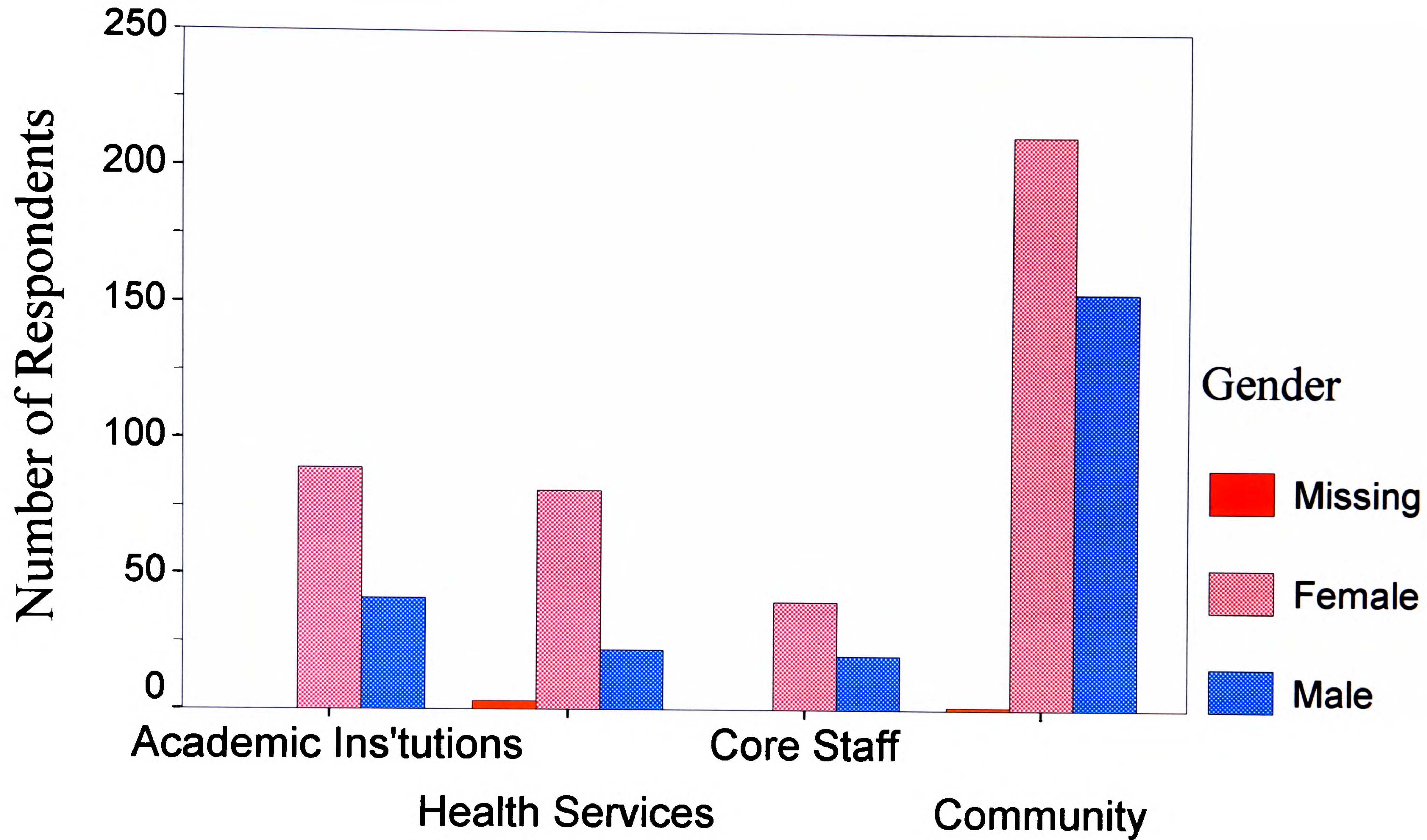


Figure (17). Ethnic Group Distribution of Respondents
($\underline{N = 668}$)

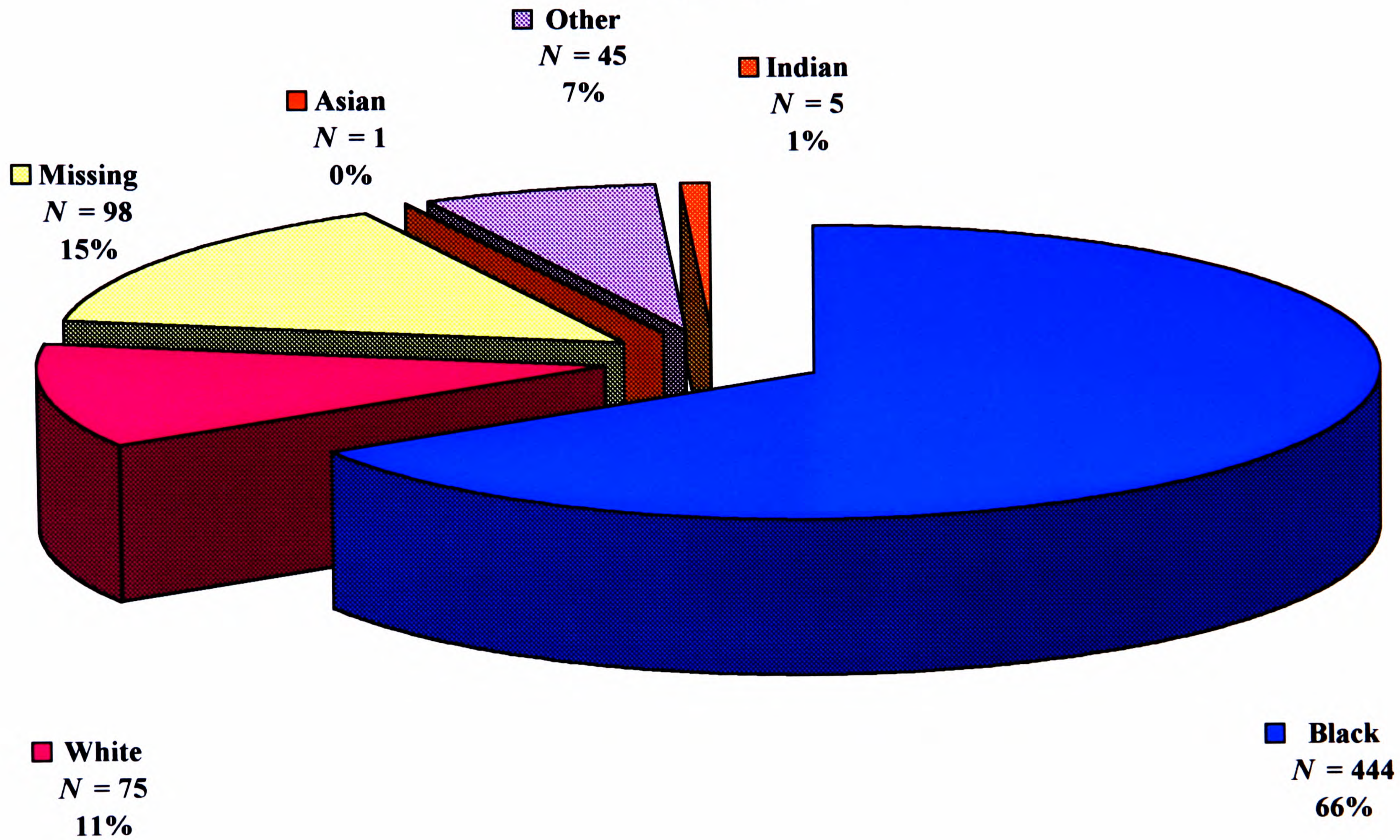


Figure (18). Months Past Experience in other CPs

by Stakeholder Group (N = 62)

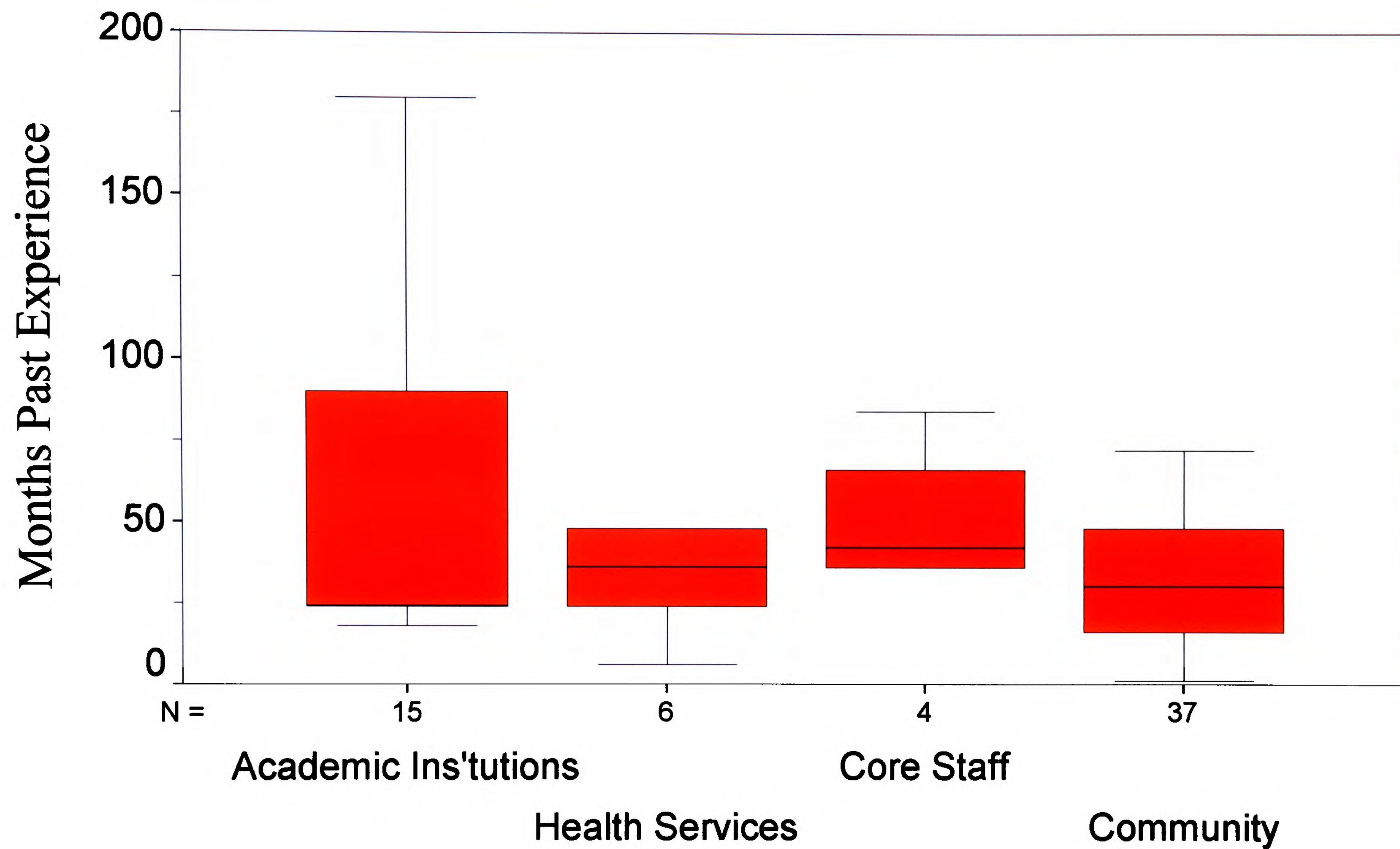
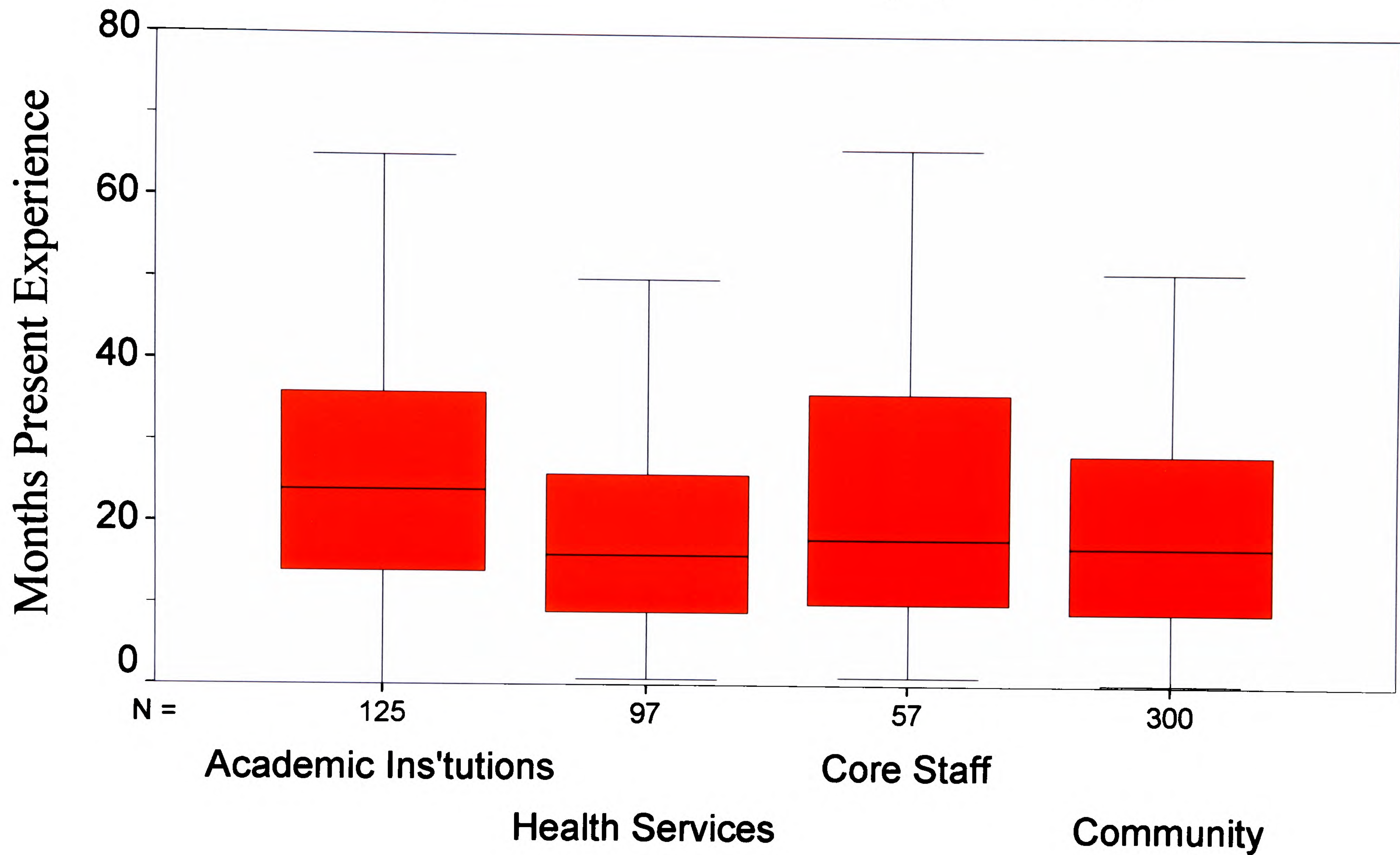


Figure (19). Months Present Experience in current CPs by Stakeholder Group (N = 579)



4.1.4. Comparative Analysis

Four comparison groups were constructed namely, the Academic institutions (AI), the Health services (HS), the community members (CM) and the full time paid Core staff (CS) employees employed by the Partnership.

It was not always straight forward to place respondents in these four groups, especially in the AI and the HS partners (some academic faculty were seconded, other health services professionals had their salary coming from two sources, etc.). Likewise, not all respondents who were physically stationed at the CP could be classified as Partnerships' CS, as several respondents were there simply for the physical office space offered by the CP, but actually represented a non-governmental organisation (NGO) or a community-based organisation (CBO), i.e. representing the communities group.

Conversely, although most of the community health workers (CHWs) were either granted a token monthly monetary appreciation from the CPs or were employed by the health services as a separate cadre, nevertheless, they were placed in the community group. No attempt was made by the researcher to identify where each respondent's salary came from, but rather care and attention were given to group the respondents into their appropriate functional groups by discussing it widely with each of the respondents. The groups were then compared regarding their views and perceptions on various aspects of their CPs..

After summarizing the responses and reporting the scores of the comparison groups on individual questions of each section separately in line graphs, a summary radar graph was constructed to further summarise for each comparison group, the responses of all the questions in a particular section into one composite score plotted on the arm of the radar.

Tables (4 - 36) summarise the areas of agreement and disagreement in the responses of the four comparison groups as regards their views on the various aspects of their CPs, while Figures (20- 57) plot the responses summarized in Tables (4 - 36).

4.1.4.1. <u>Sections with Continuous Scales</u> (16 Sections)

[Tables (4 - 21); Figures (20- 32)].

1. <u>Management Capabilities</u>

For many of the statements in general, the CM agreed more than the AI, with the responses of the HS and CS lying in between. For several of the statements the CS scored about the saine or higher than CM [Table (4) and Figure (20)].

<u>Areas of agreement</u>

The participants had similar views on half of the management capabilities that were tested. The groups agreed that at the meetings, technical terms used were clear/understood by all (whole sample $M = 4.6$) and routine matters were handled quickly ($M = 4.4$); that everyone participated in the discussions ($M = 4.5$); that members seemed well informed and understood what is going on at all times ($M = 4.6$); that there was no fighting for status or hidden agendas ($M = 4.4$); that the CP used the resources of all its members ($M = 4.6$); that meeting times were convenient ($M = 4.9$); that meetings run smoothly without interruptions ($M = 5.0$); that interest was generally high ($M = 5.3$); that CP members felt safe speaking out ($M = 5.2$); that the atmosphere of the meetings was friendly, co-operative, and pleasant ($M = 5.3$); and that meetings had free discussion ($M = 5.7$).

<u>Areas of disagreement</u>

The groups disagreed on the other half of the management capabilities in their CPs. The CM scores were higher than the AI to many of the statements in general, with the responses of the other two groups lying in between.

The CM agreed that meetings started and stopped on time, differing with each of the other three groups who all disagreed with the statement, indicating that meetings did not start and stop on time. Furthermore, the CM agreed that the purpose of each task or agenda item was well defined and kept in mind; that reports were routinely made to their entire CPs; that minutes accurately reflected the proceedings of the meetings; that members stayed with the subject that is being discussed; and that that they were usually clear about their roles as CP members. The other stakeholders did not share this view to such an extent.

On the other hand, the CS agreed more than the other stakeholders that materials (agendas and minutes) for the meetings were prepared adequately and in advance HS; that notification of meetings was timely and location of meetings was convenient; and that partners had a good record of attendance at the meetings.

2. Community Representation

The four comparison groups agreed regarding the average representativeness of their CPs of the various stakeholders in their area, where M for the whole sample = 4.78 [Table (5) & Figure (29)] .

Under-representation of Stakeholder Groups

Table (5) and Figure (21) summarise the percentages of groups reporting on stakeholders that needed more representation in their CPs. Further inquiry into other stakeholders that the groups felt were not well represented in their CPs revealed the following:

Areas of agreement

When further asking the sample about which stakeholders they viewed to be under-represented in their CPs, the percentages of respondents from each of the comparison groups did not differ as regards about 70 % of the statements. Circa 10-20 % of each group viewed that the following stakeholders could benefit from more representation on the CPs: specific workgroups; rural population; community based organisations; worksites/ businesses; medical community; the elderly; the media; schools (teachers, students); and the youth.

Areas of disagreement

The groups however expressed significant differences as regards the representation of several other stakeholders. More CM, than the other stakeholders, viewed that the low income/ unemployed and families were under-represented. About 45 % of CM perceived that the low income/ unemployed could benefit from more representation, while about 20 % perceived that families needed to be more represented. On the other hand, more academic staff than the other partners reported that policy makers were under-represented. About 30 % of AI viewed that their CPs could benefit from more representation of policy makers. In parallel, more CS respondents perceived that voluntary agencies were underrepresented. About 25 % of CS felt that voluntary agencies needed to be more represented.

The findings suggested that each of the stakeholders was relatively more concerned about certain underrepresented sectors. While CM were concerned about the unemployed and families, the AI wanted more of the influential policy makers to help support and exert leverage to the decisions that were being made. Similarly, the CS were more concerned about coverage and spread, articulated as the need for the inclusion of more voluntary agencies.

Table (4). Stakeholder Groups' views of on their Management Capabilities at the Partnership meetings

Variable	AI	HS	CM	CS	F Prob.
1. Meetings start and stop on time	3.65	3.81	4.53 4.53 4.53	3.44	0.0000*
2. Purpose of each task or agenda item is defined and kept in mind	4.62	(5.12)	5.33	(4.94)	0.0006*
3. Technical terms are clear and understood by all	4.66				NS
4. Routine matters are handled quickly	4.41				NS
5. Sub-committee and / or other reports are routinely made to the entire Partnership	4.1	(4.31)	4.80	(4.38)	0.0004*
6. Materials for meetings are prepared adequately and in advance of meetings (agendas, minutes)	4.50 4.50	(5.04)	5.24	5.25	0.0027*
7. Minutes accurately reflect the proceedings of the meetings	5.25	(5.55)	5.86	(5.65)	0.0018*
8. Notification of meetings is timely	4.51	(4.74)	(5.02)	5.28	0.023*
9. Members have a good record of attendance at meetings	(4.57)	4.22	(4.81)	4.88	0.01*
10. Everyone participates in discussions	4.53				NS
11. Members stay with the subject being discussed	4.39	(4.77)	5.14 5.14	4.51	0.0000*
12. Interest is generally high	5.32				NS
13. Members well-informed and understand what is going on at all times	4.61				NS
14. Meetings have free discussion	5.7				NS
15. Meetings run smoothly, without interruptions or blocking	5.05				NS
16. The atmosphere is friendly, co-operative, and pleasant	(5.27)	(5.36)	5.46	4.85	0.06*
17. There is no fighting for status or hidden agendas	4.49				NS
18. Partnership members feel safe in speaking out	5.22				NS
19. The Partnership uses the resources of all, not just a few	4.67				NS
20. Meeting times are convenient	4.96				NS
21. Location of meetings is convenient	(5.19)	4.94 4.94	5.57	5.71	0.001*
22. I am clear about my role as P'ship member	(5.03)	4.71	5.42	(5.20)	0.003*

* Significant

Table (5). Stakeholder Groups' views of on Community Representation in their Partnerships

Mean scores of groups

Variable	AI	HS	CM	CS	F Prob.
How representative is your partnership of the intended beneficiaries?	4.78				NS

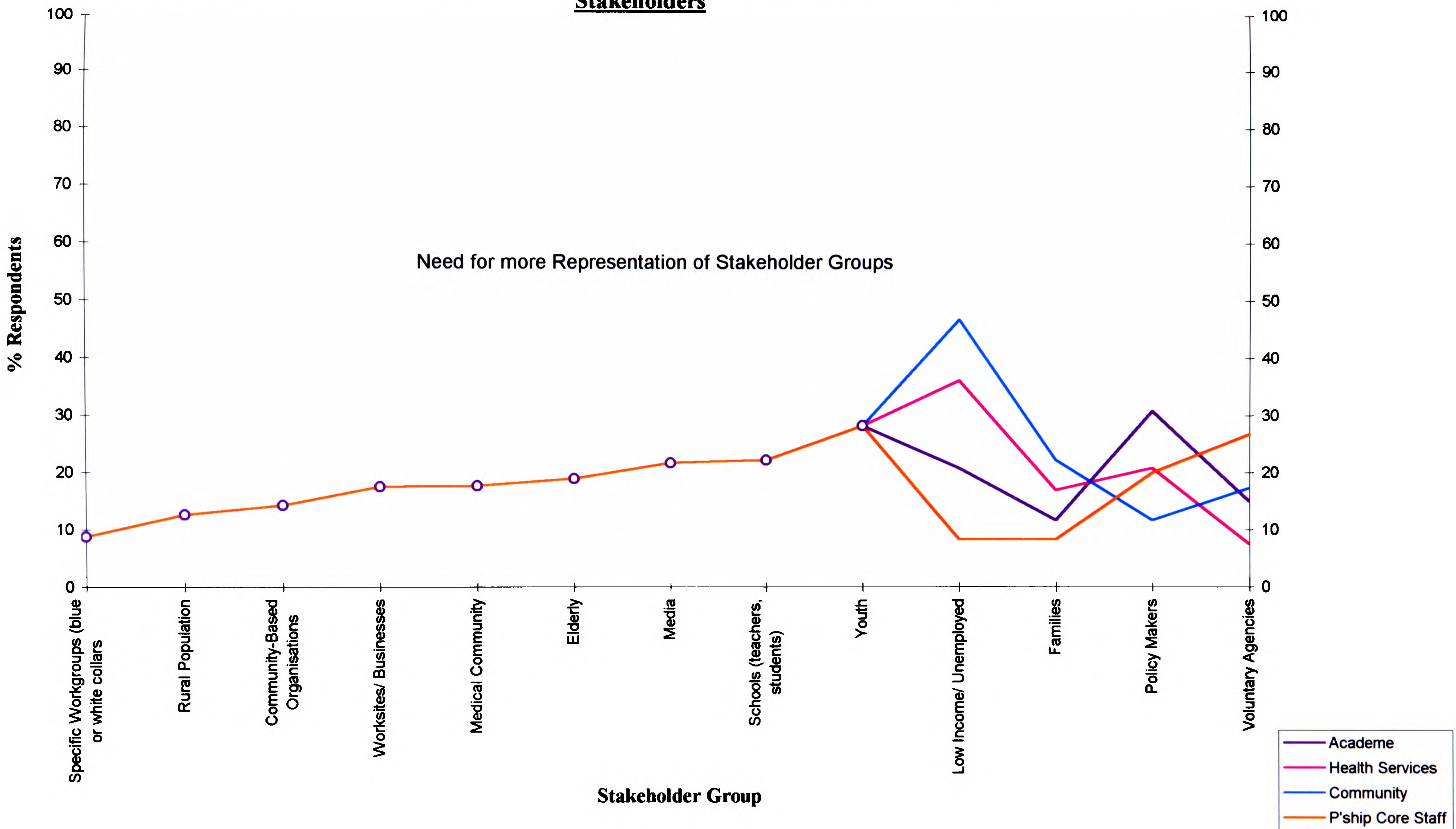
Percentages of comparison groups reporting that stakeholder is not well represented

Variable	AI	HS	CM	CS	*P* Value
1. Specific workgroups	8.7				(NS)
2. Rural population	12.6				(NS)
3. Community based organisations	14.3				(NS)
4. Worksites/busioneses	17.6				(NS)
5. Medical Community	17.7				(NS)
6. Elderly	19.0				(NS)
7. Media	21.8				(NS)
8. Schools (teachers, students)	22.3				(NS)
9. Youth	28.3				(NS)
10. Low income/ Unemployed	20.8	36.2	46.9	18.3	0.00000*
11. Families	11.7	17.0	22.3	8.3	0.009*
12. Policy Makers	30.8	20.8	11.7	20.0	0.00002*
13. Voluntary agencies	15.0	7.5	17.3	26.7	0.01*

* Significant

Figure (20). Areas of Agreement & Disagreement: Participant Groups' Mean Scores By Section of Questionnaire

Figure (21). Percentages of Participant Groups Reporting Need For More Representation Of Particular Stakeholders



3. Communication

Communication in the CPs was further divided into two categories: quality of communication between the PS and CM, and quality of communication between CM. Each is reported separately [Table (6) & Figure (22)].

3a. Professional staff- community member communication

The four comparison groups agreed as regards the qualities of communication between the PS and the CM. On seven point scales they reported above average qualities of communication between the PS and CM in their CPs (*M* for the whole sample ranging between 4.32 and 4.81).

3b. Community members communication

Areas of agreement

The participants had similar views about several of the qualities of the communication between the community members. The groups reported an above average agreement that the community members' communication is fairly good and frequent (*M* for the whole sample ranging between 4.72 and 4.73).

Areas of disagreement

The groups differed several aspects regarding the communication between the CM. The CM agreed more that communication between the community members themselves in the CPs was informative, comfortable and effective in transmitting information.

The findings suggested that in general, the stakeholders were more satisfied with the communication between the professionals and the community than they were with the communication between and within the CM. The HS in particular viewed the community members' communication poorly.

4. Flow of Information

Table (7) and Figure (22) summarise the following findings:

Areas of agreement

The respondents had similar views about three aspects connected with the flow of information in their CPs. The groups displayed a borderline agreement that far too little information on important topics was shared among the partners ($M = 4.13$), but indicated more agreement that the information they received about the CPs was accurate and relevant to their needs (*M* ranging between 4.87 and 4.91).

Areas of disagreement

Discrepancies in the groups' opinions were also revealed regarding two aspects of flow of information. The CS agreed more than the other stakeholders that they received timely information about the CPs that gave them a clear understanding of the CPs. These findings need to be viewed in the light that the CS were full time employees in the CPs under investigation. They were stationed at the projects and ran the various programmes and educational activities of the CPs. This placed them in both a strategic as well as a pivotal position when it came to flow of information.

Table (6). Stakeholder Groups' views on Communication in their Partnerships

Professional Staff- Community Member communication

Variable	AI	HS	CM	CS	F Prob.
1. poor/ good	4.45				NS
2. infrequent/ frequent	4.32				NS
3. uninformative/ informative	4.64				NS
4. uncomfortable/ comfortable	4.76				NS
5. ineffective/ effective	4.68				NS

* Significant

Community Members communication

Variable	AI	HS	CM	CS	F Prob.
1. poor/ good	4.73				NS
2. infrequent/ frequent	4.72				NS
3. uninformative/ informative	(4.68)	4.10	4.95	(4.57)	0.0002*
4. uncomfortable/ comfortable	5.00	4.28 4.28	5.08	(4.69)	0.0006*
5. ineffective/ effective	(4.55)	4.28	5.06	(4.67)	0.0006*

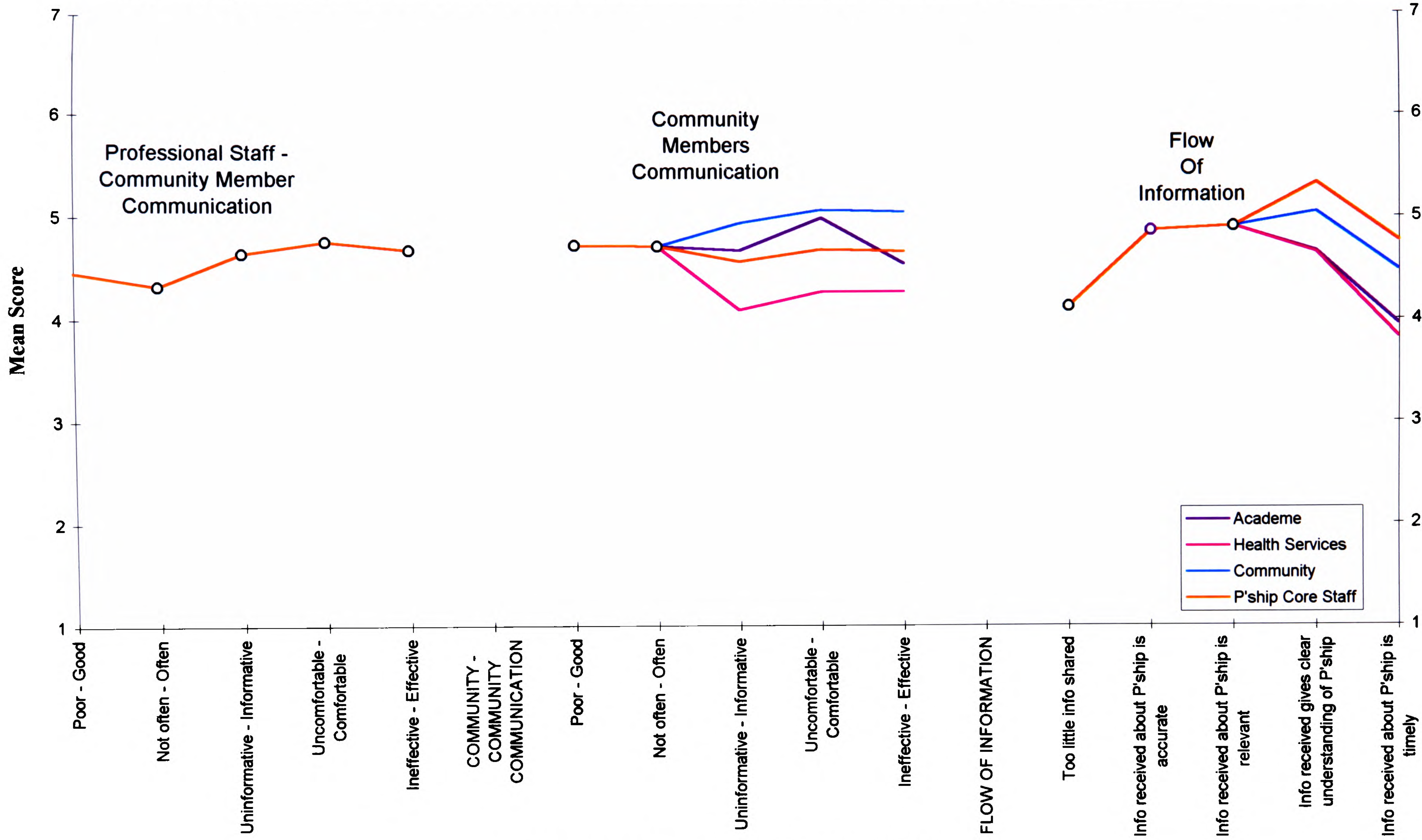
* Significant

Table (7). Stakeholder Groups' views of on Flow of Information in their Partnerships

Variable	AI	HS	CM	CS	F Prob.
1. Far too little information on important topics is shared among the partners	4.13				NS
2. The information I receive about the Partnership gives me a clear understanding of the Partnership	4.66	4.65	(5.05)	5.33 5.33	0.02*
3. The information I receive about the Partnership is accurate	4.87				NS
4. I receive information about the Partnership in a timely fashion	3.95	3.82	(4.48)	4.76 4.76	0.0006*
5. The information I receive about the Partnership is relevant to my needs	4.91				NS

* Significant

Figure (22). Areas of Agreement & Disagreement: Participant Groups' Mean Scores By Section of Questionnaire



5. Contributions to the Partnership

Table (8) and Figures (23 - 24) summarise the following:

The groups disagreed on all aspects of their contributions to their CPs. For many of the statements in general, the CS agreed more than the HS about the different contributions, with the levels of agreement of the other two groups in between.

The CS reported that they devoted more contribution of their time, more contributions of in-kind resources such as publicity, printing, equipment, facilities, etc. as well as more facilitation of access to special populations. Although the stakeholders collectively reported that their contributions of money to support joint activities of the CPs were quite low, the CS reported significantly more contribution. This reflected the availability of in-kind resources that were acessible to them for use in the CPs, as well as the occassional monetary contributions when needed.

6. Partnership's Educational Activities

Table (9) and Figure (23) summarise that the groups disagreed on the three aspects of the educational activities of their CPs. For the statements in general, the CS scores were significantly more than the HS, with the levels of agreement of the other two groups lying in between. The CS reported their CPs engaged in educational activities more than the levels reported by the HS. When asked to refer to specific CPs educational activities that the respondents were free to choose and focus upon, the CS were the highest in reporting the partners to be more involved and their educational acvities more effective.

In order to link the contributions and the educational activities, the respondents were asked about the type of contributions that they undertook at their CPs' educational activities. Figure (24) suggested that for the whole sample in general, there seemed to be a downhill gradient when the various contributions were examined, where about 55 - 75 % of the respondents reported the contribution of planning and organization. The percentages of participants then decreases as the contributions moved from speaking or presenting at CPs activities or staffing their events to the contribution of being responsible for the media or the marketing of the events, seminars and activities.

Table (8). Stakeholder Groups' views on Contributions to their Partnerships

Variable	AI	HS	CM	CS	F Prob.
1. Time of yourself and of others	5.05	4.45 4.45	5.33	5.80 5.80	0.0000*
2. Money to support joint activities	2.58	2.29	(2.91)	3.62 3.62	0.0008*
3.In - kind resources such as publicity, printing, equipment, facilities, etc.	(3.93)	3.38	3.16	4.65 4.65	0.0000*
4. Facilitate access to special populations	3.82	3.90	(4.02)	4.67 4.67	0.09*

* Significant

Table (9). Stakeholder Groups' views on Educational Activities in their Partnerships

Variable	AI	HS	CM	CS	F Prob.
1. How much has the Partnership engaged in educational activities?	(5.39)	5.20	(5.32)	5.77	0.12*
To what extent 2. were Partnership members involved in the action?	(5.56)	5.39	5.33	5.96 5.96	0.02*
3. were Partnership members effective in their work?	(5.38)	5.22	(5.40)	5.77	0.14*

* Significant

Figure (23). **Areas of Disagreement: Participant Groups' Mean Scores By Section of Questionnaire**

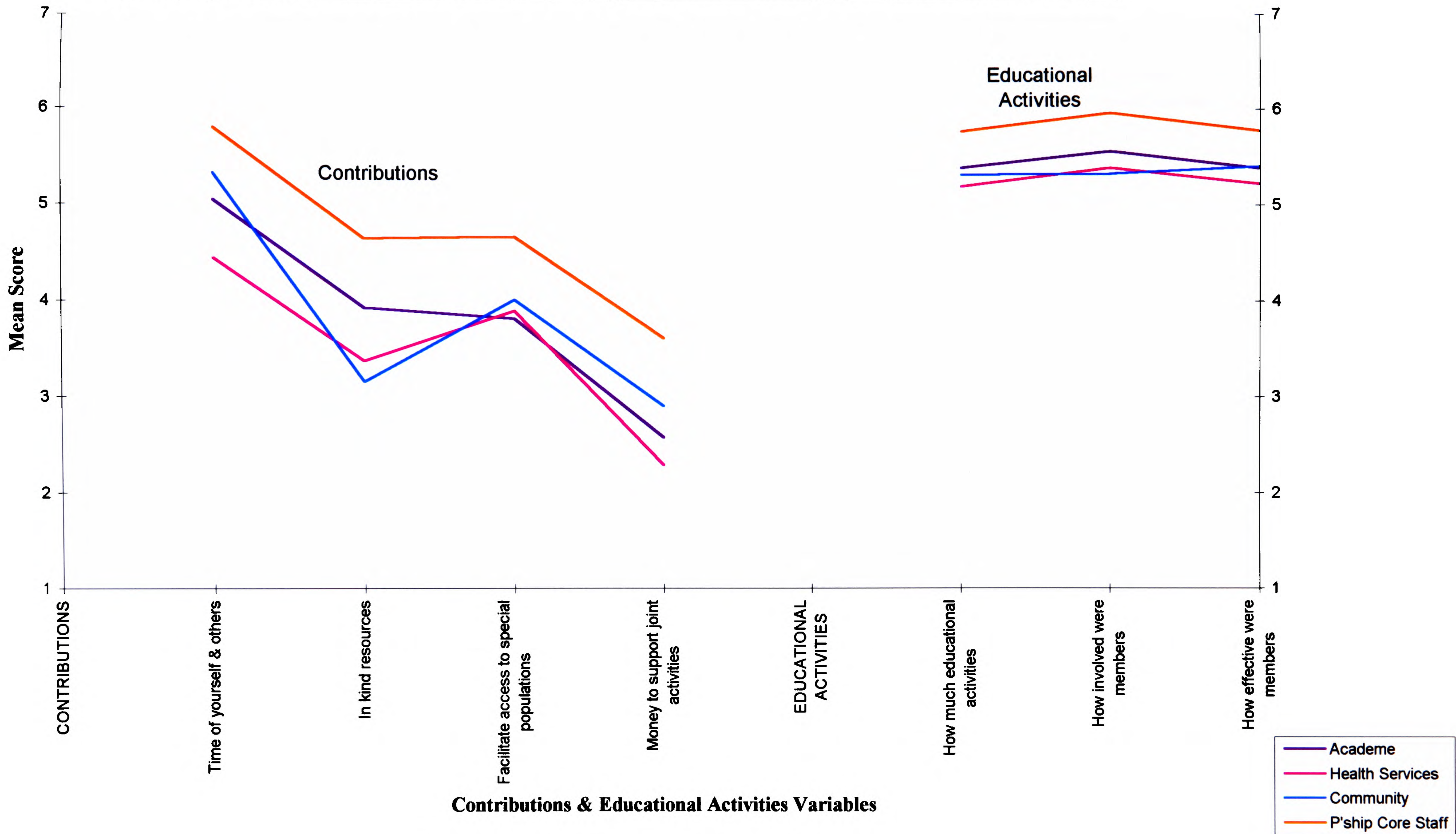
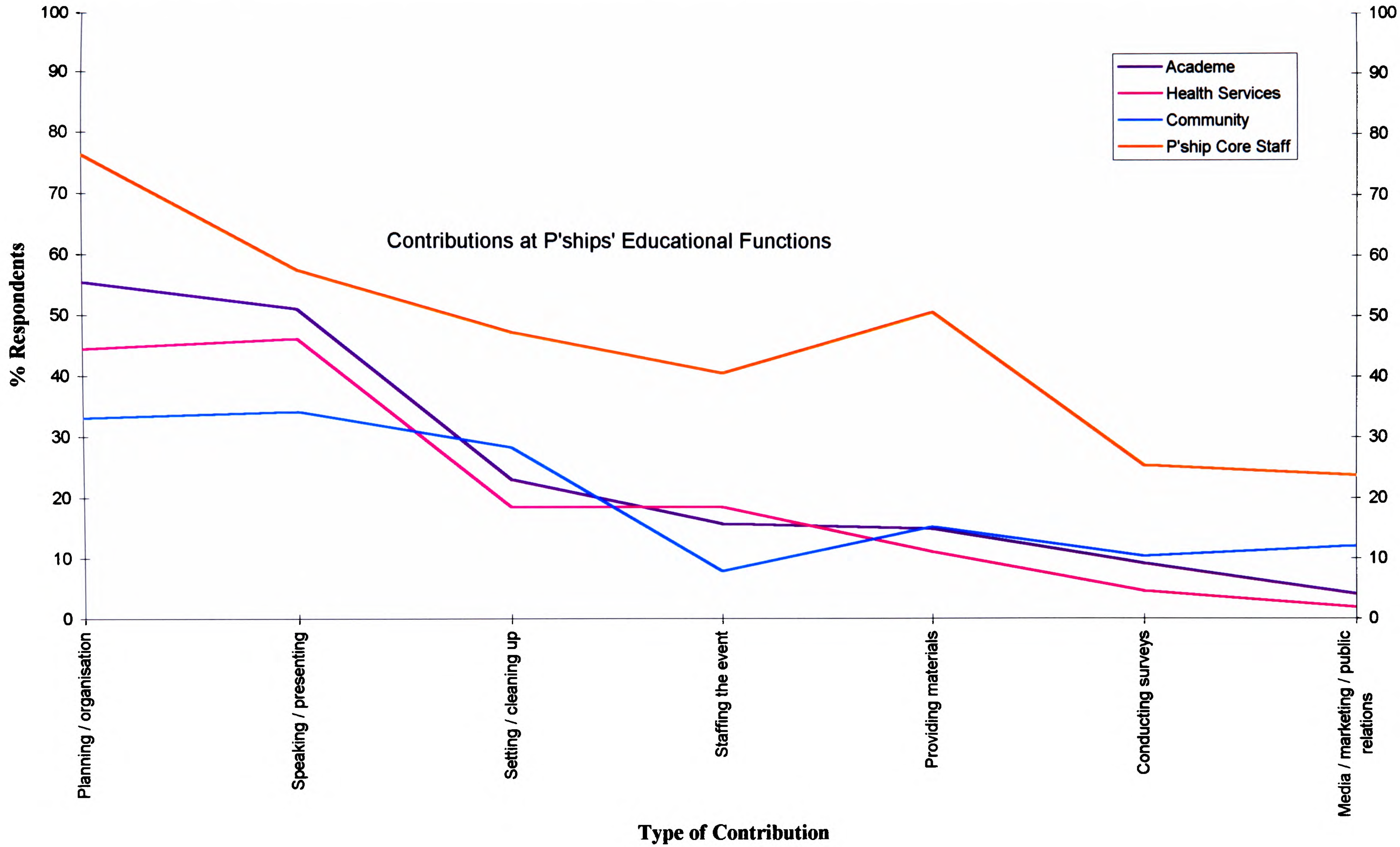


Figure (24). Percentages of Participant Groups reporting Contributions at P'ships' Educational Functions



7. Benefits of Participation

Table (10) and Figure (25) suggest that the groups disagreed on all the aspects regarding the benefits of their participation in their CPs. For most of the statements in general, the CS reported the highest benefits, with the responses of the CM following closely.

The CS viewed the benefits of getting to know other agencies and their staff, of developing collaborative relationships with other agencies and of getting help from or helping other organizations significantly more than the other three comparison groups. Similarly, as regards the benefits of gaining recognition and respect from others, learning about community events, and having access to target populations with whom they previously had little contact, again the CS reported significantly higher scores. Finally, as regards the benefit of building their organization's capacity, helping their organizations get funding, and building their own skills in partnership work, the CS reported significantly higher scores than both the AI and HS who valued this benefit less.

However, when it came to the benefits of making their community a better place to live in and helping their organizations move towards their goals, the CM scored the highest, which was significantly higher than the AI. The responses of the other two groups lied in between.

What became apparent from the findings was the clustering of the opinions of CS and CM on the CPs' benefits towards the higher end of the scale. On the other hand, the HS and AI views of the benefits seemed to cluster towards the lower end of the scale. The implication is that each of the stakeholder groups not only viewed the benefits of the CP differently, but also valued the relative benefits in a different way.

8. Costs of Participation

Table (11) and Figure (25) suggest that:

Areas of agreement

The participants had similar views on several of the costs of their participation in their CPs. The groups slightly disagreed to three statements that the CPs activities did not effectively reach their primary constituencies (intended beneficiaries); that their organizations did not get enough public recognition for

their work on the CPs; and that their skills and time were not well-used (*M* for the whole sample ranging between 3.62 and 3.85).

Areas of disagreement

The CS followed by the HS disagreed the most in relation to that the time spent on the CPs kept them from doing their work which, in the case of the CS, actually was the administration of the Partnerships. However, the AI and CM also disagreed, albeit to a lesser degree, that CPs activities kept them from doing their work. When asked if being involved in implementing the CP's activities was a problem, all the stakeholders disagreed, but again the CS disagreed the most.

As regards the costs, the impression was that for the three costs - the CPs activities not effectively reaching their constituencies; their organizations did not get enough public recognition for their work on the CP; and that their skills and time were not well used - the groups' responses were higher (less disagreement with the statements) than with the costs of time and that being involved in implementing the CPs activities was a problem. The implication was that coverage and outreach, skills and recognition were viewed as more of a cost and concern for the groups than were the issues of time and involvement in their CPs.

Table (10). Stakeholder Groups' views on the Benefits of their Partnerships

Variable	AI	HS	CM	CS	F Prob.
1. Getting to know other agencies and their staff	4.89	4.88	5.01	5.81 5.81 5.81	0.0059*
2. Gaining recognition and respect from others	4.86	(5.01)	(5.39)	5.51	0.0055*
3. Developing collaborative relationships with other agencies	4.75	5.08	5.18	5.81 5.81 5.81	0.0014*
4. Getting help from or helping other organizations	4.33 4.33	4.42	5.02 5.02	5.68 5.68 5.68	0.0000*
5. Making our community a better place to live in	5.03	(5.1)	5.81	(5.48)	0.0000*
6. Helping my organization move towards our goals	5.15	5.18	5.79 5.79	5.71 5.71	0.0000*
7. Learning about community events, services, etc	4.96 4.96	5.34	5.75	5.95 5.95	0.0000*
8. Having access to target populations with whom we've previously had little contact	(5.15)	4.80	(5.20)	5.55	0.05*
9. Building my organization's capacity	4.72 4.72	4.62 4.62	5.44 5.44	5.59 5.59	0.0000*
10. Helping my organization get funding	3.85 3.85	3.81 3.81	4.69 4.69	4.73 4.73	0.0001*
11. Building my own skills in partnership work	5.00	4.90	5.20	5.96 5.96 5.96	0.0022*

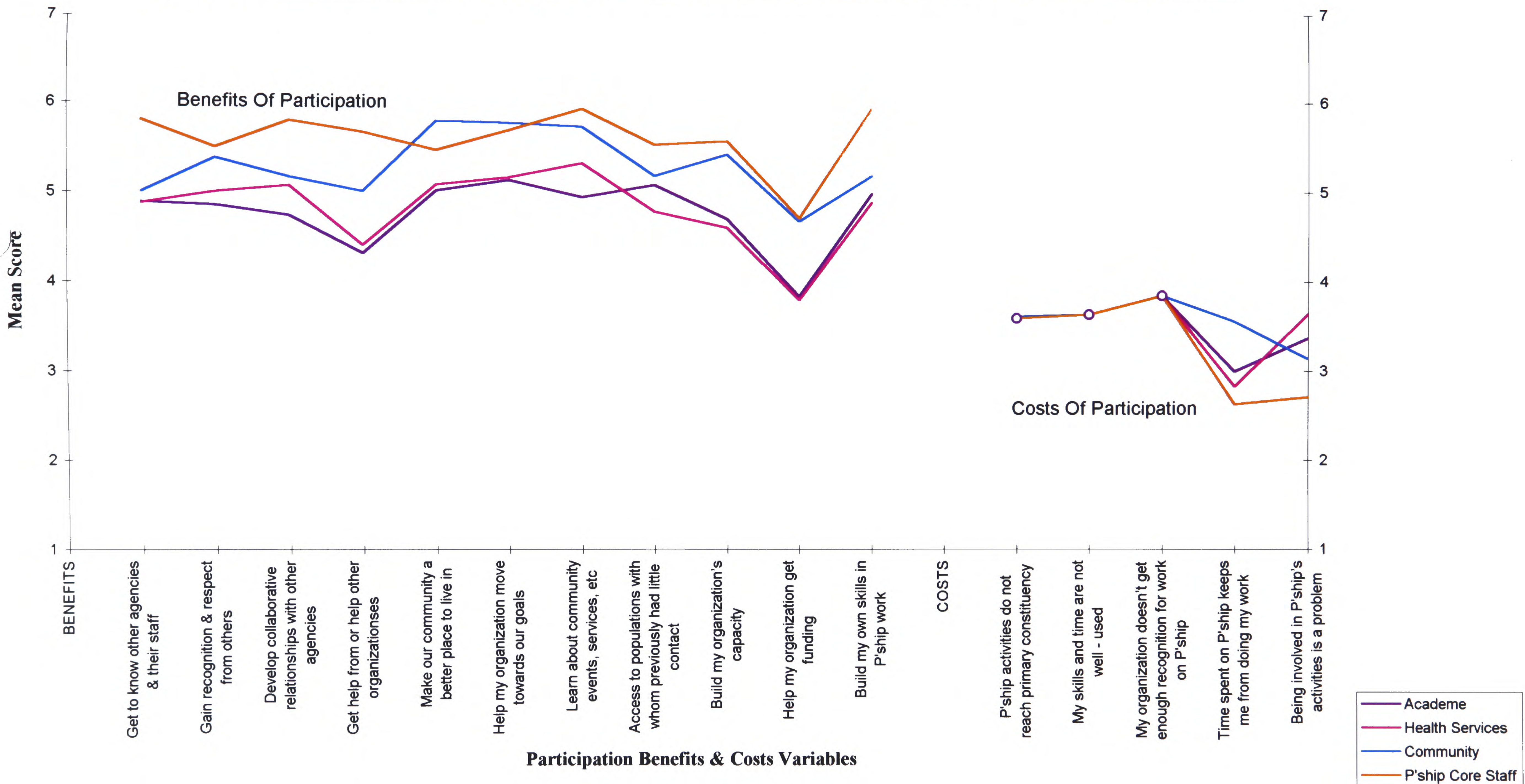
* Significant

Table (11). Stakeholder Groups' views on the Costs of their Partnerships

Variable	AI	HS	CM	CS	F Prob.
1. Partnership activities do not effectively reach intendend beneficiaries)	3.62				NS
2. Time spent on the Partnership keeps me from doing my work	(3.00)	2.83	3.56 3.56	2.63	0.0002*
3. My organization doesn't get enough public recognition for our work on the Partnership	3.85				NS
4. Being involved in implementing the Partnership's activities is a problem	(3.37)	3.64	(3.14)	2.71	0.01*
5. My skills and time are not well - used	3.64				NS

* Significant

Figure (25). Areas of Agreement & Disagreement: Participant Groups' Mean Scores By Section of Questionnaire



9. Satisfaction with the Partnership

Table (12) and Figure (26) summarize the findings:

Areas of agreement

The participants had similar views on several aspects relating to their satisfaction with their CPs. Although the groups agreed that their CPs were worthwhile efforts (*M* for the whole sample = 5.5), they agreed slightly less that the work accomplished by the CPs has met their expectations or that they were satisfied with what was accomplished by their CPs (*M* for the whole sample ranged between 4.5 to 4.6).

Areas of disagreement

When asked if they would not like to change anything about the CPs, the CM were the only group who agreed with the statement indicating some satisfaction (*M* = 4.43). The other three groups disagreed with the statement. As regards satisfaction with how the CPs operated, again the CM were the only group who indicated some satisfaction (*M* = 4.76), significantly disagreeing with the other three groups. The AI and CS groups reported dissatisfaction, while the HS was border line (*M* = 4.02).

The findings suggested that in general, the CM were the stakeholders most satisfied with their CPs. For the CM, their scores to the five statements were all above the score of 4 on a seven point scale, indicating agreement with the statements. For the other stakeholders, the responses suggested that they would like to change some aspects and were not totally satisfied with how their CPs operated.

10. Sense of Ownership

Table (13) and Figure (26) summarize the data:

Areas of agreement

The respondents had similar views with regards if they felt that they had a voice in what their CPs decided, where the stakeholders reported that the do have a voice (*M* for whole sample = 4.48).

Areas of disagreement

On the other hand, when asked if they were committed to the work of their CPs, the CS reported the highest commitment and felt a higher sense of pride in what their CPs had accomplished, which was significantly higher than the other stakeholders. Conversely, it was the CM who reported that they really cared about the future of their CPs significantly more than the other groups.

11. Commitment to the Partnership

Table (14) and Figure (26) suggest the following:

Areas of agreement

The participants had similar views on the extent that their organizations participated in CP sponsored activities. (*M* for whole sample = 5.24).

Areas of disagreement

However, the CS reported the highest commitment levels when respondents were asked to what extent their organizations had endorsed or adopted the mission and goals of the CPs. The HS commitment level was the lowest. The same was true as regards the extent to which their organizations had publicly endorsed or co-sponsored CPs activities, where again the CS reported the highest levels and the HS the lowest.

On the other hand, when respondents were queried about if the community viewed their CPs as a resource for influencing health personnel education, the CM reported the highest level while the AI reported the lowest.

The impression was that all the stakeholder groups and their organisations participated in CP activities to some extent. However, for the CS who comprised the 'driving engine' of the CPs, it might be expected that they would have fully endorsed or adopted the mission and goals of the CPs and publicly endorsed or cosponsored CP activities. When it came to valuing the partnership, it was the community who valued more their Partnerships as a resource and change agent to influence HPE.

Table (12). Stakeholder Groups' views on their Satisfaction with their Partnerships

Variable	AI	HS	CM	CS	F Prob.
1. I would not like to change anything about the Partnership	3.29	(3.78)	4.43 4.43	3.13	0.0000*
2. I am satisfied with how the Partnership operates	3.89	4.02	4.76 4.76 4.76	3.71	0.0000*
3. This Partnership is a worthwhile effort	5.53				NS
4. The work accomplished by the Partnership has met my expectations	4.58				NS
5. I am satisfied with what is accomplished by the Partnership	4.68 (4.42)	(4.41)	(4.91)	(4.30)	NS

* Significant

Table (13). Stakeholder Groups' views on Sense of Ownership in their Partnerships

Variable	AI	HS	CM	CS	F Prob.
1. I am committed to the work of the Partnership	5.27	4.72 4.72	5.53	5.95 5.95	0.0000*
2. I feel that I have a voice in what the Partnership decides	4.48				NS
3. I feel a sense of pride in what the Partnership accomplishes	(5.07)	4.73	(5.32)	5.40	0.01*
4. I really care about the future of this Partnership	5.93	5.85	6.40 6.40	(6.11)	0.0000*

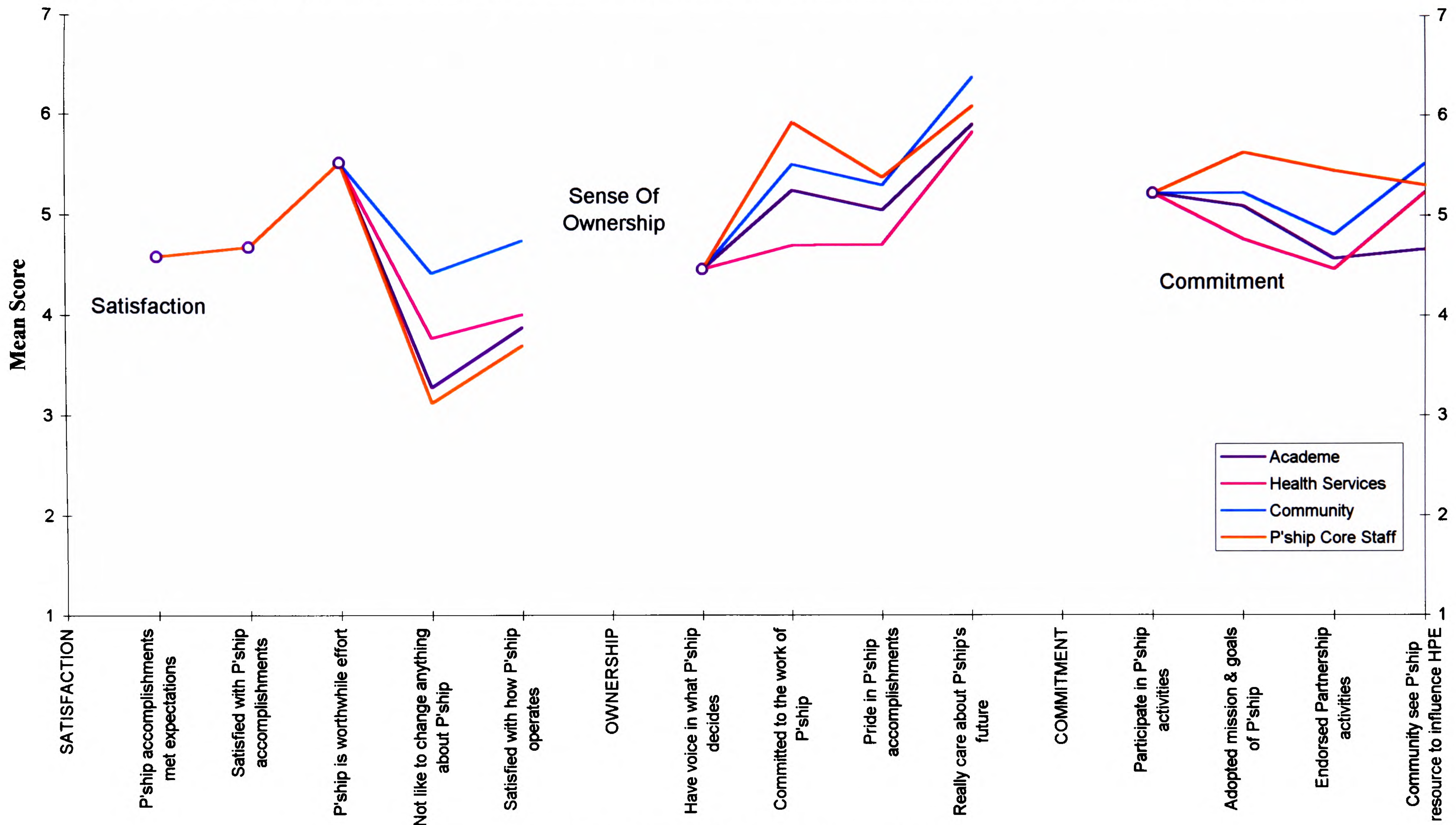
* Significant

Table (14). Stakeholder Groups' views on their Commitment to their Partnerships

Variable	AI	HS	CM	CS	F Prob.
To what extent 1. Has your organization endorsed or adopted the mission and goals of the Partnership?	(5.10)	4.77	(5.24)	5.64	0.02*
2. Does your organization participate in Partnership sponsored activities?	(5.32)	5.02	(5.19)	5.81	0.05
3. has your organization publicly endorsed or cosponsored Partnership activities?	4.57	4.47	(4.81)	5.45 5.45	0.03*
4. Does the community see the Partnership as a resource for influencing health personnel education?	4.66 4.66	(5.23)	5.52	5.30	0.0001*

* Significant

Figure (26). Areas of Agreement & Disagreement: Participant Groups' Mean Scores By Section of Questionnaire



12. Levels of Expertise

12a. Professional Staff Expertise

Table (15) and Figure (27) summarise the data:

Areas of agreement

The participants had similar views with regards multiple aspects pertaining to the skills of the PS in their CPs. The groups favourably agreed on 90 % of the questions asked about the abilities of the stakeholders in relation to three broad areas: community involvement skills; change agents skills; and, educational skills and an assorted CPs fostering skills as well as strategic and management abilities (*M* for whole sample ranged between 4.69 and 5.41).

As regards the set of skills required in working with communities, the groups agreed on the above average abilities of the professionals in reaching target populations, community organising and working with community groups. With the second area of skills relating to implementing change, again the groups agreed on the professionals' above average abilities in bringing about change in both the community and the academic institutions, although the groups reported higher professional abilities in bringing about change in the latter. Relating to the third area of assorted expertise, the groups similarly expressed agreement on the above average abilities of the professionals in HPE policy and planning, management of the budgets and generally maintaining effective and active CPs.

Areas of disagreement

The only area of expertise where the groups differed in their ratings of their abilities of the professionals was in their ability to bring about change in the HS or department, where the CM viewed and rated the professional staffs' abilities in this domain the highest whereas the AI viewed it the lowest.

12b. Community Members Expertise

Table (16) and Figure (28) summarise the data:

Areas of agreement

The only area of expertise where the groups agreed in their ratings of the abilities of the CM were in their ability to bring about change in the community, where the groups agreed that the CM abilities in this domain was good ($M = 5.03$).

Areas of disagreement

The respondents expressed differences in their opinions with regards multiple aspects pertaining to the skills of the CM in their CPs. The groups significantly differed on 90 % of the questions asked about the three domain areas of expertise.

As regards the first domain of skills required in working with communities, the groups differed about the CM abilities in community organising, working with community groups and reaching target populations, where the CS and CM groups viewed and rated the CM abilities in this domain the highest, whereas the HS viewed it the lowest. Furthermore, there was a tendency for the groups to view the CM abilities in reaching target populations less than the former two.

With the second area of skills relating to implementing change, again the groups differed on the CM abilities in bringing about change in both the AI and the HS or department, where the CM group viewed and rated their abilities in this domain the highest, whereas the AI viewed it the lowest. Furthermore, there was a tendency for the groups to view the CM abilities in changing the AI less than their abilities in changing the HS.

Relating to the third area of assorted expertise, the groups similarly differed on the CM abilities in HPE policy and planning, management of the budgets and generally maintaining an effective and active CP. The CM viewed their abilities in these areas the highest. The AI on the other hand rated the CM expertise in HPE policy and planning as well as their educational skills the lowest, whereas with budget management it was the HS who viewed the CM abilities the least. Furthermore, in relation to this group of assorted skills and especially with HPE policy and budget management all three groups, the AI, HS and CS rated the CM abilities less than average.

The evidence suggested that the stakeholders agreed about and appreciated the expertise and abilities that the professional staff bring to the CPs. The groups had a positive view of the professionals' skills, in particular their abilities as resource persons in the areas of introducing and managing change in the health department, policy formulation, implementing educational activities and planning in general. When it came to the expertise of the community, the professionals seemed to be somewhat cautious of the levels of skills and indigenous capacities of the communities that they were working with. The lack of full appreciation of community members skills by the professionals stretched across all the three domains of expertise that were tested. In some domains e.g. bringing about change in the academic institutions and in

HPE policy, as well as budget management, the CM abilities were seen to be below average (less than 4 on a seven point scale. The general observation was the overrating of the PS by the CM when asked about the professionals abilities, and the persistent underrating of the CM by the PS when queried about the community's skills and expertise.

Table (15). Stakeholder Groups' views on Professional Staff Expertise in their P'ships

Variable	AI	HS	CM	CS	F Prob.
1. Designing/ implementing educational activities	5.31				NS
2. Maintaining an effective and active Partnership	5.02				NS
3. Working with community groups	5.03				NS
4. Community organizing	4.7				NS
5. Planning	5.41				NS
6. How to bring about change in the community	4.81				NS
7. How to bring about change in the teaching institutions	5.21				NS
8. How to bring about change in the health department	4.67 4.67	 (5.02)	5.54	 5.27	0.0000*
9. Health personnel education policy	5.21				NS
10. Budget management	5.1				NS
11. Reaching target populations	4.69				NS

* Significant

Table (16). Stakeholder Groups' views on Community Members Expertise in the P'ships

Variable	AI	HS	CM	CS	F Prob.
1. Designing/ implementing educational activities	3.75	 (4.10)	4.68 4.68	 4.03	0.0000*
2. Maintaining an effective and active Partnership	(4.73)	4.50	5.09	(4.88)	0.0055*
3. Working with community groups	5.42	 5.07 5.07	 5.60	5.94 5.94	0.0008*
4. Community organizing	 (5.24)	4.80 4.80	5.42	 5.76	0.0005*
5. Planning	4.09	 4.21	4.85 4.85	 (4.56)	0.0000*
6. How to bring about change in the community	5.03				NS
7. How to bring about change in the teaching institutions	3.36	 3.73	4.56 4.56 4.56	 3.77	0.0000*
8. How to bring about change in the health department	3.69	 4.01	4.78 4.78 4.78	 4.15	0.0000*
9. Health personnel education policy	3.21	 (3.77)	4.34 4.34	 3.54	0.0000*
10. Budget management	 (3.50)	3.30	4.10	 (3.57)	0.0001*
11. Reaching target populations	 (4.59)	4.37 4.37	5.01	 5.12	0.0015*

* Significant

Figure (27). **Areas of Agreement & Disagreement: Participant Groups' Mean Scores By Section of Questionnaire**

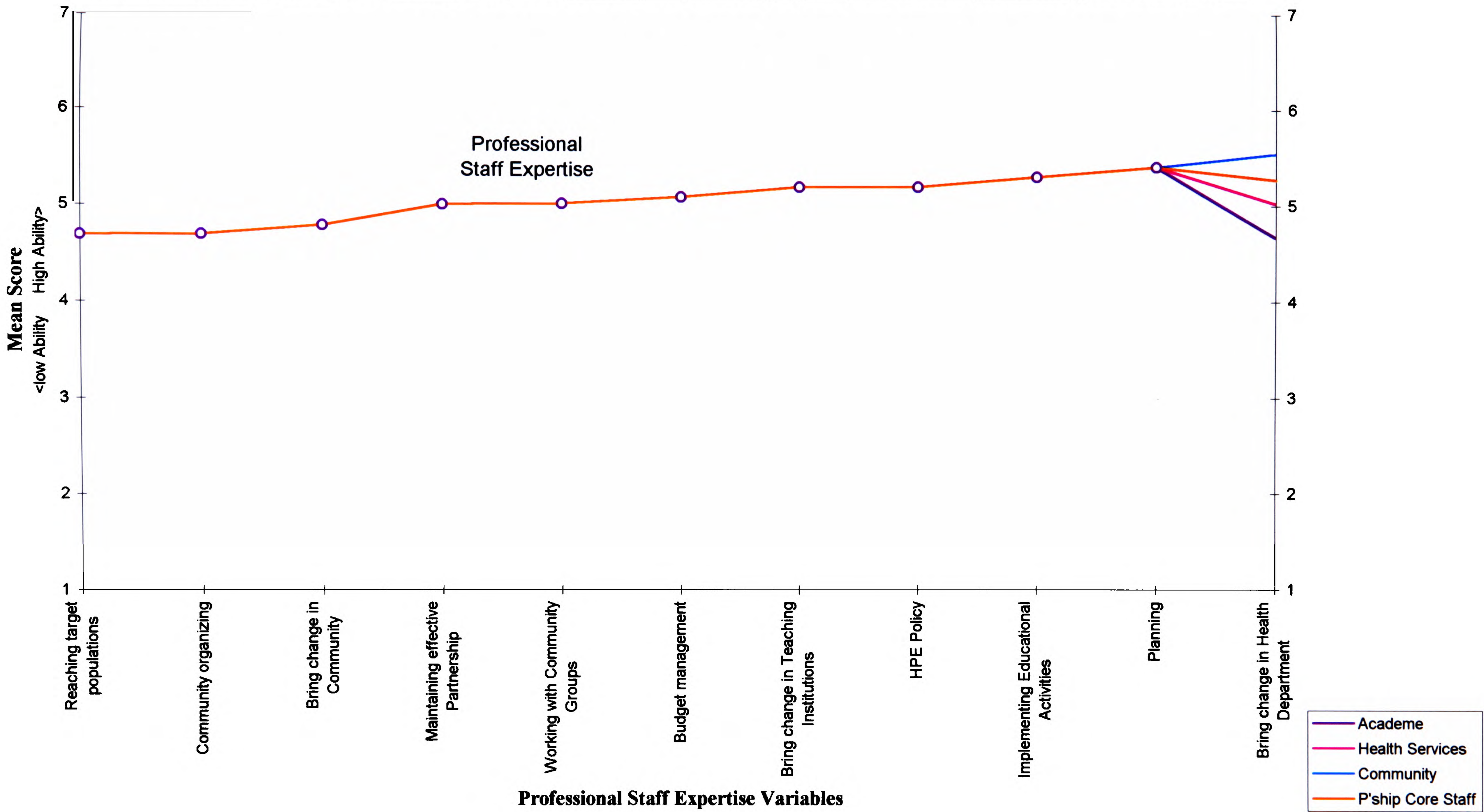
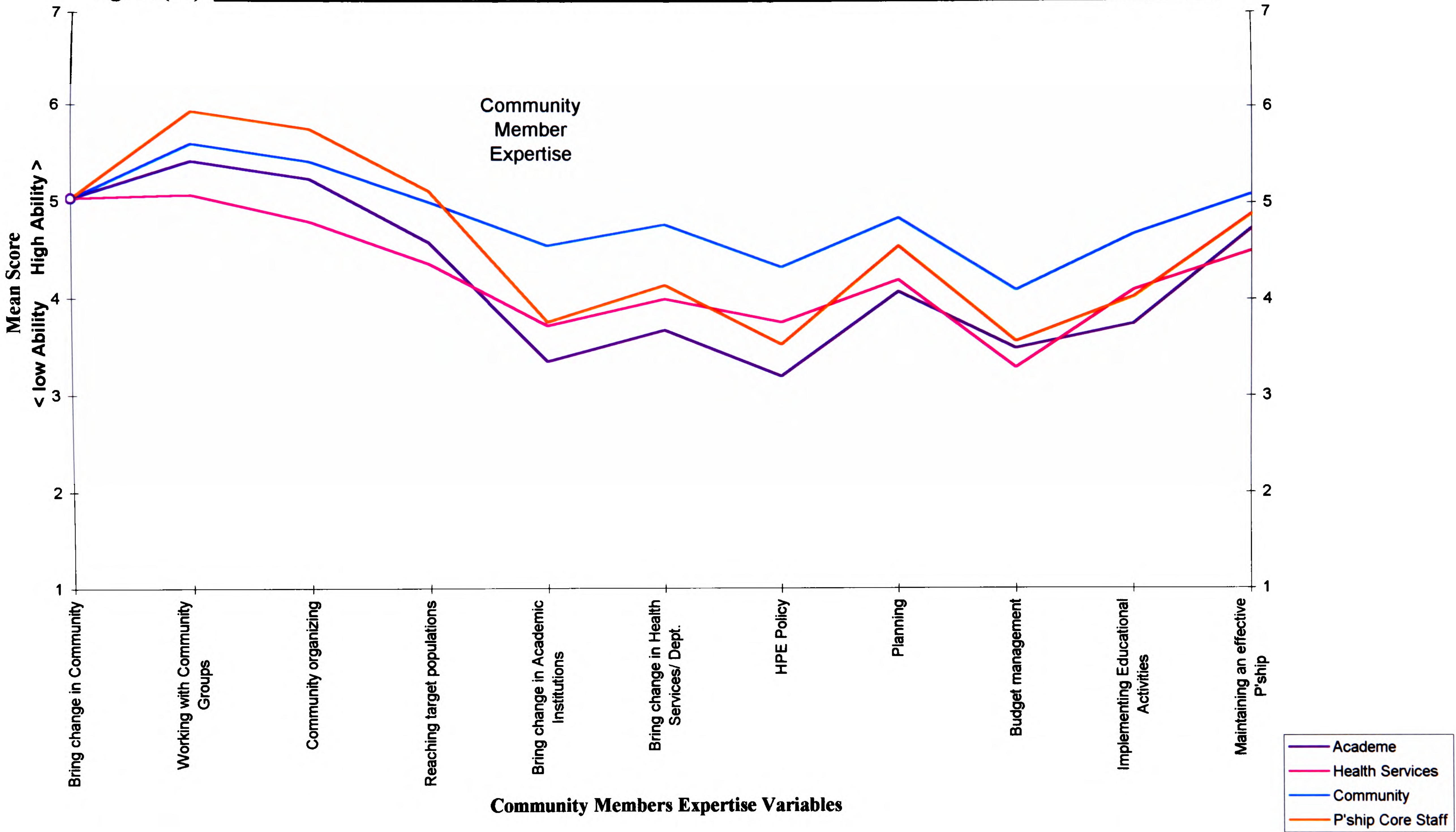


Figure (28). <u>Areas of Agreement & Disagreement: Participant Groups' Mean Scores By Section of Questionnaire</u>



13. **Resource Allocation Satisfaction**

Table (17) and Figure (29) indicate that the CS reported an above average satisfaction with the allocation of funds in their CPs. However, their levels of satisfaction were significantly higher than both the CM and HS whose satisfaction levels were below average. The level of resource allocation satisfaction of the AI lied in between.

14. **Partnership Interaction**

Table (18) and Figure (30) indicate that:

Areas of agreement

The participants had similar views with regards to several aspects pertaining to the interactions in their CPs. The stakeholders agreed that there were established ways to settle most differences that arise; that conflict was handled effectively; that the CP team was tolerant of differences or disagreements; and that the CPs professional staff encouraged participation in decision making (*M* for whole sample ranged between 4.52 and 4.84).

Areas of disagreement

However, significant discrepancies in the groups' opinions were also revealed regarding two aspects. When queried about if their CPs had a feeling of togetherness and teamwork, the CM agreed most, significantly more than both the HS and CS. The AI level of response was in between. When asked if the CPs professional staff were too controlling, again the CM agreed more than both the other groups. Only the AI disagreed to the statement indicating that they did not view the professional staff as too controlling.

The impression was that in an atmosphere of participative decision making, there was some degree of tolerance to conflicts that arose between the stakeholders. But as a team, the professionals were seen to be too controlling.

15. Decision Making

Table (19) and Figure (30) indicate that:

Areas of agreement

The respondents had similar views with regards to aspects connected with decision making processes in their CPs. The groups agreed that it was easy to get their ideas across to the CPs leadership if they had suggestions; that they felt they had many opportunities for participation in their CPs; and that participation in decision making by community representatives was high (*M* for whole sample ranged between 4.58 and 4.70). However, the groups agreed less that community representatives had a lot of influence in major decisions or that decisions were made only by a small group of leaders (*M* for whole sample ranged between 4.21 and 4.27).

Areas of disagreement

When queried about if participation in decision making by university representatives was high, the HS agreed most . Similarly, when reporting on the influence in major decisions, the HS indicated that the AI have a lot of influence in major decisions. The AI was the only group who indicated a border line disagreement to this statement.

When it came to if participation in decision making by HS representatives was high, the scores of the CM where highest indicating that they viewed the HS representatives participation in decision making to be high and that HS representatives had a lot of influence in major decisions.

The findings suggested that although the stakeholders agreed ($M = 4.21$) that decisions were made by a small group of leaders, there were opportunities for them to express concerns and it was easy to get their ideas across to the leadership. The CM seemed to have a high participation in decision making but a slightly less influence on the actual decisions that were taken. Generally, the AI were seen to have both high participation and influence on decisions. The HS participation and influence in decision making were perceived at a level higher than the CM, but less than the AI.

Table (17). Stakeholder Groups' views on Resource Allocation Satisfaction in P'ships

Variable	AI	HS	CM	CS	F Prob.
1. How satisfied are you with the allocation of funds in your Partnership?	(4.14)	3.66	3.68	4.43 4.43	0.003*

* Significant

Table (18). Stakeholder Groups' views on the Interaction in their Partnerships

Variable	AI	HS	CM	CS	F Prob.
1. There are established ways to settle most differences that arise in the Partnership	4.52				NS
2. Conflict is handled effectively in the Partnership	4.61				NS
3. The Partnership team is tolerant of differences or disagreements	4.84				NS
4. Partners of this project have a shared vision of what they would like to accomplish	5.26				NS
5. The Partnership has a feeling of togetherness and teamwork	(4.93)	4.80	5.47 5.47	4.74	0.0001*
6. The Partnership's professionals are too controlling	3.47 3.47	4.03	4.72 4.72	4.24	0.0000*
7. The Partnership's professionals encourages participation in decision making	4.81				NS

* Significant

Table (19). Stakeholder Groups' views on the Decision Making in their Partnerships

Variable	AI	HS	CM	CS	F Prob.
1. It is easy to get my ideas across to the project leadership if I have a suggestion	4.58				NS
2. I feel I have many opportunities for participation in the Partnership	4.94				NS
3. Participation in decision making by community representatives is high	4.70				NS
4. Participation in decision making by university representatives is high	4.71 4.71	5.50	(5.28)	5.32	0.002*
5. Participation in decision making by health services representatives is high	4.48 4.48	4.66	5.37 5.37	5.15	0.0000*
6. Decisions are made only by a small group of leaders	4.21				NS
7. University representatives have a lot of influence in major decisions	4.25 4.25	5.20	5.04	(4.77)	0.0002*
8. Community representatives have a lot of influence in major decisions	4.27				NS
9. Health services representatives have a lot of influence in major decisions	3.96	4.17	5.06 5.06 5.06	4.44	0.0000*

* Significant

Figure (29). **Areas of Agreement & Disagreement: Participant Groups' Mean Scores By Section of Questionnaire**

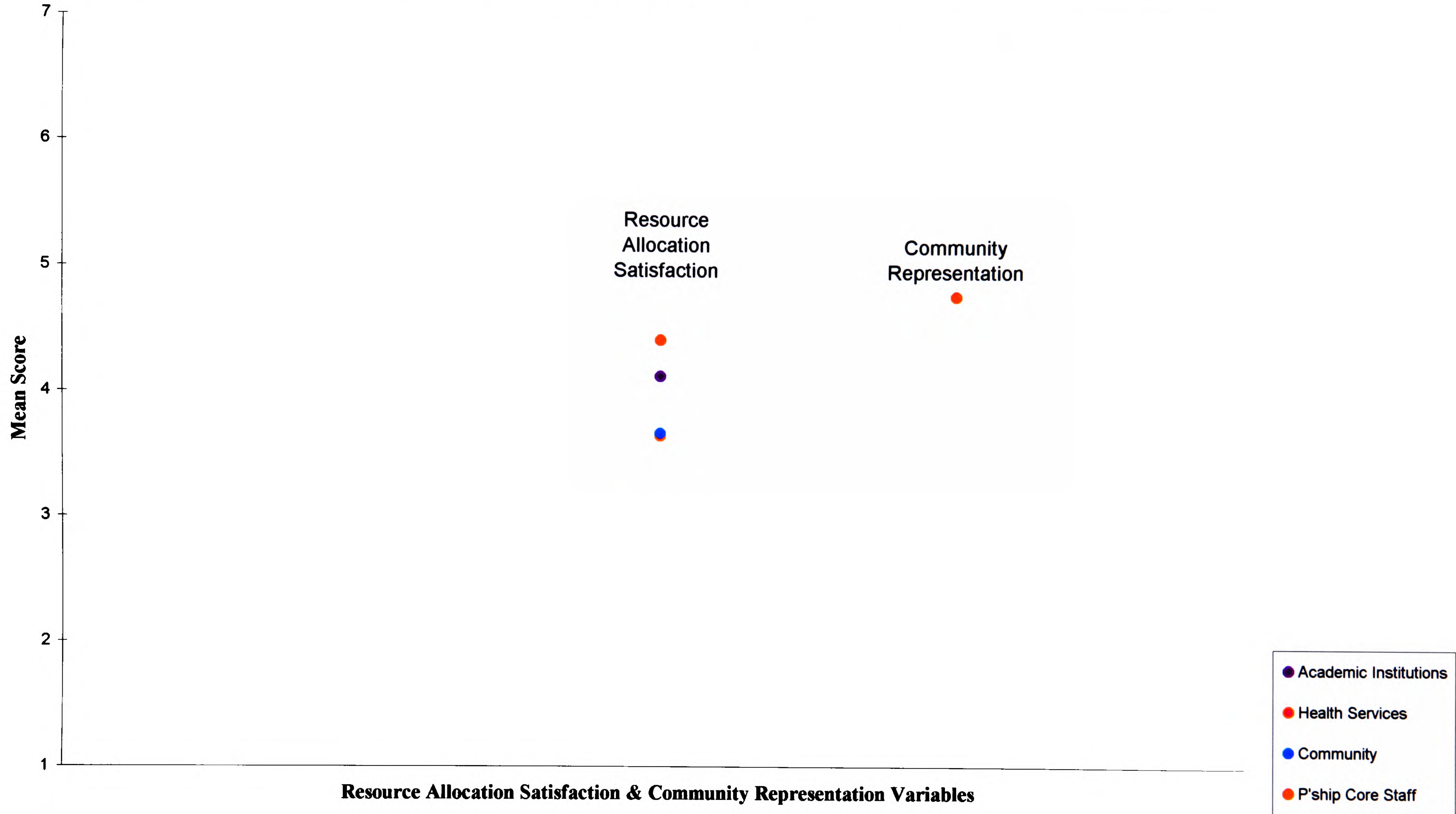
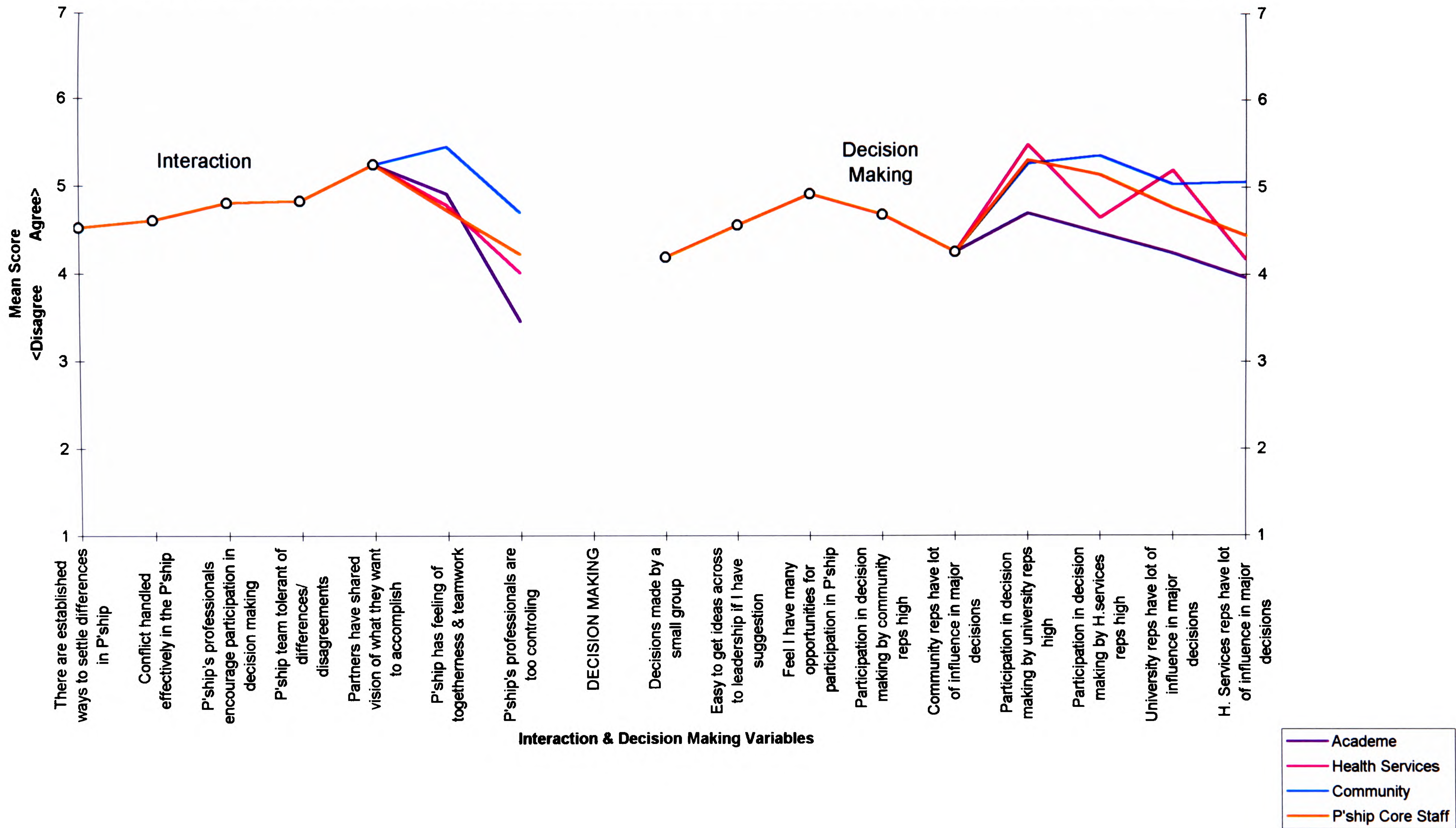


Figure (30). Areas of Agreement & Disagreement: Participant Groups' Mean Scores By Section of Questionnaire



16. Partnership's Outcomes

Table (20) and Figure (31) indicate that:

Areas of agreement

The participants had similar views with regards multiple aspects connected with their CPs outcomes. The groups displayed agreement in being quite certain that their CPs would be able to do what it has planned related to the changing of the medical/nursing curricula and providing PHC services; and in increasing the number of nursing and other health professions students who would enter PHC practice or who would practice in under-served areas once they finished their training. The groups also agreed about the certainty that due to the CPs' efforts there would be an increase in the use of multi-professional teams in providing health care (for these statements *M* for whole sample ranged from 4.44 to 4.93).

Areas of disagreement

When queried about how important were the CPs in influencing HPE in their local areas /health jurisdictions, the AI viewed their CPs as less important than how both the CM and CS perceived it. As regards student outcomes, the AI reported less certainty that there would be an increased number of medical students who would enter PHC practice or who would practice in underserved areas once they finished their training.

On the other hand, it was the HS who were least certain that their CPs would be able to do what they had planned in relation to that the CPs efforts would influence HPE.

In relation to continuity, the CS were more certain that their CPs would continue as identifiable organizations, that they would exist beyond the W.K. Kellogg funding, that their CPs activities would increase community involvement in health care reforms and that their CPs would have influence on policy with respect to HPE. Finally, the CS and CM were more certain than the AI and HS that as a result of their CPs activities were structured, there would be an increase in the use of multi-professional teams in providing health care to patients.

The findings suggested an atmosphere of agreement on some partnership issues like implementing new community-based training curricula and providing PHC. The observation, however, is that the stakeholders also agreed with some certainty when the outcomes were related to nursing or other health professions students, but not when it came to medical students. It was felt that there would be an increase

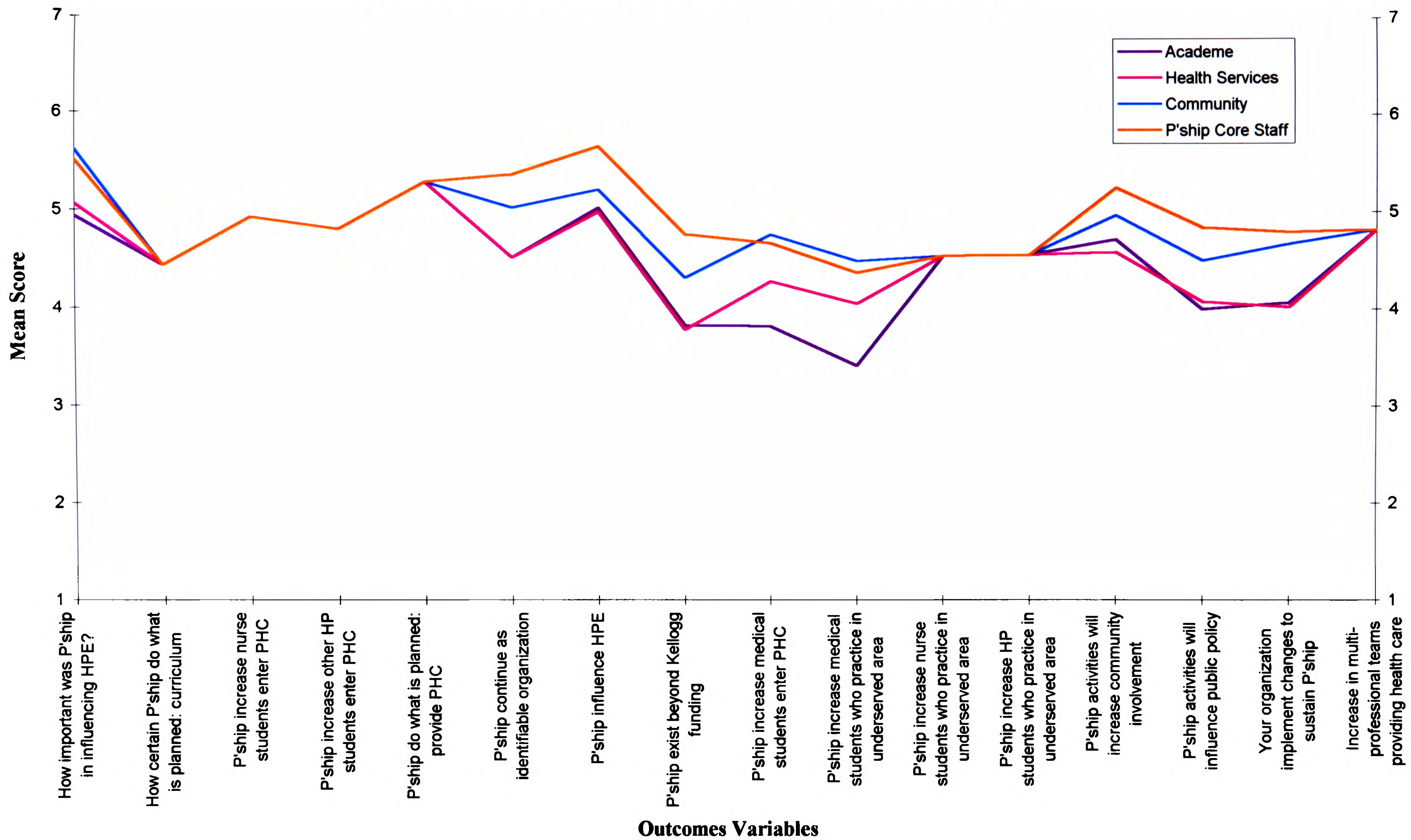
in nursing and other health professions students that would choose PHC as a career and would practice in uinderserved areas. However, with the medical students, the stakeholders' opinions differed, with the AI themselves being the least certain group if there would be an increase in freshly graduated doctors who would choose PHC as a career and would practice in underserved areas.

Table (20). Stakeholder Groups' views on the Outcomes of their Partnerships

Variable	AI	HS	CM	CS	F Prob.
1. how important was the Partnership in influencing Health Personnel Education in your local health jurisdiction?	4.94 4.94	(5.06)	5.62	5.51	0.0001*
How certain that your Partnership will be able to do what it has planned related to: 2. the curriculum	4.44				NS
3. providing primary care services	5.30				NS
4. continuation of the Partnership as an identifiable organization	4.53	4.53	(5.04)	5.38 5.38	0.001*
5. that Partnership efforts will influence health personnel education	5.04	5.00	(5.23)	5.67 5.67	0.06*
6. the Partnership existing beyond Kellogg funding	3.84	3.79	(4.33)	4.77 4.77	0.0029*
increased number of 7. medical students who will enter primary care practice	3.83 3.83	(4.29)	4.77	4.68	0.0001*
8. nursing students who will enter primary care practice	4.93				NS
9. other health professions students who will enter primary care practice	4.81				NS
10. medical students who will practice in underserved once they finish their training	3.42 3.42	(4.06)	4.50	4.38	0.0000*
11. nursing students who will practice in underserved once they finish their training	4.55				NS
12. other health professions students who will practice in underserved once they finish their training	4.56				NS
13. that Partnership's activities will increase community involvement in health care reforms?	(4.72)	4.59	(4.97)	5.25	0.03*
14. will have influence on policy with respect to health professions education	4.00	4.08	(4.50)	4.84 4.84	0.0019*
15. your organization is ready to implement structural changes to sustain the Partnership	4.07 4.07	4.02 4.02	4.67 4.67	4.79 4.79	0.0001*
16. be an increase in the use of multi-professional teams in providing health care	4.81				NS

* Significant

Figure (31). **Participant Groups' Mean Scores By Section of Questionnaire**



Summary of Findings: Sections With Continuous Scales; Radar Graph

Table (21) and Figure (32) helped to organise the data that emerged from the variables with continuous scales. First, Table (21) summarized the areas of agreement and disagreement for each questionnaire section with continuous scores. Second, a radar graph was constructed, based on the composite score for each comparison groups for each of the questionnaire sections. This was done by the averaging of scores to yield a single group response that was plotted on the appropriate arm of the radar graph [Annex (13)]. This was done for the four comparison groups for all sections with continuous scores. In doing so, it was assumed that higher scores were "better". For this reason, any question in the questionnaire that were phrased in the *negative* (e.g. 'Professional staff are too controlling') were excluded in this calculation, as a low score to such questions would have indicated some level of disagreement to the statement, and thus a "good thing". The number of questions excluded was very restricted and ranged from nothing in most sections to a maximum of 3 questions in the section on decision making.

An exception to this rule was the section querying about the costs of participation in the CPs. Here, all the questions were phrased in the *negative* sense (e.g. 'my organisation doesn't get enough public recognition for our work on the Partnership' or 'time spent on the Partnership keeps me from doing my work'), so lower scores indicated disagreement with the negative statement thus meaning lower costs, where it is assumed that lower costs are a "good thing".

The radar graphs helped to gain a multifaceted view of the respondent groups' views. Figure (32) depicts the comparisons of groups' views as 17 domains of partnership fostering (17 sections of the questionnaire). In the figure, the 17 arms (radii) of the web represented the 17 parameters of partnership building, while the four webs represented the mean scores of the stakeholder groups. As the continuous scales used for these sections were all Likert-type seven point scales (e.g. 1 = 'Strongly Disagree' and 7 = 'Strongly Agree'; or 1 = 'Not at all certain' and 7 = 'Totally certain'; or 1 = 'Not At All' and 7 = 'Very much'), in this sense a larger circle with a wider radius would indicate a 'better thing'. In general, the further out to the periphery the web is, i.e. the greater its radii were, the greater the ability of that particular group in that particular skill (1 = 'low ability' and 7 = 'high ability'). Thus the figure summarized the responses of 668 respondents from four stakeholder groups.

A Bird's eyeview

What emerged from the figure was the following:

1. In general, for all the four comparison groups, their scores (curves) seemed to fall within the range of 4 and 6 i.e. above average. This could be either an agreement to a positive statement (e.g. 'Routine matters are handled quickly') or an above average contribution (e.g. 'time of yourself and of others') or commitment (e.g. 'to what extent has your organisation endorsed or adopted the mission and goals of the CP?') or level of certainty about outcomes (e.g. 'how certain that your Partnership will be able to do what it has planned related to providing primary care services').

2. Within the above mentioned range where the four webs fluctuated, the CS and CM groups seemed to score persistently higher than the HS and AI, both of whom exhibited webs of smaller diameters in most sections.

2.1 Within the above mentioned range where the four curves fluctuated, the CS group seemed to score higher on multiple aspects of the CPs. They viewed their CPs as representative of the beneficiary communities, and reported high commitment, contributions and sense of ownership. This group also appreciated the skills and expertise of both professional staff and the community members and viewed communication between the groups and flow of information in their CPs as above average. They also were more certain that many positive outcomes will accrue and were quite happy with the educational activities and other benefits of their CPs. Finally they perceived their costs of participation as low. The scores of CS group (and consequently the web) were followed closely by those of the CM group, whose scores were nearest to the CS.

2.2 The other two stakeholders, the AI and the HS perceived their CPs as less representative of the beneficiary communities than the first two groups. The AI and HS also reported less commitment, contributions and sense of ownership. These two stakeholders felt that both professional staff and the community members were in need of more skills and expertise. They viewed communication between the groups and flow of information in their CPs as slightly above average, and were less certain than the CS and CM that many positive outcomes would accrue. Finally, they felt quite happy with the educational activities, valued the benefits of the CPs less than the other partners and perceived higher costs of participation in comparison with the CS group.

3. Within the smooth contours of the webs, the curves show three depressions or 'dips'; one expected, the second uncertain, and the third a true dip:

3.1 The first is in relation to the "Costs" arm of the radar graph. This dip could have be expected due to the methodological explanation of the negative phrasing of the questions on the costs of participation that has been described above. Thus, the webs reverse their order of positions and arrangement as they pass from the 'Benefits' arm of the radar to 'Costs' arm. The point to be noted, however was that the CS, which was the group that viewed the most benefits in these CPs were also the same individuals who perceived their costs as lowest. Similarly, the HS and AI groups who viewed their benefits lower than the CS are also the same individuals who viewed their costs of participation as being higher than the CS group. The CM group responses were in between: they viewed a lot of benefits but simultaneously felt higher costs than all the other three groups. This finding also further supported the reliability of the questionnaire, that the questions were well understood by the respondents.

3.2 The second dip was related to the "Contributions" arm of the radar graph denoting the contributions that the respondents made to their CPs. It was however not a totally certain dip, as only three out of four curves were low, while the CS curve is of wider radius. It was not clear where the average zone fell i.e. were the first three groups low on contributions or was it that the CS were contributing more.

3.3 The third dip was on the arm related to "Resource Allocation Satisfaction". Higher satisfaction was assumed to be a "good thing". Accordingly, this was a true dip in the levels of satisfaction of all the groups, especially the CM, HS and AI. The finding was that, in relation to resource allocation satisfaction, the CS exhibited above average satisfaction while the other HS and CM groups had below average satisfaction.

Table (21). Differences in participants' perceptions on aspects of their Partnerships. Sections with continuous scales

(Comparison of means, one way ANOVA of groups, * Significant difference - $P < 0.05$)

Section	Areas of Agreement	Areas of Significant Disagreement*
1. Management Capabilities	1. Technical terms are clear and understood by all 2. Routine matters are handled quickly 3. Everyone participates in discussions 4. Members informed/ understand what is going on 5. There is no fighting for status or hidden agendas 6. The P'ship uses resources of all, not just a few 7. Meeting times are convenient 8. Meetings run smoothly, without interruptions or blocking 9. Interest is generally high 10. Partnership members feel safe in speaking out 11. Atmosphere is friendly, co-operative, pleasant 12. Meetings have free discussion	13. Meetings start and stop on time 14. Purpose of each task or agenda item is defined and kept in mind 15. Reports are routinely made to the entire P'ship 16. Minutes accurately reflect proceedings of the meetings 17. Materials for meetings are prepared adequately and in advance of meetings (agendas, minutes) 18. Notification of meetings is timely 19. Members have a good record of attendance at meetings 20. Members stay with the subject being discussed 21. Location of meetings is convenient 22. I am usually clear about my role as a P'ship member
2. Community Representation	How representative is your P'ship of intended beneficiaries	
3. Communication PS - CM communication	1. poor/ good 2. infrequent/ frequent 3. uninformative/ informative 4. uncomfortable/ comfortable 5. ineffective/ effective	
CM communication	1. poor/ good 2. infrequent/ frequent	3. uninformative/ informative 4. uncomfortable/ comfortable 5. ineffective/ effective
4. Flow of Information	1. Far too little information on important topics is shared among the partners 2. Information I receive about the P'ship is accurate 3. The information I receive about the P'ship is relevant to my needs	4. The information I receive about the P'ship gives me a clear understanding of the P'ship 5. I receive information about the P'ship in a timely fashion
5. Contributions		1. Time of yourself and of others 2. Money to support joint activities 3.In-kind resources e.g. publicity, printing, equipment, facilities, etc. 4. Facilitate access to special populations
6. Educational Activities		1. How much has the Partnership engaged in educational activities? To what extent: 2. were P'ship members involved in the action? 3. were P'ship members effective in their work?

Table (21). *contin'd.* **Differences in participants' perceptions on aspects of their Partnerships. Sections with continuous scales**

Section	Areas of Agreement	Areas of Significant* Disagreement
7. **Benefits of Participation**		1. Getting to know other agencies and their staff 2. Gaining recognition and respect from others 3. Developing collaborative relationships with other agencies 4. Getting help from or helping other organizations 5. Making our community a better place to live in 6. Helping my organization move towards our goals 7. Learning about community events, services, etc 8. Having access to target populations with whom we've had little contact 9. Building my organization's capacity 10. Helping my organization get funding 11. Building my own skills in partnership work
8. **Costs of Participation**		1. P'ship activities do not effectively reach their intendend beneficiaries 2. My skills and time are not well - used 3. My organization doesn't get enough recognition for our work on P'ship 4. Time spent on the Partnership keeps me from doing my work 5. Being involved in implementing the P'ship's activities is a problem
9. **Satisfaction**		1. The work accomplished by the P'ship has met my expectations 2. Am satisfied with what is accomplished by the Partnership 3. This Partnership is a worthwhile effort 4. I would not like to change anything about the Partnership 5. I am satisfied with how the Partnership operates
10. **Sense of Ownership**	1. I feel I have a voice in what the P'ship decides	2. I am committed to the work of the Partnership 3. I feel a sense of pride in what the P'ship accomplishes 4. I really care about the future of this Partnership
11. **Commitment**	To what extent: 1. Does your organization participate in P'ship sponsored activities?	To what extent: 2. Has your organization endorsed/ adopted mission & goals of the P'ship? 3. Has your organization publicly endorsed/ cosponsored P'ship activities? 4. Does the community see the P'ship as a resource for influencing HPE?
12. **Levels of Expertise** PS Expertise (double check the analysis for 9a & b)	1. Reaching target populations 2. Community organizing 3. How to bring about change in the community 4. Maintaining an effective and active Partnership 5. Working with community groups 6. Budget management 7. How to bring about change in the teaching institutions 8. HPE policy 9. Designing/ implementing educational activities 10. Planning	11. How to bring about change in the health department

Table (21). *contin'd.* **Differences in participants' perceptions on aspects of their Partnerships. Sections with continuous scales**

Section	Areas of Agreement	Areas of Significant* Disagreement
CM Expertise	1. How to bring about change in the community	2. Designing/ implementing educational activities 3. Maintaining an effective and active P'ship 4. Working with community groups 5. Community organizing 6. Planning 7. How to bring about change in the teaching institutions 8. How to bring about change in the health department 9. HPE policy 10. Budget management 11. Reaching target populations
13. Resource Allocation Satisfaction		How satisfied are you with the allocation of funds in your P'ship?
14. Interaction	1. There are established ways to settle most differences that arise in the P'ship 2. P'ship's professionals encourage participation in decision making 3. P'ship team is tolerant of differences or disagreements	4. Partners of this P'ship have a shared vision of what they would like to accomplish 5.The P'ship has feeling of togetherness & teamwork 6. Conflict is handled effectively in the P'ship 7. The P'ship's professionals are too controlling
15. Decision Making	1. Decisions are made only by a small group of leaders 2. It is easy to get my ideas across to the project leadership if I have a suggestion 3. Feel I have many participation opportunities in the P'ship 4. Participation in decision making by CM Reps is high	5. CM Reps have lot of influence in major decisions 6. Participation in decision making by AI Reps is high 7. Participation in decision making by HS Reps is high 8. AI Reps have a lot of influence in major decisions 9. HS Reps have a lot of influence in major decisions
16. Partnership's Outcomes	How certain that your P'ship will be able to do what it has planned related to: 2. the curriculum 3. providing primary care services 4. increase nursing students who will enter PHC practice 5. increase other HP students who will enter PHC practice 6. increase nursing students who will practice in underserved areas once they finish their training 7. increase other HP students who will practice in underserved areas once they finish their training 8. increase in the use of multi-professional teams in providing health care	1. how important was the P'ship in influencing HPE in your area 9. continuation of the P'ship as an identifiable organization 10. that P'ship efforts will influence HPE 11. the P'ship existing beyond Kellogg funding 12. increase medical students who will enter PHC practice 13. increase medical students who will practice in underserved areas once they finish their training 14. P'ship activities will increase CM involvement in health care reforms 15. P'ship will have influence on policy with respect to HPE 16. your organization is ready to implement structural changes to sustain the P'ship

Figure (32). <u>Comparison of 4 Participant Groups: A Selection of 17 Parameters with Continuous Scores</u>

4.1.4.2. Sections With Categorical Scales (12 Sections)

Tables (22 - 36) and Figures (33 - 57) summarize the areas of agreement and disagreement in responses of the four comparison groups as regards their views on the various aspects of their CPs.

1. Formalised rules and procedures

Table (22) and Figure (33) suggest the following:

Areas of agreement

The participants had similar views with regards only one aspect of the formalised rules and procedures in their CPs. The stakeholders agreed that their CPs engaged in strategic planning (≈ 75 % of each group agreed to the statement).

Areas of disagreement

The participants expressed differences in all the other aspects of formalised rules and procedures in their CPs. The CS had the highest scores when queried about written mission statements, objectives, by-laws and operating principles. Similarly, relatively more CS reported that their CPs reviewed these guidelines, had a long-range funding plan, as well as clear procedures for selection of leaders and provided orientation for new members.

In spite of the differences between the stakeholders as regards formalised rules and procedures, the findings suggested some similarities. Common in between the groups were three issues: (a) the high knowledge of respondents that their CPs had both a written mission statement and written objectives (at least 65 % of each group reported "Yes" to these questions); (b) an intermediate knowledge of respondents if their CPs had by-laws and operating principles, had a long-range plan for funding beyond W.K. Kellogg, and if their CPs provided orientation for new members (45 to 65 % of each stakeholder reported "Yes" to these questions); and, (c) their low knowledge about whether their CPs reviewed their by-laws and operating principles periodically and if there was a clear procedures for selection of leaders. The AI and HS respondents' knowledge in both these areas were low (at least 60 % of each group reported "No" to these questions).The CS group persistently scored the highest on all items of this section while in contrast, the HS group scored persistently lower.

2. Operational Understanding

Table (23) and Figure (33) suggest the following:

Areas of disagreement

The participants expressed significant differences in all the aspects of operational understanding as regards their CPs. Throughout this section, relatively more respondents from CS group reported positive responses on all items than the other stakeholders. In contrast, the HS group scored persistently lower.

Two areas exhibited a wide variation in the responses: when informants were queried if they knew how new members were chosen in their CPs or if they knew how the CPs' committees and task forces were formed. The AI, HS and CM groups scored low (≈35-45 % answered "Yes" as opposed to 70 % in the CS group). On the other hand, all four respondent groups scored high when asked if they knew their CPs mission and understood it, if they knew what their roles in the CPs were, as well as the CPs organisational structure and staffing (≈50-95 % answered "Yes").

3. Involvement in the Partnership

Table (24) and Figures (34 - 43) suggest the following:

Significant differences existed between the percentages of each respondent group that reported to be either moderately or very involved in the CPs, where the CS showed the highest percentage of participants being involved. Between 70 - 90 % of participants in each stakeholder group viewed themselves as being moderately or very involved in their CPs. The observation is that there were little differences in the percentages of respondents who perceived themselves to be not very involved, ranging from 20 % to just under 30 % of each stakeholder. In contrast, as regards those who were very involved, where the differences were big and ranged from about 20 % to about 55 % of participants.

Table (22). Stakeholder Groups' views on the Rules and Procedures in their Partnerships

Differences in participants' perceptions of Partnership rules and procedures (summaries of the percentages of respondents of comparison groups who reported "yes")

Variable	AI	HS	CM	CS	*P* Level
1. Have written mission statements	82.3	68.5	77.0	91.7	0.0009*
2. Have written by-laws/ operating principles	45.0	48.6	59.1	69.0	0.0001*
3. Review its by laws/ operating principles	32.3	28.7	41.8	50.0	0.00005*
4. Engage in strategic planning	78.5	70.4	77.9	88.1	0.21 (NS)
5. Have long-range funding plan	50.0	40.7	48.2	56.9	0.001*
6. Have written objectives	86.0	70.6	75.7	90.0	0.005*
7. Reviews mission, goals and objectives	50.0	47.2	58.9	69.0	0.00003*
8. Clear procedures for selection of leaders	33.1	29.6	52.4	56.7	0.00000*
9. Provide orientation for new members	50.8	41.3	56.7	71.2	0.0000*

* Significant

Table(23). Stakeholder Groups' views on the Operational Understanding in their Partnerships

Differences in participants' perceptions of operational understanding of their Partnership (summaries of the percentages of respondents of comparison groups who reported "yes")

Variable	AI	HS	CM	CS	*P* Level
Do you know					
1. How new members are chosen	41.9	35.8	45.2	68.4	0.0007*
2. How committees/ task forces are formed	45.7	39.8	44.9	71.7	0.0005*
3. The P'ship's organisational structure/ staffing	76.2	54.2	55.3	89.7	0.00000*
4. The P'ship's mission and clearly understand it	79.4	66.7	72.0	91.4	0.001*
5. What your role in the Partnership is	78.9	75.2	78.9	95.0	0.01*

* Significant

Table (24). Stakeholder Groups' views on the Levels of Involvement in their Partnerships

Differences in participants' perceptions of levels of involvement in their Partnership (summaries of the percentages of respondents of comparison groups)

Variable	AI	HS	CM	CS	*P* Level
How involved are you in the Partnership					
1. Moderately or very involved	73.4	75.3	77.4	87.7	0.00000*

* Significant

Figure (33). Percentage of Participant Groups reporting positive responses by Section of Questionnaire

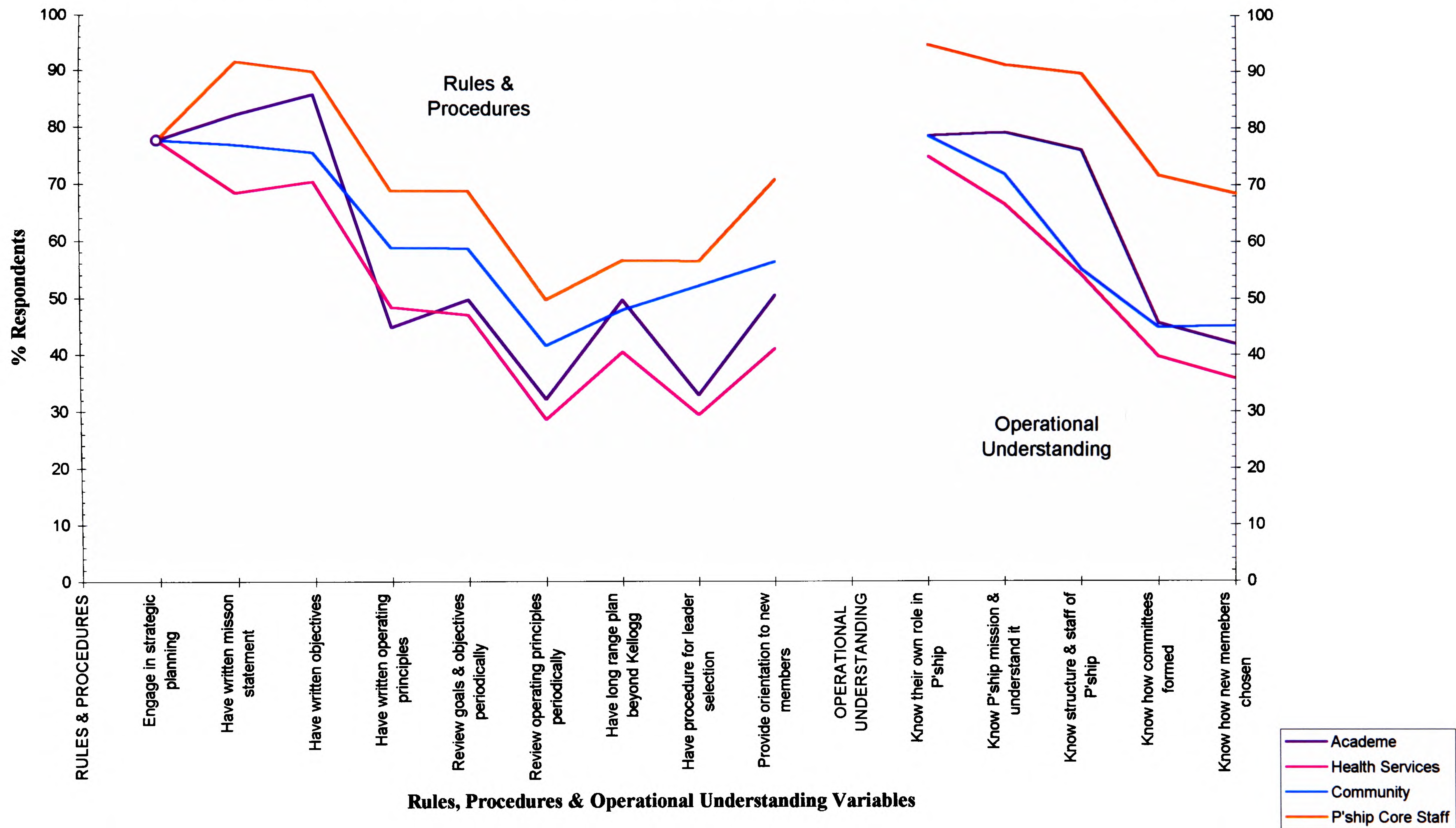


Figure (34). Percentages of Respondent Groups' Degree of Involvement in their Partnerships
(N = 618)

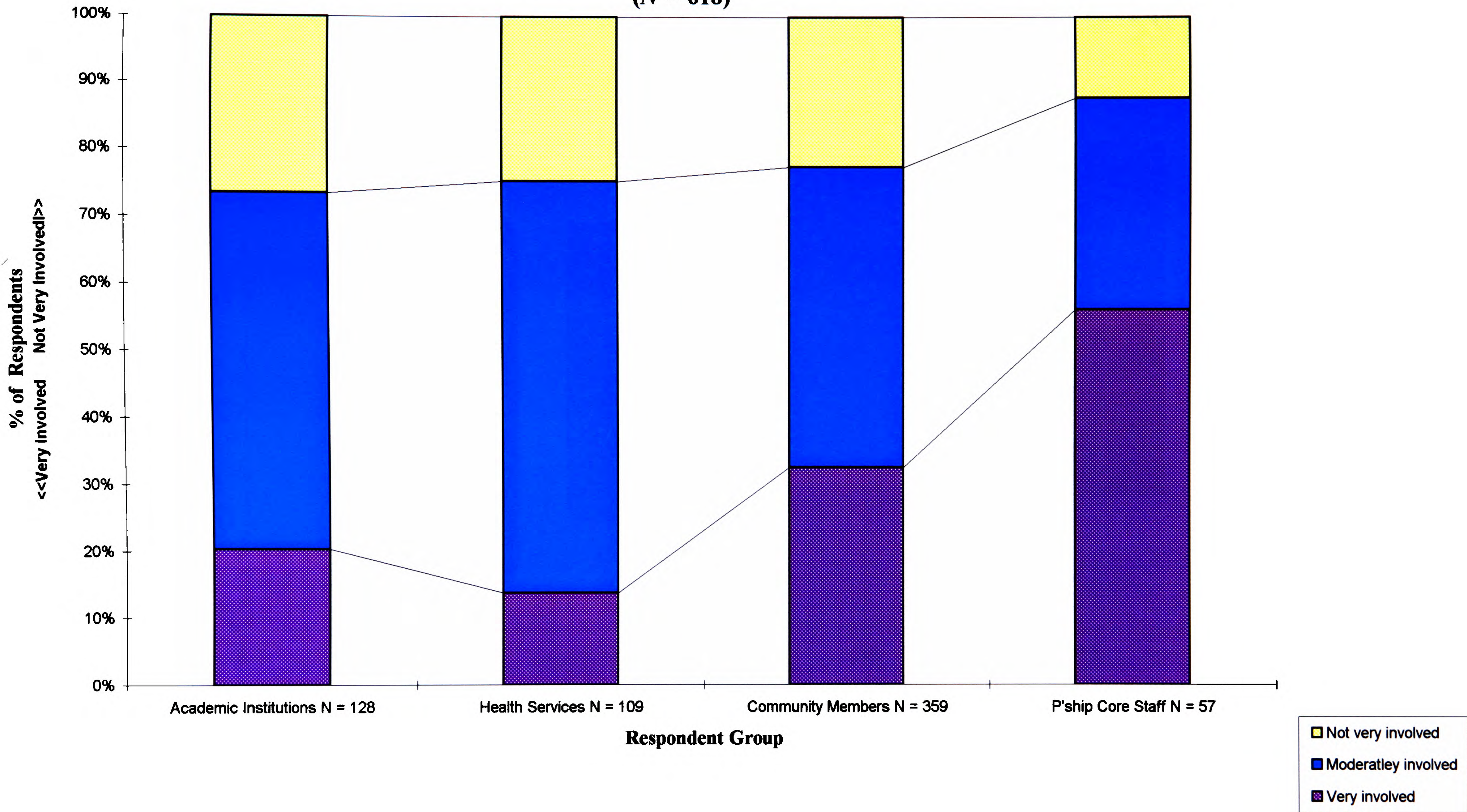


Figure (35). Percentage of P'ship Meetings Attended over Past Year by Stakeholder Group (N = 591)

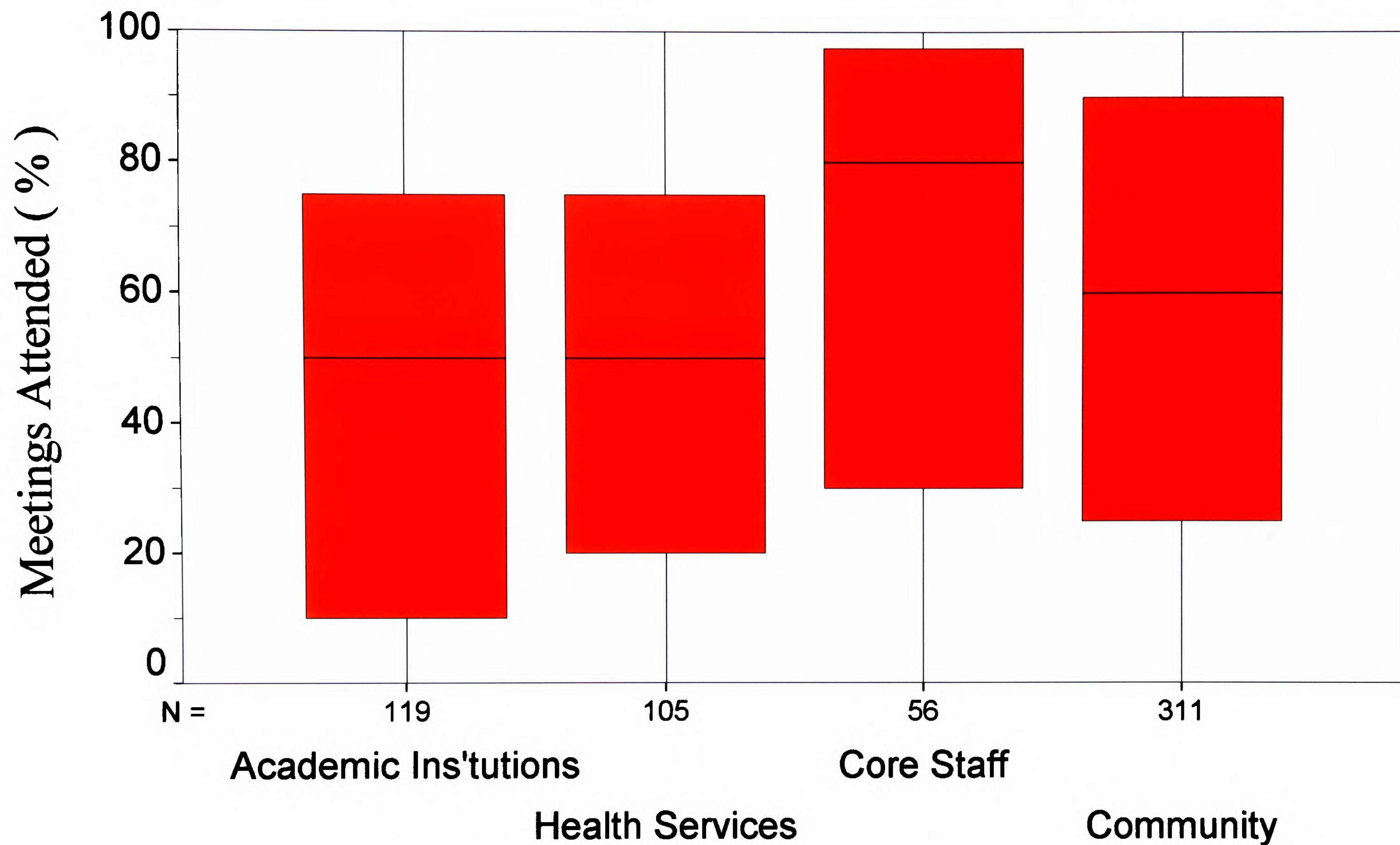


Figure (36). Hours per week spent on P'ship activity by Stakeholder Group (N = 533)

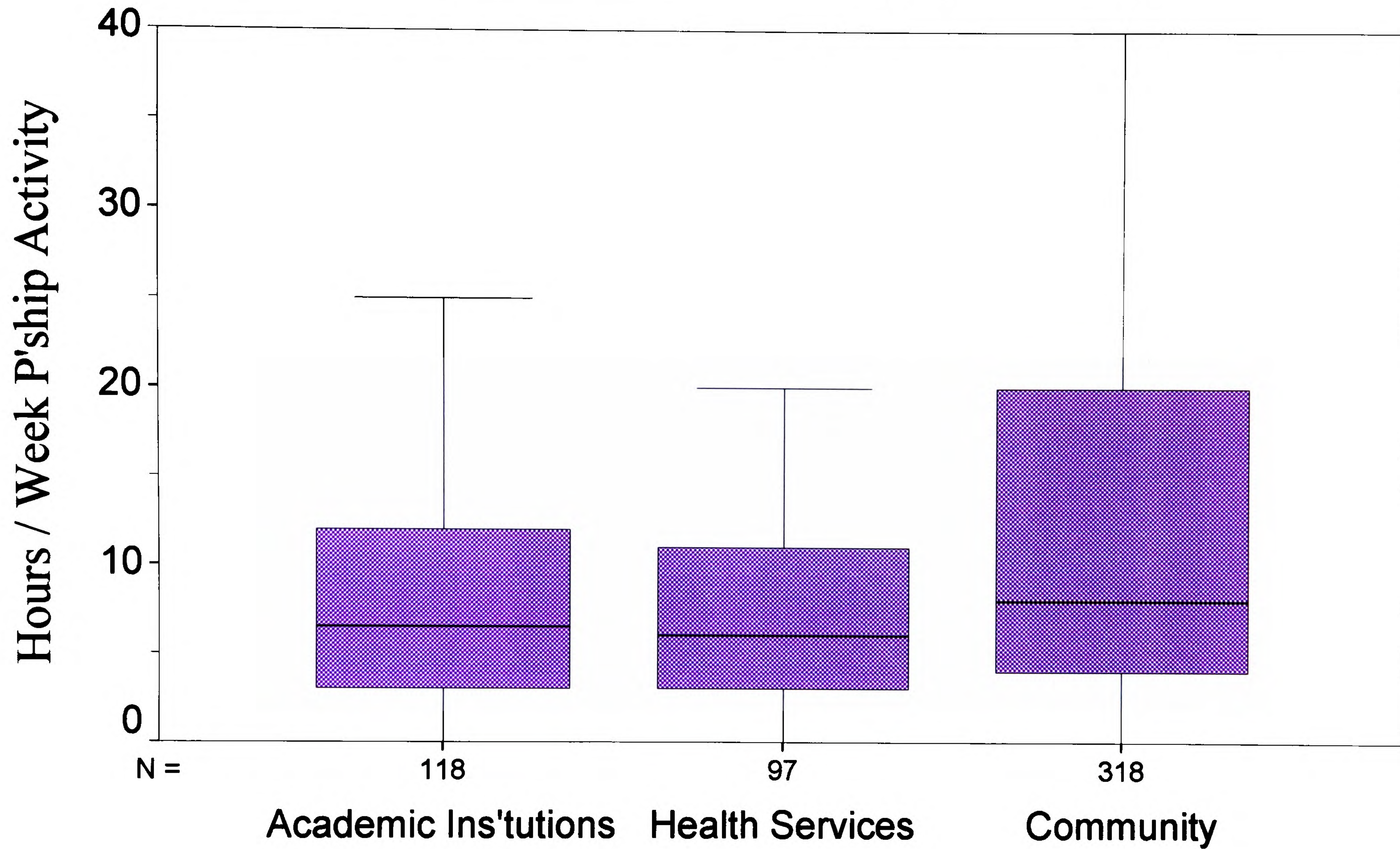


Figure (37). Involvement: Recruiting New Members by Stakeholder Group (N = 638)

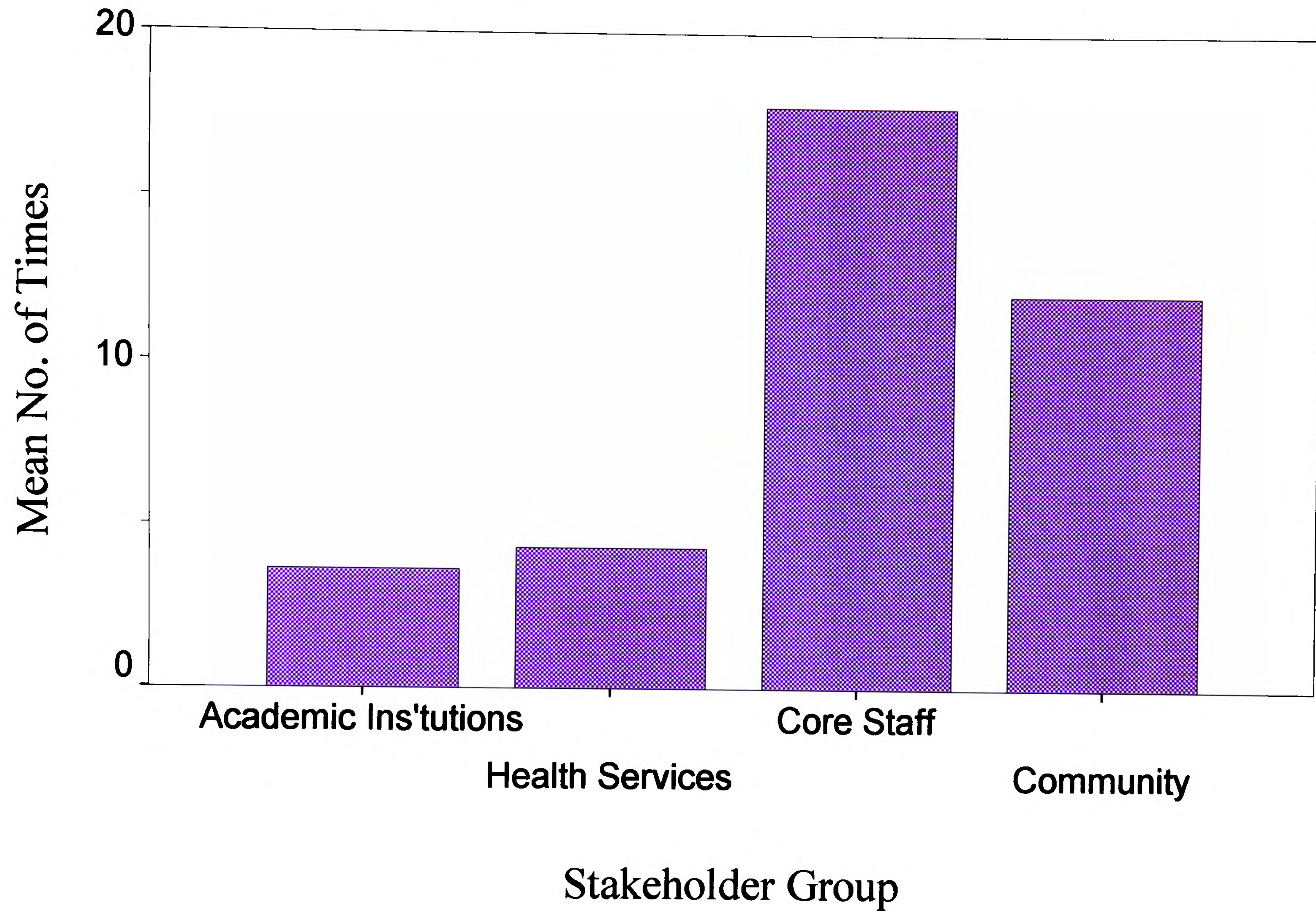


Figure (38). Involvement: Served as Spokesman by Stakeholder Group (N = 638)

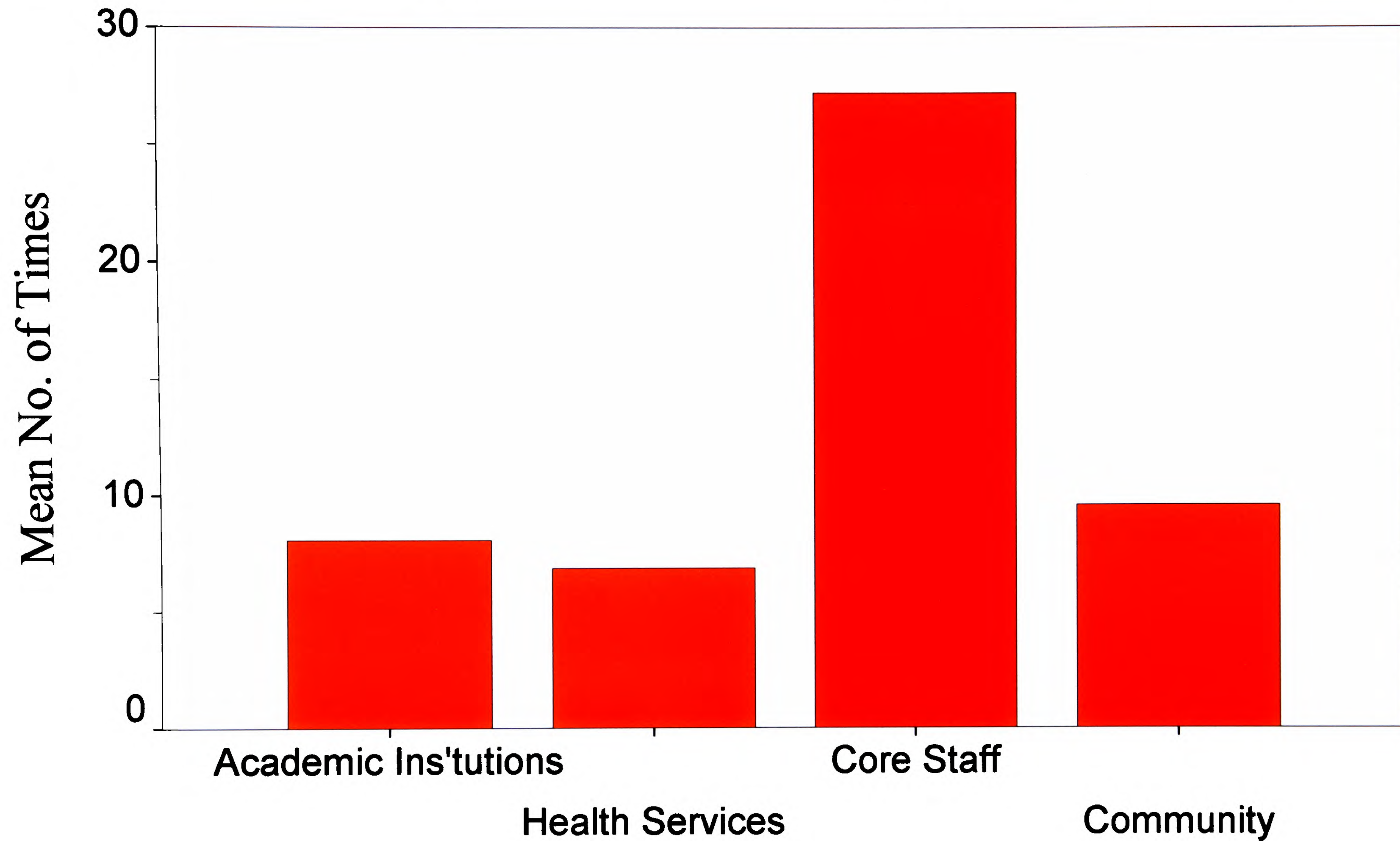


Figure (39). Involvement: Implemented Activities by Stakeholder Group (N = 629)

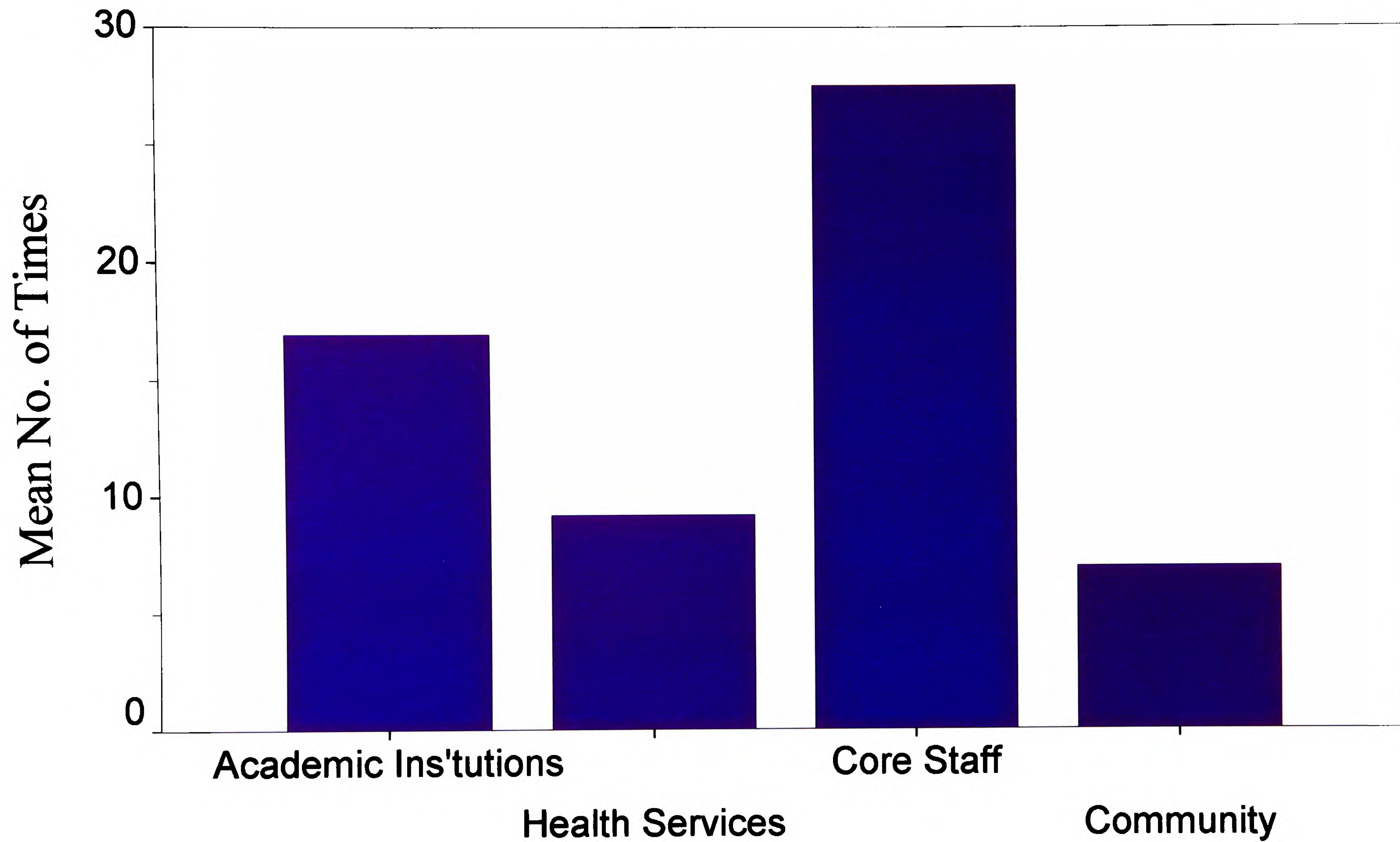


Figure (40). Involvement: Times Represented the P'ship by Stakeholder Group (N = 635)

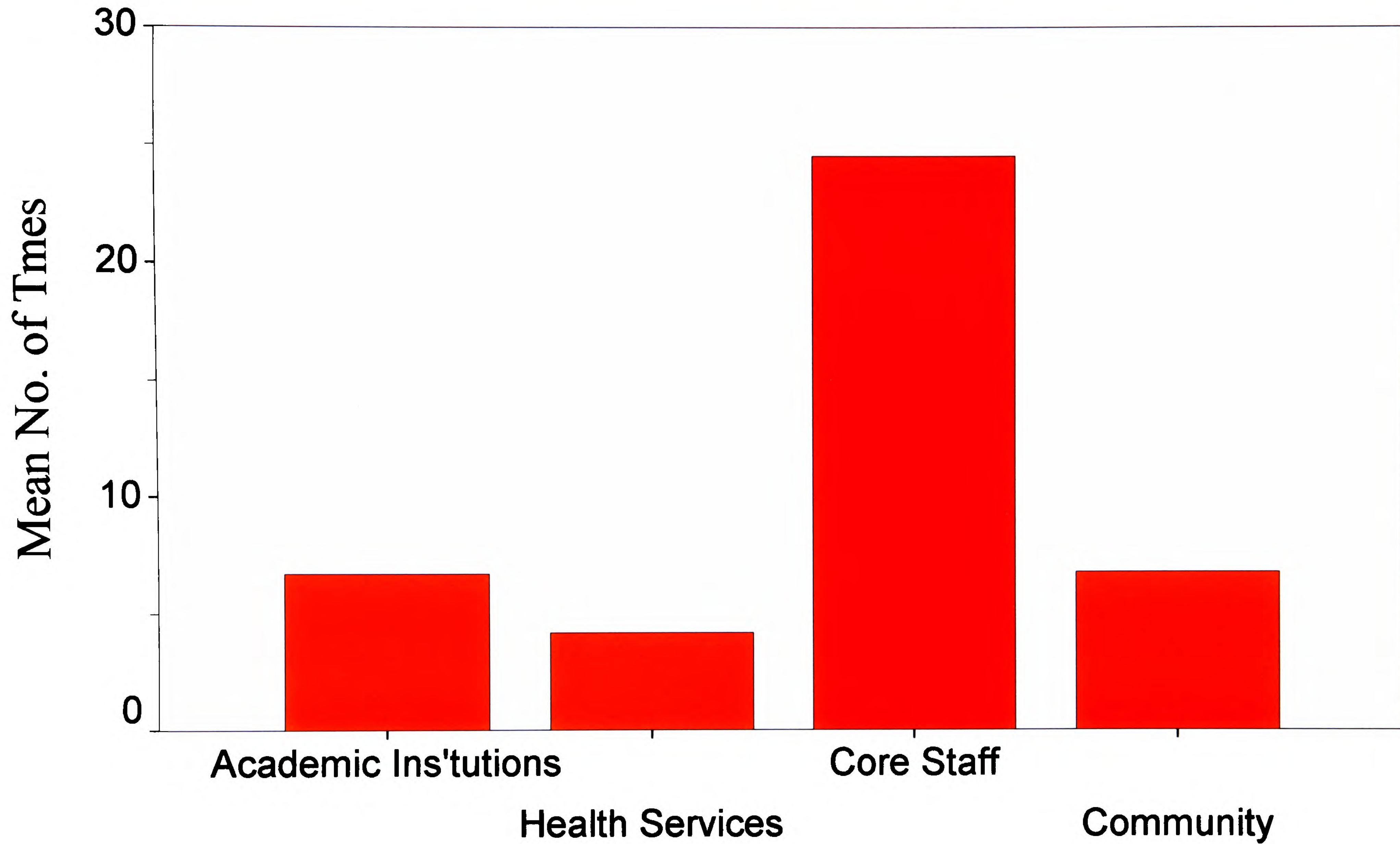


Figure (41). Involvement: Committees worked on by Stakeholder Group (N = 617)

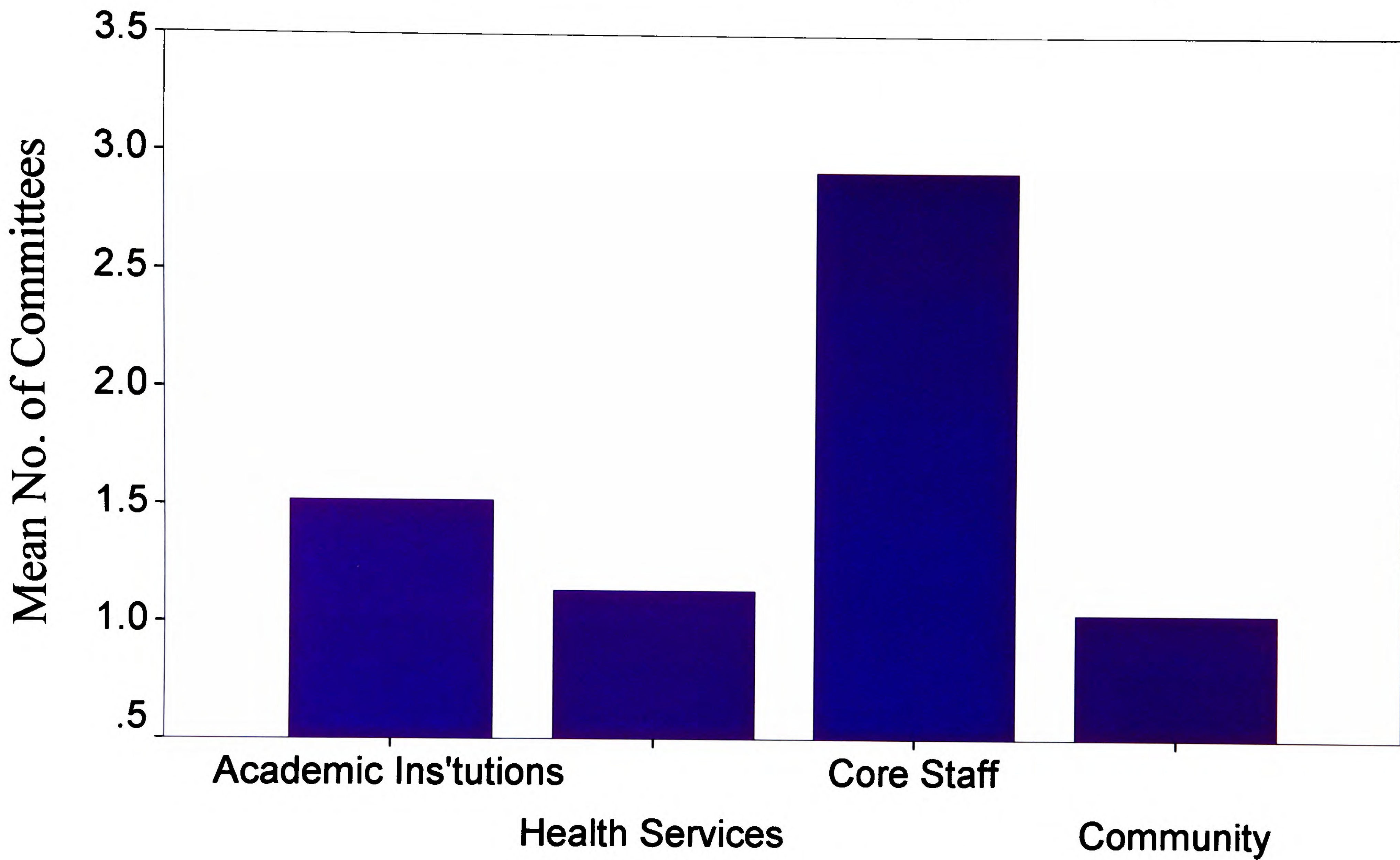


Figure (42). Involvement: Leadership positions held by Stakeholder Group (N = 598)

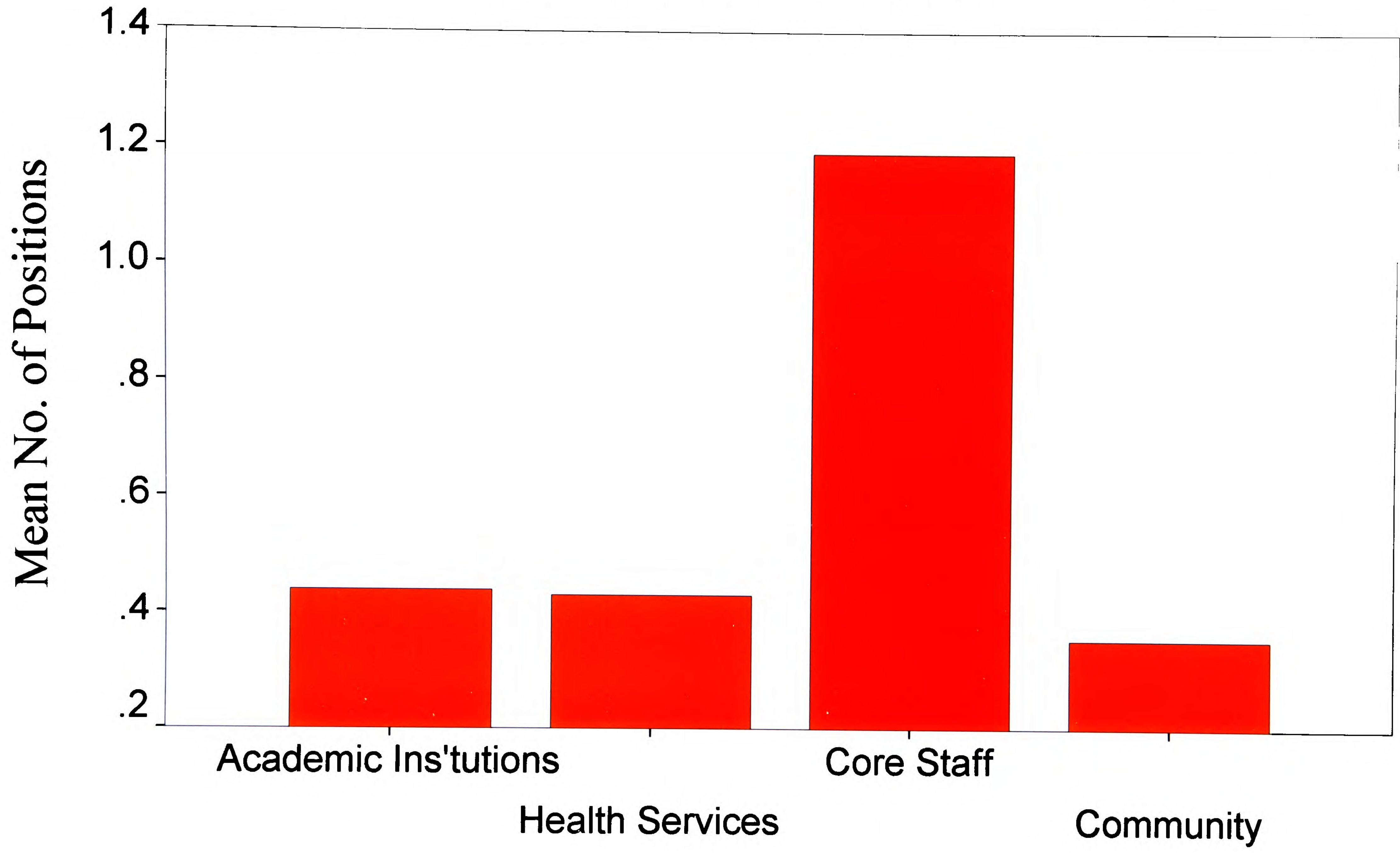
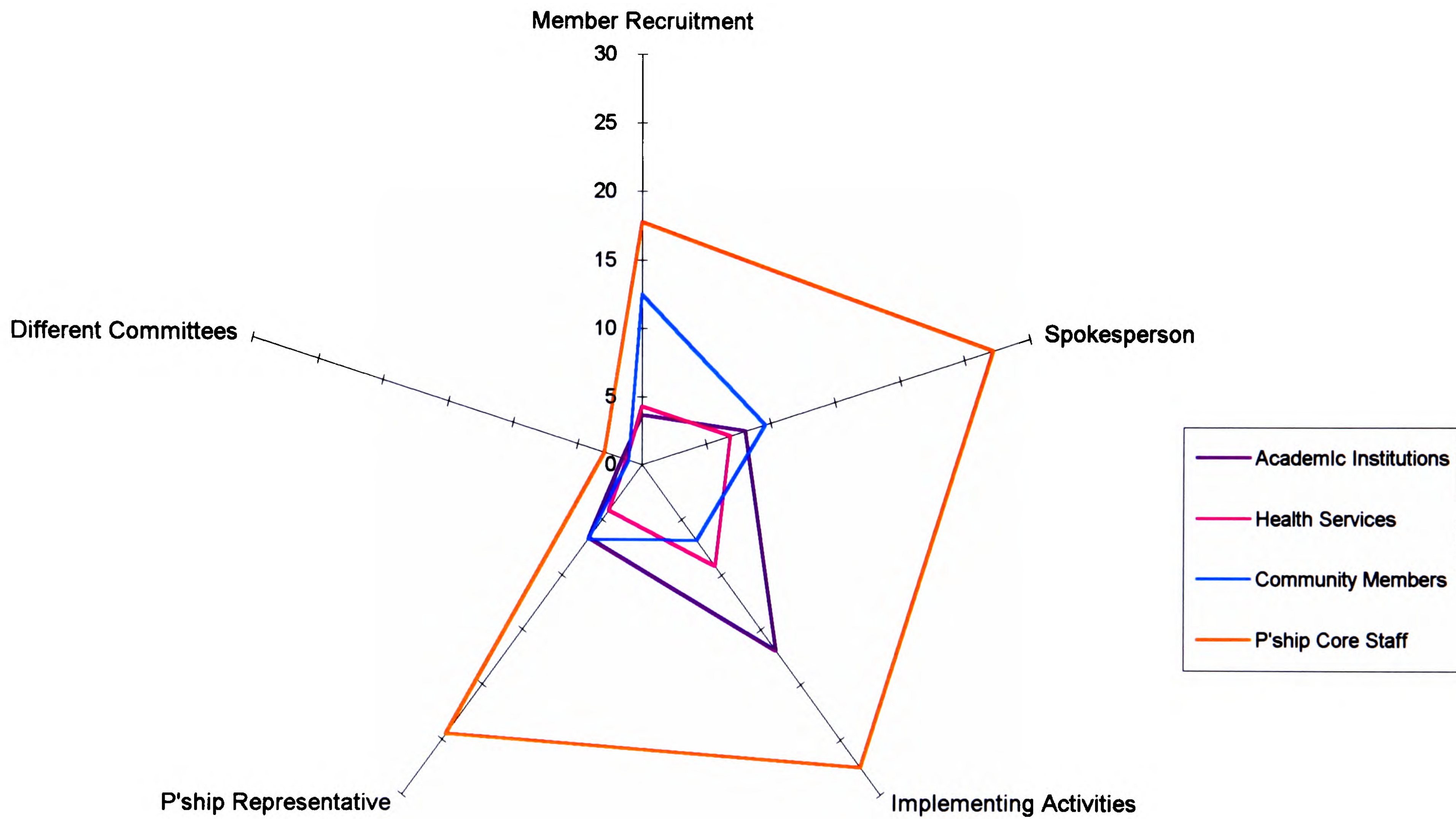


Figure (43). Aspects of Involvement of Stakeholder Groups



4. **Authority to make decisions**

Table (25) and Figure (44) suggest the following:

Differences existed between the percentages of the stakeholders who reported their full authority to make decisions on behalf the organisation they represented at the CPs meetings (≈25-30 % answered "Yes"). The rest of the sample had to first get approval from either other staff or from the board of memberships in their organisations.

The observation was the large proportions of participants in each stakeholder group who had limited authority of representation and could only make decisions after consulting with either other staff in their agencies or their boards. This was particularly apparent in the stakeholders who originated from hierarchical bureaucratic government controlled institutions, namely the AI and the HS. In contrast, for the CM, the proportions of participants who needed to consult with their constituencies or boards were notably less. However, this need be viewed in the light that many CM did not actually represent any agencies and were attending at their CPs on their own behalf, a situation that was not met with by the other stakeholders.

5. **Benefits to Difficulties Ratio**

Table (26) and Figures (45 - 46) suggest the following:

The participants had similar views with regards their perceptions of the ratio and balance of benefits to difficulties that accrued from their participation in the CPs. An average of 67 % (range 56 - 77 %) of the sample viewed their CPs positively i.e. with equal or more benefits than difficulties. The point to note was, as participation in CPs was voluntary, the decision to participate may frequently be associated with the perceived balance between benefits and difficulties. Furthermore, when the perceptions of the benefits to difficulties ratio where examined by level of involvement regardless of stakeholder group [Figure (46)], there were no significant differences.

6. <u>Role Clarity</u>

Table (27) and Figures (47 - 51) suggest the following:

<u>Areas of disagreement</u>

The participants expressed differences in all the aspects of role clarity as regards the type of inputs they or their organisations typically had in various functional and administrative domains of their CPs. About 60 - 75 % of the AI, HS and CM groups reported some role in either setting the budget, designing programme goals and objectives for the CPs' programmes, or developing the CPs overall plans. This was significantly lower than the CS group, and especially in the area of selecting local contractors or subcontractors to the CPs' programmes, less than 60 % of all groups reported any input as opposed to above 80 % of the core staff.

Recognizing that the steering committees or the executive boards of trustees were responsible for the major decisions taken in the CPs under investigation, the findings suggested that through this section of role clarity about the type of input that participants or their agencies typically had, relatively more participants from the CS group reported to have some kind of input than the other three stakeholders. The impression was that whether it was setting the CPs budgets for the programmes that were being initiated or designing programme goals & objectives or developing the CPs overall plans, more CS than the other stakeholders had an active role, whether in the form of simple advice or more involvement in the development and recommendation of potential programmes to the full approval of plans that were undertaken by the CPs.

7. <u>Personnel Barriers</u>

Tables (28 - 29) and Figures (47 and 52) suggest the following:

<u>Areas of agreement</u>

The participants had similar views with regards three aspects of personnel. Fifty five to seventy percent of the whole sample agreed that volunteer availability, keeping volunteer interest and expertise of both the professional staff and volunteers represented either major or minor problems in their CPs.

<u>Areas of disagreement</u>

The respondent groups, however, expressed differences as regards all the other aspects of personnel barriers in their CPs. Significantly less participants from the CM group (≈ 55 - 70 %) than the others felt

that the professional staff availability, turnover and interest were problems in their CPs. Similarly, significantly less participants from the CM group than the others felt that volunteer turnover, general interest in the CPs activities and the priorities of the professionals to be either major or minor problems in their CPs (≈ 45 - 60 %).

The observation is that for many of the statements in this section pertaining to the personnel barriers in the CPs, more than half the participants from each stakeholder group viewed the statements to be either major or minor problems in relation to their CPs. All through the section, relatively more respondents from either the HS or CS groups viewed the personnel barriers related to the professional staff and volunteer availability, turnover and interests as problems in their CPs.

In order to get a feel for the kind of personnel barriers encountered for the whole sample of informants from this clsuter of SA CPs, the general percentages of respondents reporting problems related to personnel barriers are shown in Table (28). The highest ranking barriers which were viewed as major problems by the whole sample were the turnover of the professional staff, volunteer availability, and keeping volunteer interest (each was reported by ≈30 % of whole sample). On the other hand, the top three barriers which were viewed as minor problems by the whole sample were professional staff priorities, the expertise of the both the professionals as well as the community volunteers, and general interest in CP activities (≈ 35 - 40 %).

Table (25). Stakeholder Groups' views on Authority to make decisions in the P'ships

Differences in participants' perceptions of authority to make decisions on behalf of their organisations in their Partnership (summaries of the percentages of respondents of comparison groups who reported "yes")

Variable	AI	HS	CM	CS	*P* Level
Authority to make decisions on behalf the organisation you represent in the Partnership 1. yes	29.0	30.2	22.7	26.4	0.00000*

Table (26). Stakeholder Groups' views on Benefits to Difficulties ratio in their P'ships

Differences in participants' perceptions of Benefits to Difficulties in their Partnership (summaries of the percentages of respondents of comparison groups who reported "equal or more benefits than difficulties")

Variable	AI	HS	CM	CS	*P* Level
Ratio of benefits to difficulties in the Partnership: 1. Equal, slightly more or much benefits than difficulties	77.3	68	66.8	56.6	NS

Table (27). Stakeholder Groups' views on the Role Clarity in their Partnerships

Differences in participants' perceptions of the clarity of their roles in their Partnerships (summaries of the percentages of respondents of comparison groups who reported any role)

Variable	AI	HS	CM	CS	*P* Level
Any role: type of contribution (advise, develop, recommend or approve) that you typically have in: 1. Setting P'ship's programmes budget	60.2	67.0	70.6	78.6	0.0001*
2. Designing program goals & objectives	81.2	76.1	75.4	86.2	0.00001*
3. Selecting local subcontractors	45.6	58.2	61	84.4	0.00000*
4. Developing P'ship's overall plans	72.3	64.7	71.4	81.9	0.0008*

Table (28). Percentages of respondents reporting Personnel Barriers as problems (Whole Sample)

Personnel Barrier	Valid cases *N*	Major problem	Minor problem	Not a problem
Professional Staff turnover	632	31.5	32.9	35.6
Volunteer availability	630	31.0	29.2	39.8
Keeping volunteer interest	609	30.9	31.0	38.1
Professional Staff priorities	613	25.6	40.0	34.4
Volunteer changing/ turnover	604	24.7	32.8	42.5
Professional Staff availability for the partnership	629	24.5	34.8	40.7
Keeping Professional Staff interest	633	23.5	34.9	41.5
Expertise of Professional Staff & Volunteers	625	20.3	38.9	40.8
Interest in partnership activities	634	15.9	36.4	47.6

Table (29). Stakeholder Groups' views on the Personnel Barriers in their P'ships

Differences in participants' perceptions of personnel barriers in their Partnerships (summaries of the percentages of respondents of comparison groups who reported barrier to be either a "major or minor problem")

Variable	AI	HS	CM	CS	*P* Level
1. Professional Staff availability	69.9	71.8	52.6	54.3	0.00005*
2. Professional Staff turnover	60.5	72.7	62.2	70.7	0.01*
3. Professional Staff interest	61.6	70.4	51.8	69.5	0.0003*
4. Professional Staff priorities*	72.5	70.9	59.9	74.2	0.002*
5. Volunteer availability	67.3	58.6	56.6	69.5	0.08 (NS)
6. Volunteer turnover	62.6	56.1	53.6	75.0	0.03*
7. Keeping volunteer interest	63.6	64.7	58.8	72.7	0.42 (NS)
8. Expertise of Professional Staff and Volunteers	63.6	65.7	54.5	66.7	0.06 (NS)
9. General interest in Partnership activities	60.0	63.4	46.6	51.7	0.002

* Significant

Figure (44). Percentages of Respondent Groups' Authority to Make Decisions on behalf their Organisations
(*N* = 618)

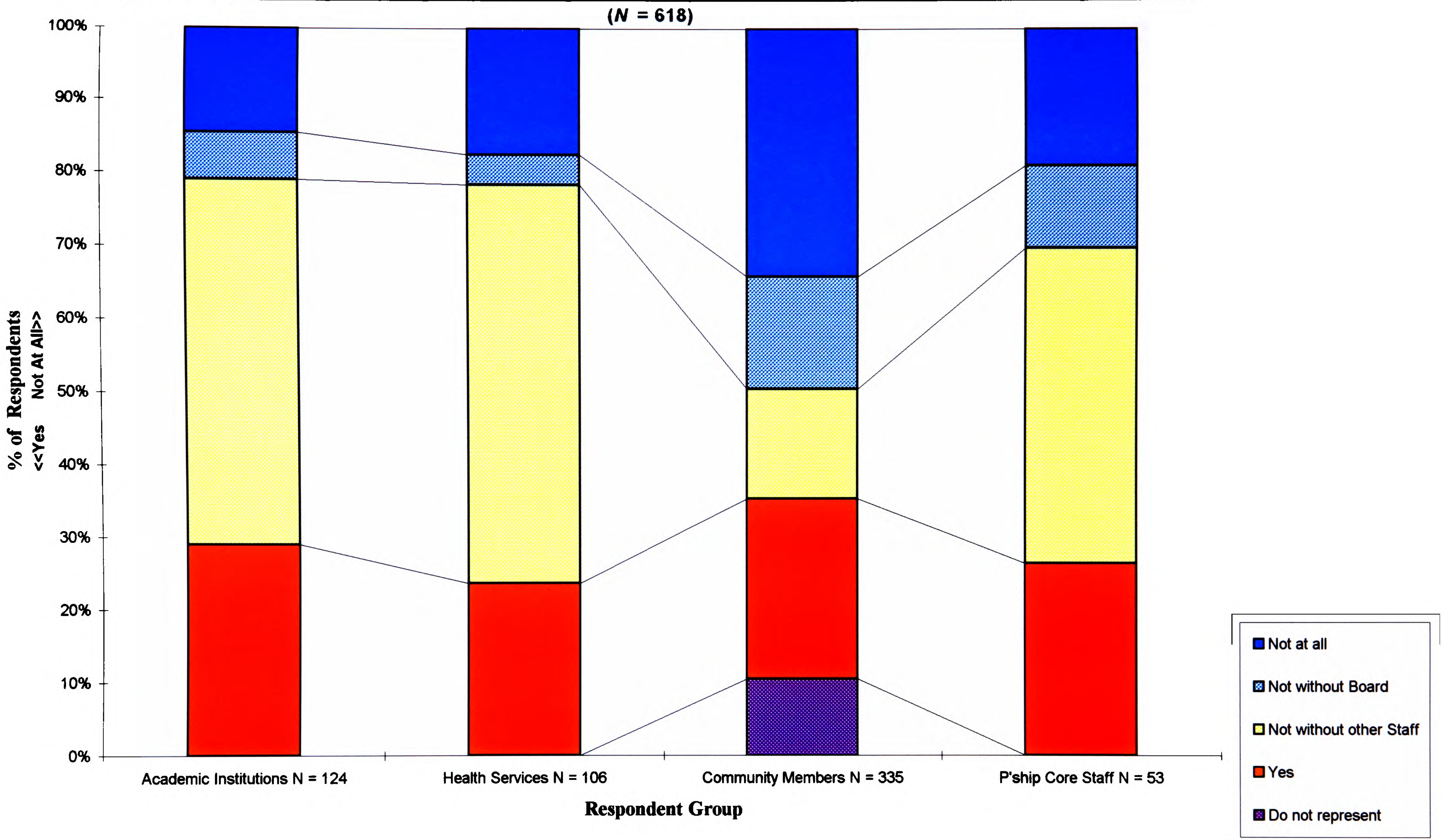


Figure (45). Percentages of Respondent Groups' Perceptions of Benefits and Difficulties in their Partnerships (*N* = 637)

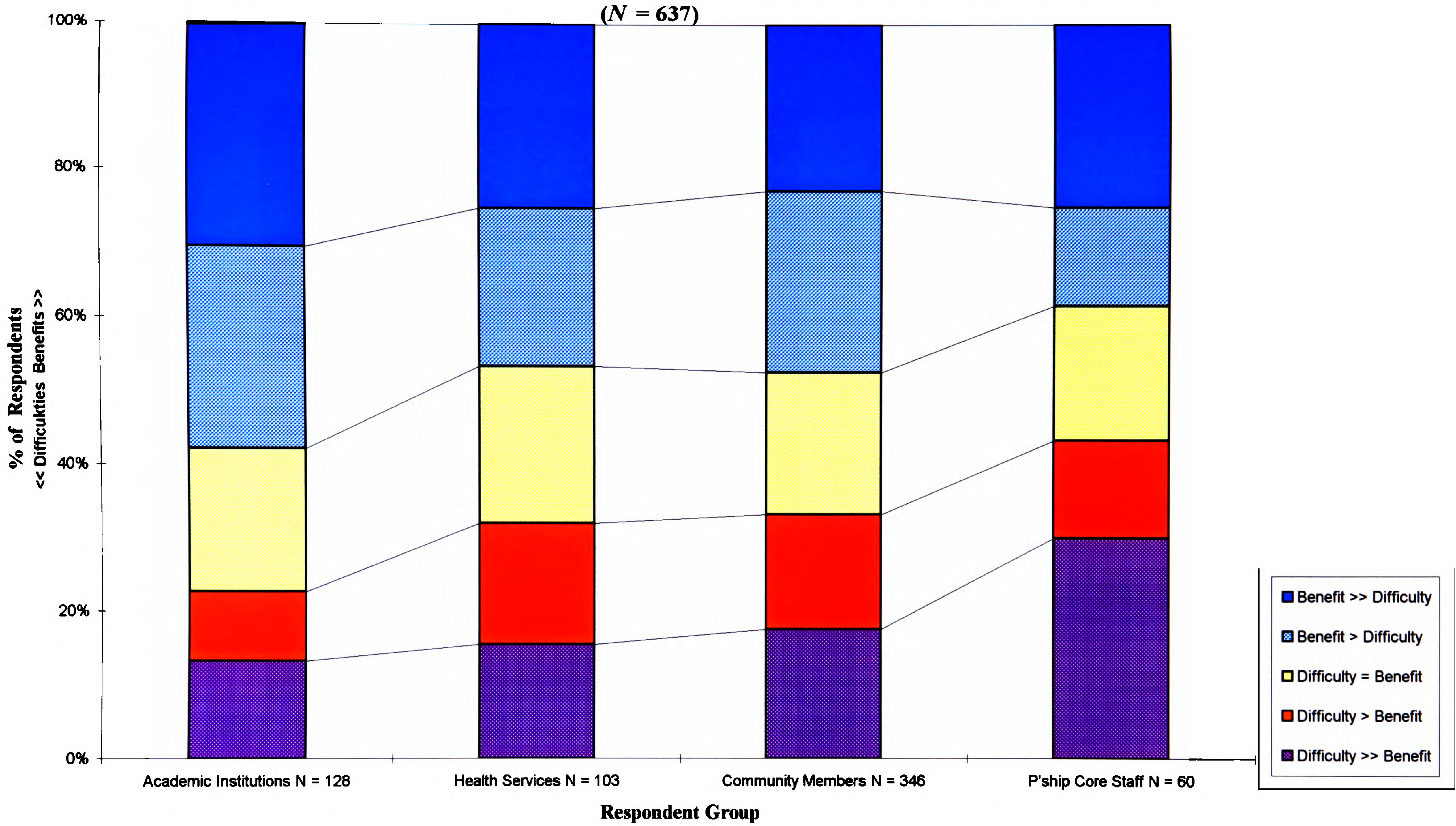


Figure (46). Benefits to Costs Ratio by Degree of Involvement (N = 626)

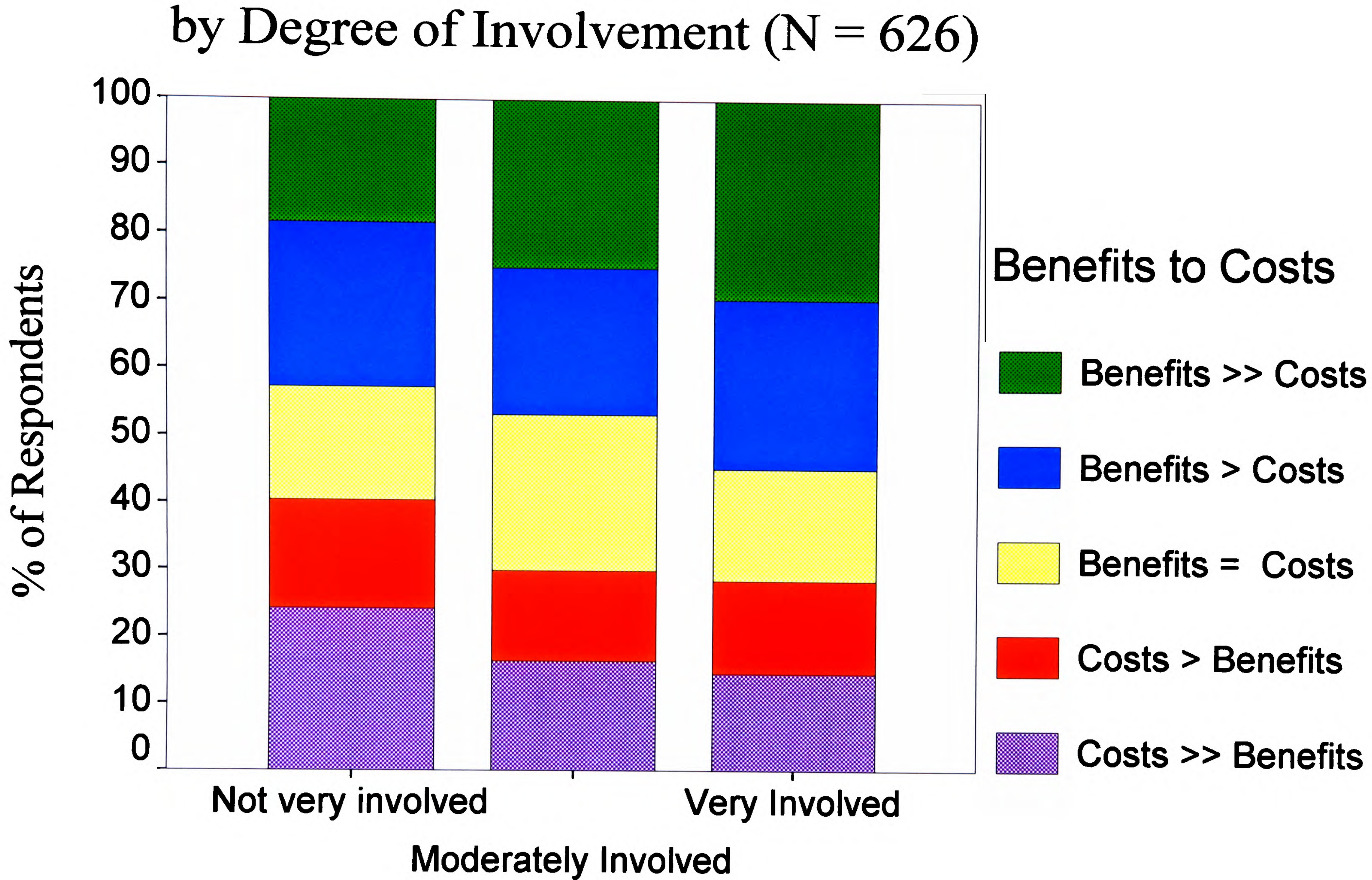


Figure (47). Percentages of Participant Groups reporting a) Any Role in their P'ships; b) Personnel Barriers to be either a major or minor problem

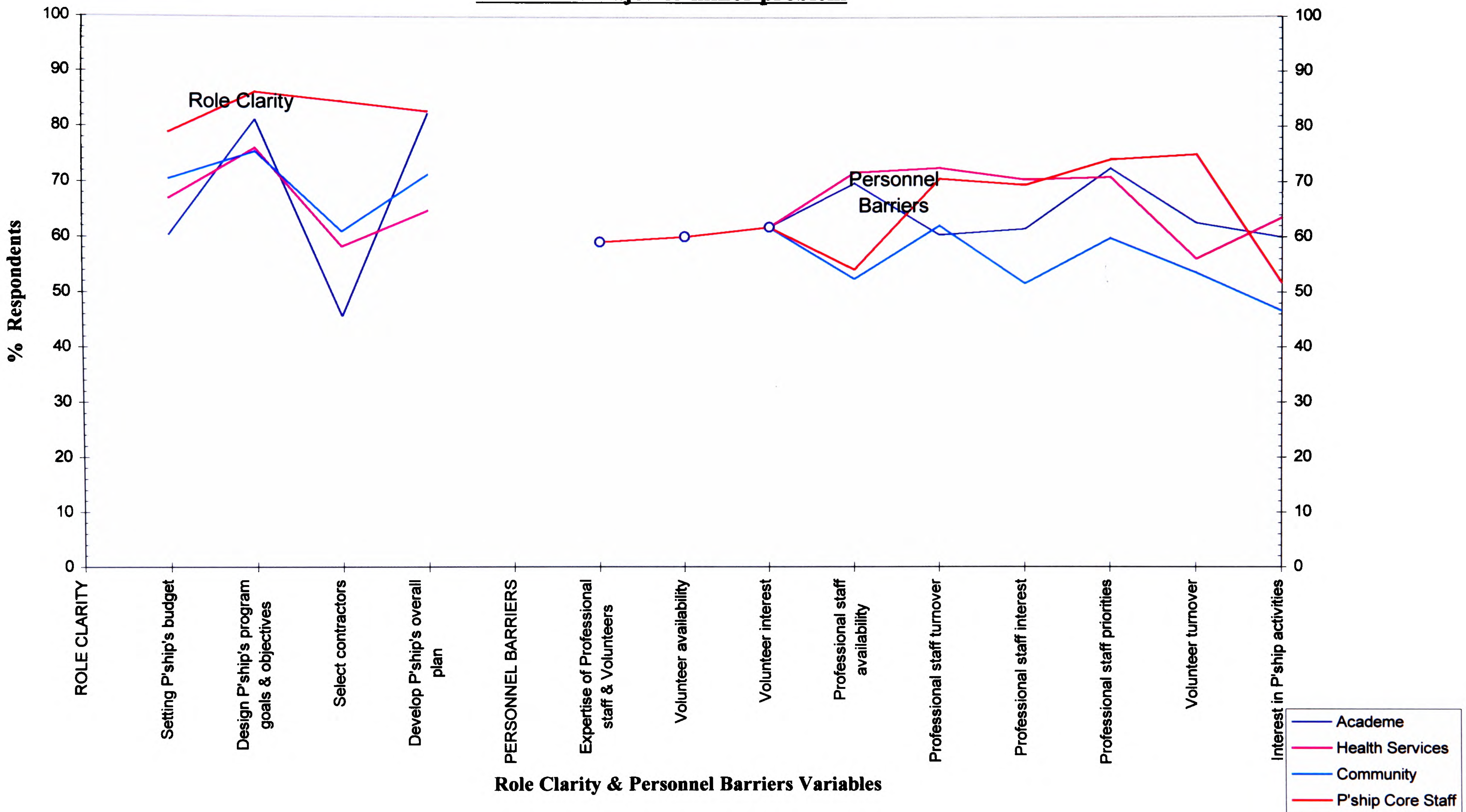


Figure (48). Roles of Stakeholders

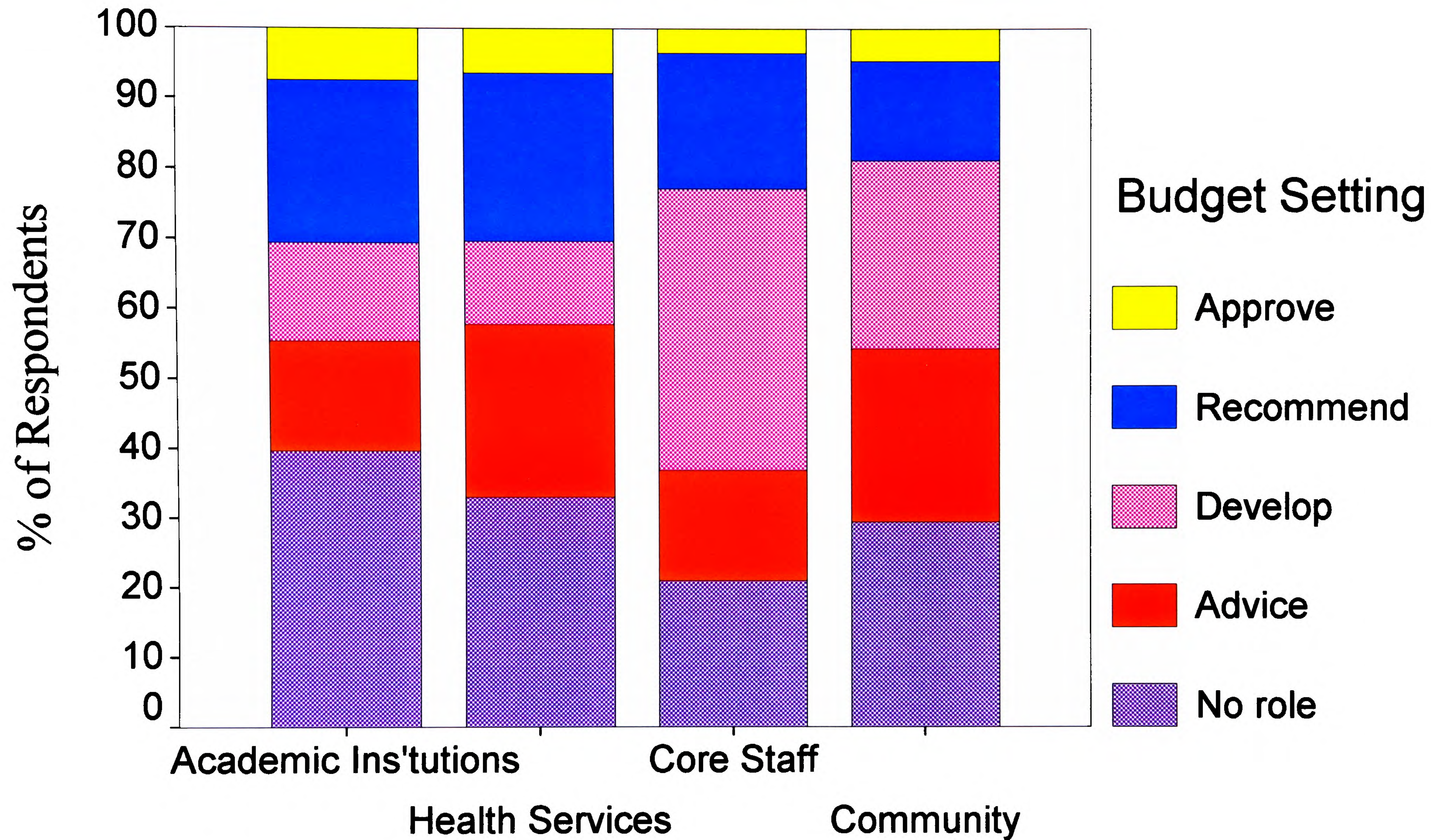


Figure (49). Roles of Stakeholders

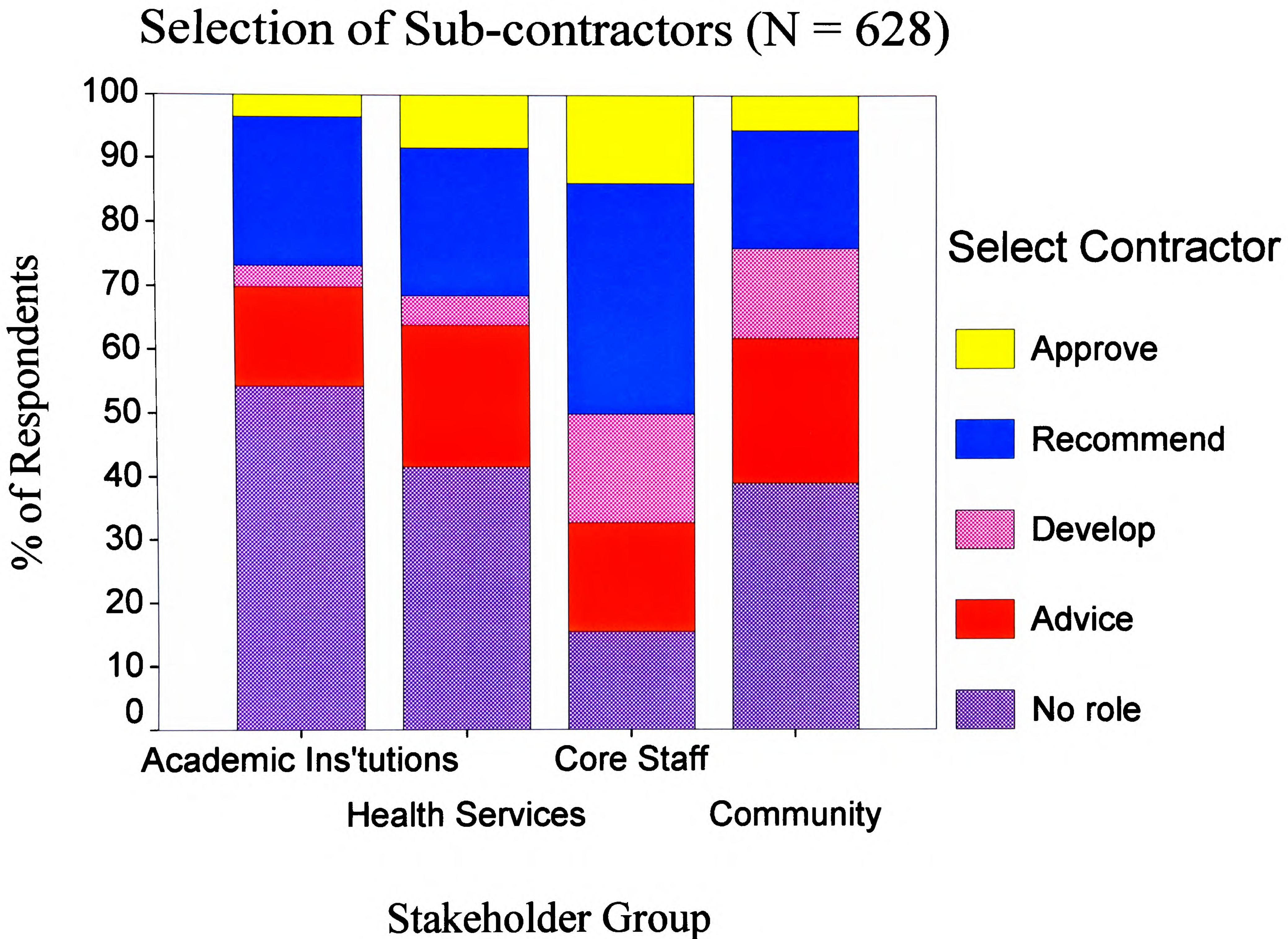


Figure (50). Roles of Stakeholders

Programme Design (N = 639)

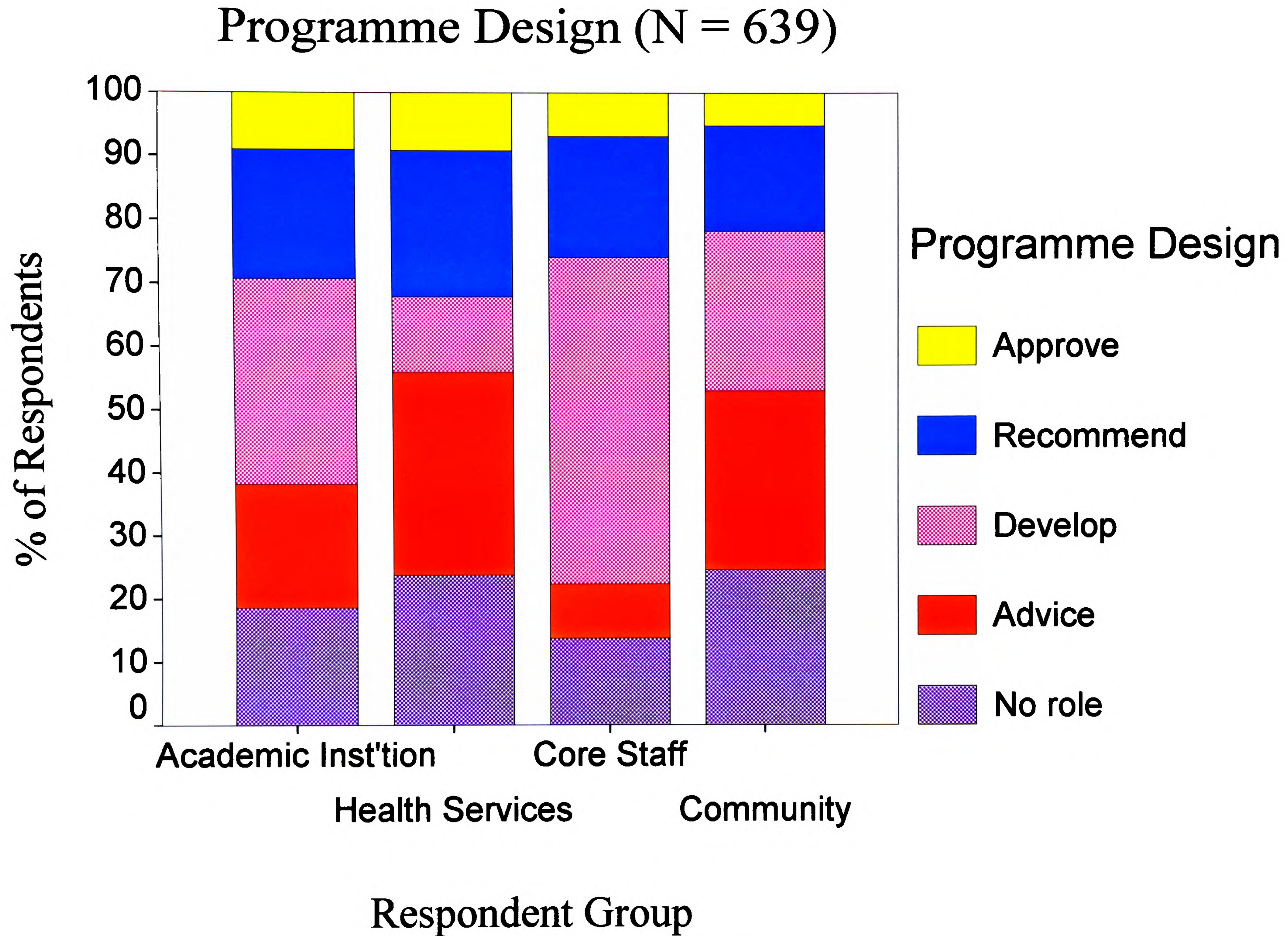


Figure (51). Roles of Stakeholders

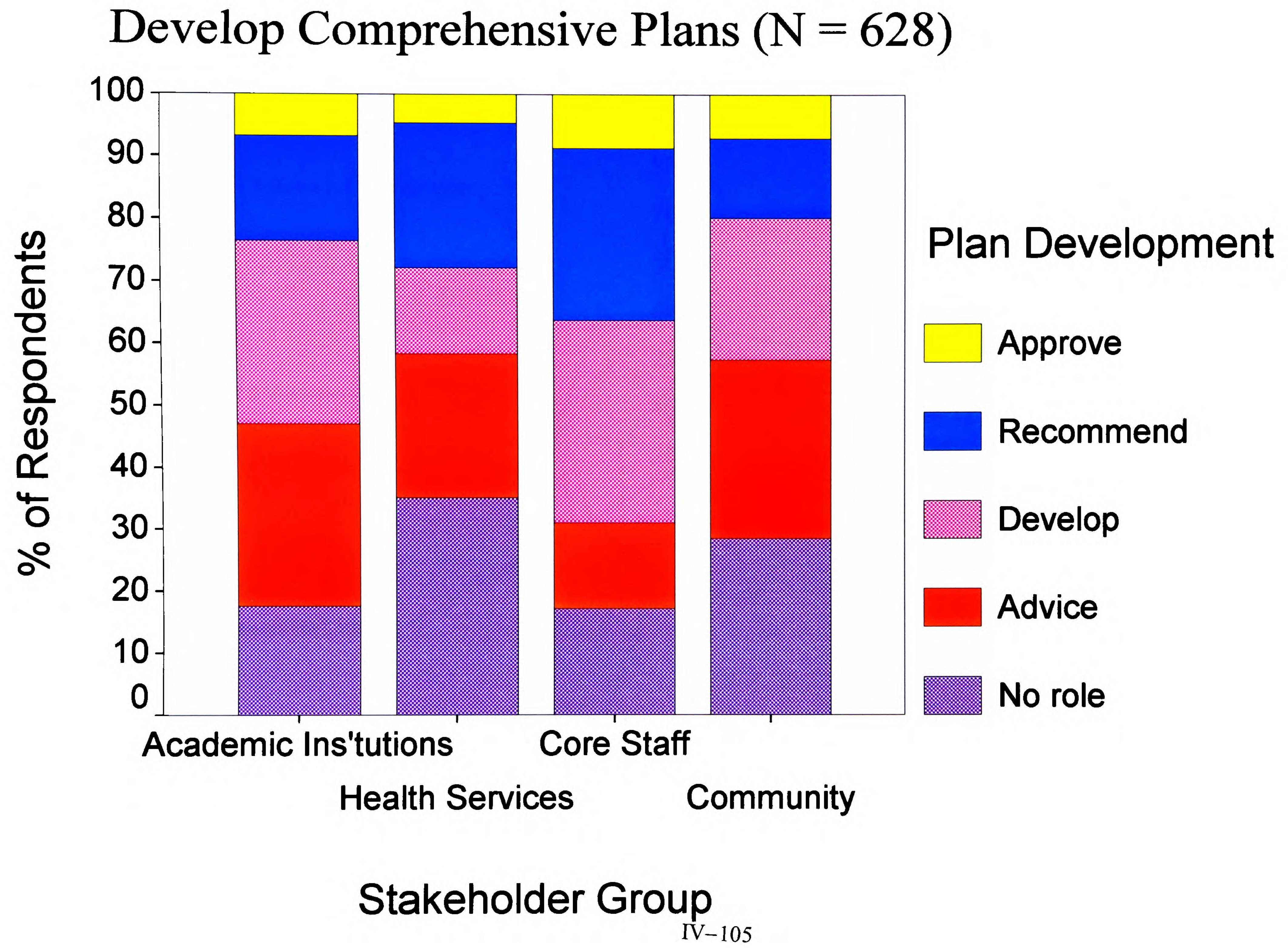
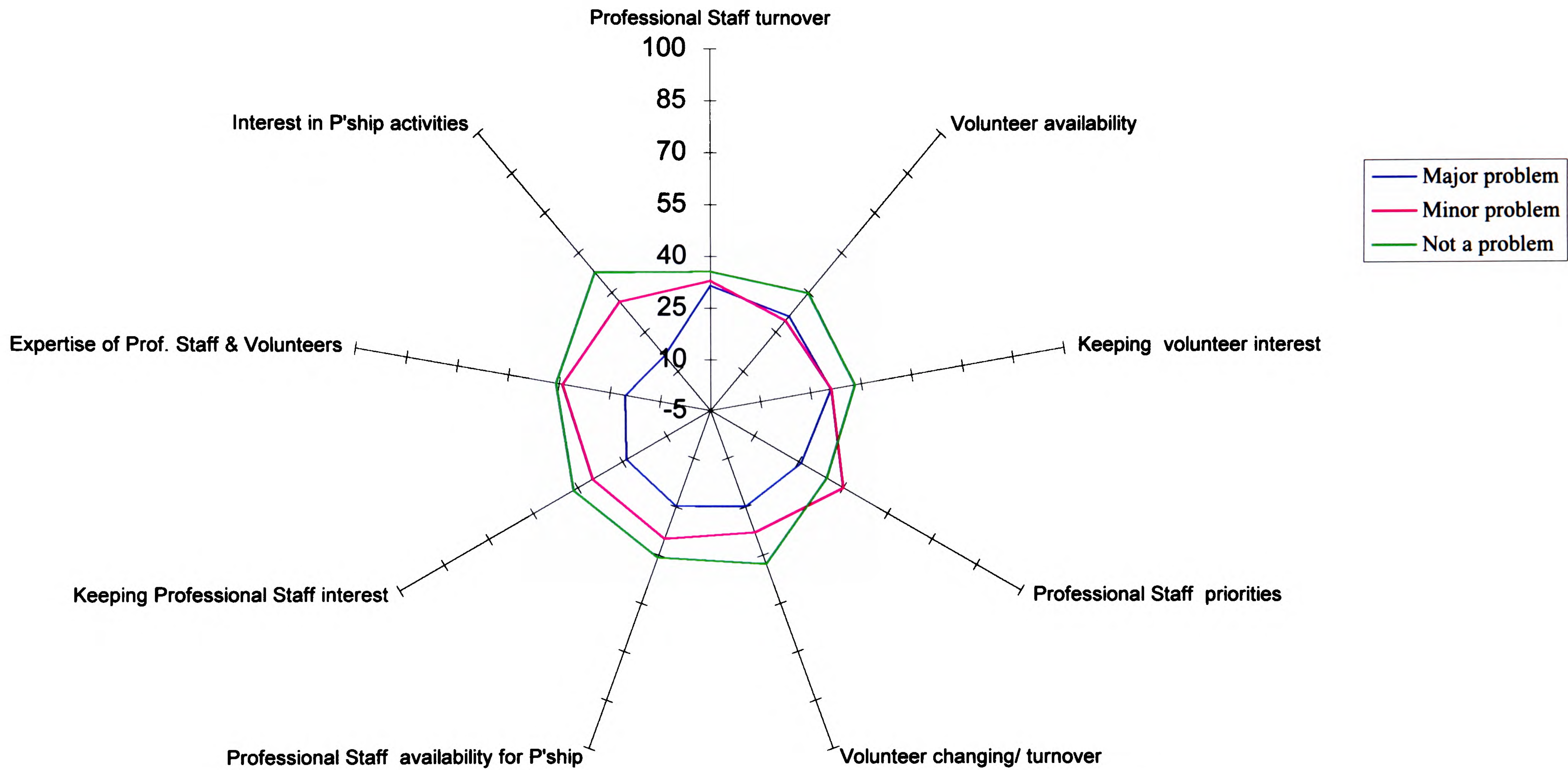


Figure (52). Stakeholders' perceptions of Personnel Barriers (Percentage of Whole Sample)



8. Leadership Skills

Table (30) and Figure (53) suggest the following:

Areas of agreement

The participants had similar views with regards several aspects of the leadership skills in their CPs. The stakeholders agreed that the leadership in their CPs made them feel welcome, gave praise or recognition and listened to opinions and comments during meetings. They also agreed that the leadership provided continuing education opportunities and offered group activities to CPs members (≈ 60 - 90 % of each group reported "Yes"). A lower number of participants also reported that the leadership reported the CPs achievements through newsletters, etc. (≈ 45 - 65 % of each group).

Areas of disagreement

However, participants expressed significant differences in other aspects of the leadership skills in their CPs. The differences between the stakeholders did not follow any special pattern or trend but were rather erratic. For instance, more CM expressed that the leadership provided them with a lot of good information, a point that less AI participants reported. On the other hand, more participants from the CS reported that the leadership held social gatherings for CPs members, and asked them to assist with organisational tasks, two points that less respondents from the other three groups agreed to. However, more CS than AI felt that leadership seeked out and welcomed their views. Conversely, the picture was reversed when more AI than CS reported that leadership seeked views of people outside the CPs.

The general impression was that a considerable proportion (50 - 90 %) of respondents felt many positive aspects of the leadership in their CPs. This was in the form of disseminating reports of achievement, multiple and varied group activities, educational opportunities locally, nationally and overseas, or alternatively in the form of recognition and consultation that the leadership undertook. For other aspects of leadership skills, e.g. the quality of information or skills in eliciting different constructive views from within as well as from outside the CPs, the proportions of groups reporting positively were still in the same range (50 - 90 %), but there were significant differences in perceptions.

9. Communication Mechanisms

Table (31) and Figure (53) suggest the following:

Areas of disagreement

The respondent groups expressed significant differences in all aspects of the communication mechanisms in their CPs. More CS reported a regularly published newsletter as a communication mechanism, a point that was reported by less than 50 % of respondents from any of the other three groups. Then, the respondents were further asked about two kinds of communication: that within their own CPs; and communication with the other sister SA CPs. First, as regards the mechanisms within their own CPs, again more CS participants reported that they received written reports from their CPs' staff, and verbal reports whether at or outside their CPs meetings. The CM group reported the lowest scores on the latter three mechanisms.

Second, when queried about the mechanisms of communication with the other SA CPs, the general number of respondents within the stakeholders reporting positively generally dropped, indicating that fewer participants are in any form of contact, directly or indirectly, with the other sister SA CPs. In spite of this finding, again, significantly more CS than the other groups reported that they received, directly or indirectly, written reports from other SA CPs and had opportunities to talk with other SA CPs, whether at meetings or outside of meetings. Only small proportions (20 - 50 %) of the AI, HS and CM participants reported these as communication mechanisms. This finding has an implication, given the context and existence of the SA network of CPs that was formed by representatives from the seven CPs, with the main duty of networking between the seven sister partnerships to inform and facilitate their development.

Besides written and verbal reports at or outside meetings, other means of communication reported included meeting at conferences, seminars or awareness workshops, annual reports, memos and irregular publications, presentations, informal socials and reporting back, telephone, faxes and telephone conferences, and visits to other SA CPs or abroad. Broadcasting over air (radio) was used in one CP that had dispersed and remote communities and joint purchase of mobile telephones for the partners was adapted in another.

Table (30). Stakeholder Groups' views on the Leadership Skills in their Partnerships

Differences in participants' perceptions of leadership skills in their Partnerships (summaries of the percentages of respondents of comparison groups who reported "Yes")

Variable	AI	HS	CM	CS	*P* Level
The Partnership's leadership 1. Provides me with a lot of good information	65.9	68.8	78.9	75.9	0.01*
2. Makes me feel welcome at meetings	90.3	88.2	87.1	87.9	0.81 (NS)
3. Gives praise/ recognition at meetings	82.9	80.4	75.1	76.8	0.28 (NS)
4. Seeks out and welcomes my views	66.1	81.5	77.2	74.1	0.03*
5. Provides continuing education opportunities	67.9	66.0	70.0	72.9	0.81 (NS)
6. Reports achievements through newsletters, etc.	57.1	45.5	54.7	67.2	0.05 (NS)
7. Holds social gatherings for P'ship members	57.5	56.7	68.2	69.5	0.04*
8. Seeks views of people outside the P'ship	75.9	61.2	65.1	52.6	0.01*
9. Listens to opinions/comments during meetings	57.1	45.4	54.7	67.2	0.05 (NS)
10. Asks me to assist with organisational tasks	58.1	57.0	56.4	84.7	0.0005*
11. Offers group activities to P'ship members	70.0	60.0	62.6	75.4	.06 (NS)

* Significant

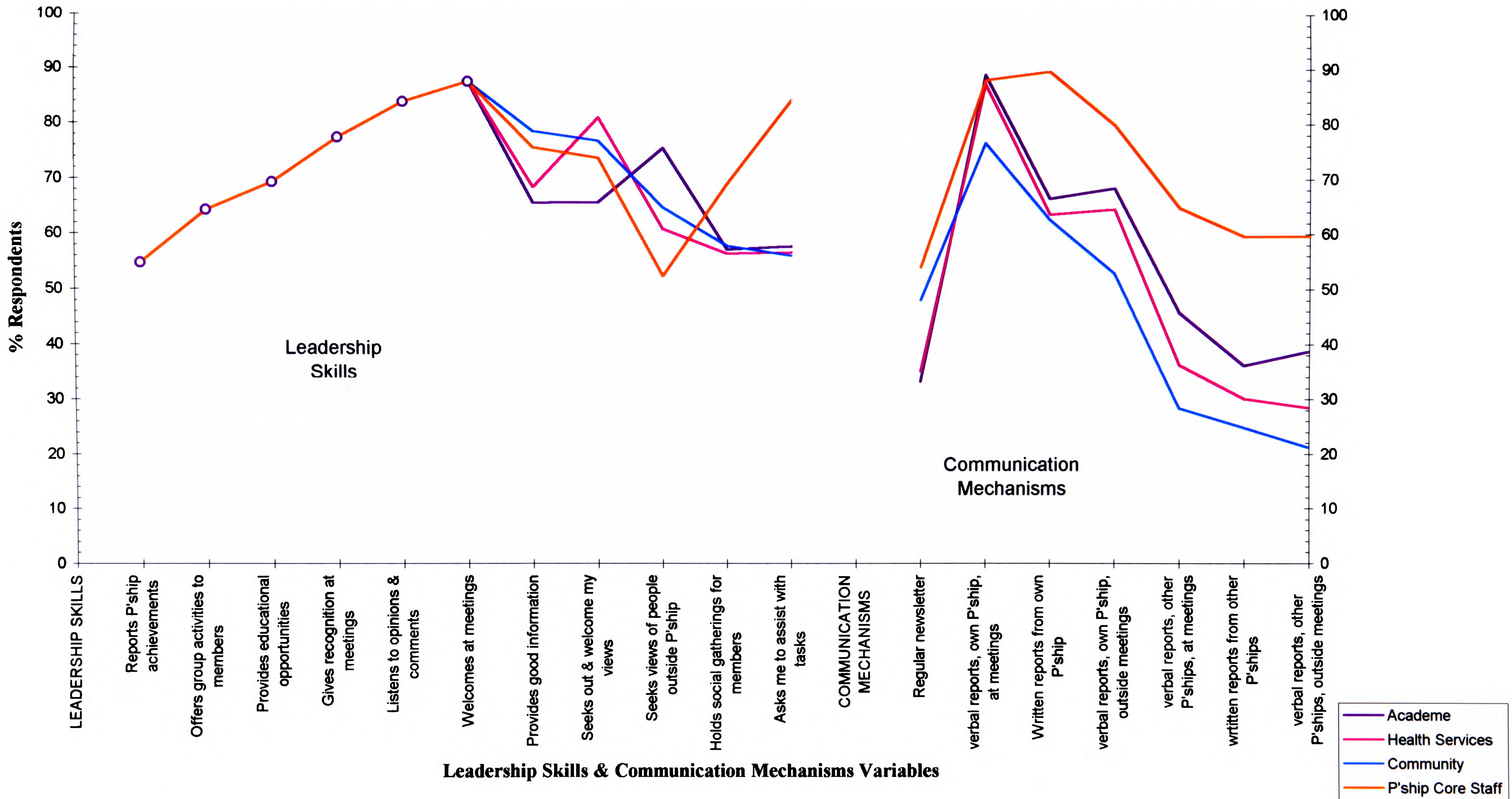
Table (31). Stakeholder Groups' views on the Communication Mechanisms in their Partnerships

Differences in participants' perceptions of communication mechanisms in their Partnerships (summaries of the percentages of respondents of comparison groups who reported "Yes")

Variable	AI	HS	CM	CS	*P* Level
1. Regularly published newsletter	33.3	35.2	48.2	54.2	0.002*
2. Written reports from own P'ship's staff	66.7	63.8	62.8	89.8	0.0007*
3. Written reports from other SA P'ships	36.1	30.1	24.8	59.6	0.0000*
4. Verbal reports at own P'ship's meetings	89.3	87.6	76.9	88.3	0.002*
5. Verbal reports outside own P'ship's meetings	68.5	64.7	53.1	80.0	0.00007*
6. Opportunities to talk with other SA P'ships at meetings	45.8	36.3	28.4	64.9	0.00000*
7. Opportunities to talk with other SA P'ships outside of meetings	38.7	28.4	21.2	59.6	0.00000*

* Significant

Figure (53). Percentages of Participant Groups reporting positive responses By Section of Questionnaire



10. Organisational Barriers

Areas of agreement

Tables (32 - 33) and Figures (54 - 55) suggest that the participants had similar views with regards the organisational barriers in their CPs. Fifty to sixty percent of the whole sample agreed that partnership vs. organisational fund raising, the setting of goals in the CPs and leadership from the national level (the SA Network of CPs) were either major or minor problems.

Areas of disagreement

The respondent groups expressed differences as regards all the other organisational barriers in their CPs. Significantly less participants from the AI group than the other three felt that the barriers of partnership versus organisational credit for activities, the assumption of leadership by a lead partner, the marketing of individual partner's materials, and the differences in partner's financial/ tax years to be either major or minor problems in their CPs. Differences in partner's philosophy and co-ordination of activities between the partners were reported by about 50-70 % of each respondent group, although the CM participants reported the least scores of all the groups.

More HS respondents than the other three groups viewed the differences in partner's service areas and in partner's structure to be a problem. The lack of participation and availability of funds were viewed by about 60 - 80 % of the sample as a problem. Significantly less CM viewed decision making and communication to be problems in their CPs

Taken collectively, the findings suggest that for many of the statements in this section, approximately 50 % or more of participants from each group viewed them to be either a major or minor problem in relation to their CPs. All through the section (60 % of statements), the HS and CS generally scored higher than the other two groups indicating that more respondents from those two groups view the statements as problems in their CPs.

In order to get a feel for the kind of organisational barriers encountered for the whole sample of informants from this cluster of CPs, the general percentages of respondents reporting problems related to organisational barriers are shown in Table (32). The top four barriers viewed as major problems by the whole sample were availability of funds, lack of participation by one or more partners, competing priorities among partners, and differences in partners' financial/ tax years (each was reported by ≈ 30 -

45 % of the whole sample). On the other hand, the top four personnel barriers viewed as minor problems by the whole sample were competing priorities among partners, differences in partners' philosophies, partnership versus organisational credit for activities, and differences in partners' structure.

11. Perceived Effectiveness

Table (34) and Figure (56) suggest that for all of the statements in this section, the respondent groups disagreed with each other. Firstly, the AI group seemed to score highest all through the section (80 % of the questions) indicating that more AI respondents generally viewed the domains posed as either effective or extremely effective in their CPs. Secondly, the general trend of the overall numbers of respondents from all groups who viewed the queried aspects of their CPs to be either effective or extremely effective exhibited three phases: it started high, then steadily decreases in a smooth down sloped curve as the domain of the inquiry moves from decision making and a PHC focus of the CPs (≈ 70 - 90 % of all sample) to aspects of fund-raising and the development of public relations or media inputs in the CPs which were percieved as more problematic (≈ 45 - 60 % of all sample). The curve then smoothly rises again indicating that large overall number of participants viewed their CPs as resources for improving the quality and increasing the accessibility of local health services, as well as raising public awareness of health issues and planning (≈ 75-85 % of all sample).

However, less CS respondents (≈ 35 - 45 %) than the other groups reported the volunteer co-ordination or public relations or media inputs in the CPs to be effective. Conversely, less HS respondents (≈ 46-48 %) perceived their CPs activities of fund-raising and involving minorities to be effective [Tables (32 - 33) and Figures (54 - 55)].

12. Perceived Activity

Tables (35) and Figure (56) suggest that the participants had similar views with regards the perceived levels of their CPs activities in the year previous to the commencement of the study and in the year of the study. Between 85 - 90 % of the sample reported that their CPs were either active or very active during those two time periods.

Table (32). Percentages of respondents reporting Organisational Barriers as problems (Whole Sample)

Organisational Barrier	Valid cases *N*	Major problem	Minor problem	Not a problem
Goal setting	621	16.4	31.9	51.7
Differences in partners' structure	607	20.9	39.5	39.5
Differences in partners' service areas	570	18.9	38.1	43.0
Leadership from national level	490	22.4	30.4	47.1
Co-ordination of activities among partners	624	23.2	34.0	42.8
Communication between the partners	595	23.7	35.6	40.7
Marketing of individual partners' materials	577	21.1	28.4	50.4
Assumption of leadership by a lead partner	619	24.2	35.4	40.4
Differences in partners' philosophies	609	24.5	41.5	34.0
Partnership versus organisational fund raising	603	26.0	33.8	40.1
Differences in partners' financial/ tax years	561	27.8	34.9	37.3
Partnership versus organisational credit for activities	612	26.8	39.9	33.3
Decision making	631	26.6	35.5	37.9
Competing priorities among partners	633	27.2	42.7	30.2
Lack of participation by one or more partner	621	33.7	36.9	29.5
Availability of funds	625	46.7	27.4	25.9

* Significant

Table (33). Stakeholder Groups' views on the Organisational Barriers in their P'ships

Differences in participants' perceptions of organisational barriers in their Partnerships (summaries of the percentages of respondents of comparison groups who reported barrier to be either a "major or minor problem")

Variable	AI	HS	CM	CS	*P* Level
1. Competing priorities among partners	79.5	79.1	62.1	79.3	0.0002*
2. P'ship vs. organisational fund raising	58.9	51.0	62.5	61.4	0.53 (NS)
3. P'ship vs. organisational credit for activities	54.4	66.0	69.2	76.2	0.03*
4. Assumption of leadership by a lead partner	53.8	73.3	56.6	64.9	0.03*
5. Marketing of individual partner's material	42.3	57.7	50.0	46.3	0.01*
6. Differences in partner's financial/ tax years	43.8	60.0	69.8	57.2	0.00004*
7. Differences in partner's philosophy	68.7	70.9	62.8	70.2	0.01*
8. Co-ordination of activities between partners	70.3	64.7	47.3	74.6	0.00001*
9. Goal setting	49.5	51.5	46.4	51.7	0.57 (NS)
10. Differences in partner's service areas	60.2	63.7	53.5	56.1	0.005
11. Differences in partner's structure	50.8	72.4	58.5	50.8	0.04*
12. Leadership from the national level	57.2	52.4	53.2	44.7	0.22 (NS)
13. Lack of participation by partner/s	76.1	74.3	65.7	81.8	0.01*
14. Availability of funds	67	67.4	77.1	66.7	0.04*
15. Decision making in the Partnership	63.4	70.4	57.9	69.5	0.01*
16. Communication between partners	77.1	63	50	69.8	0.00003*

* Significant

Figure (54). Percentages of Participant Groups reporting Organisational Barriers to be either major or minor problem

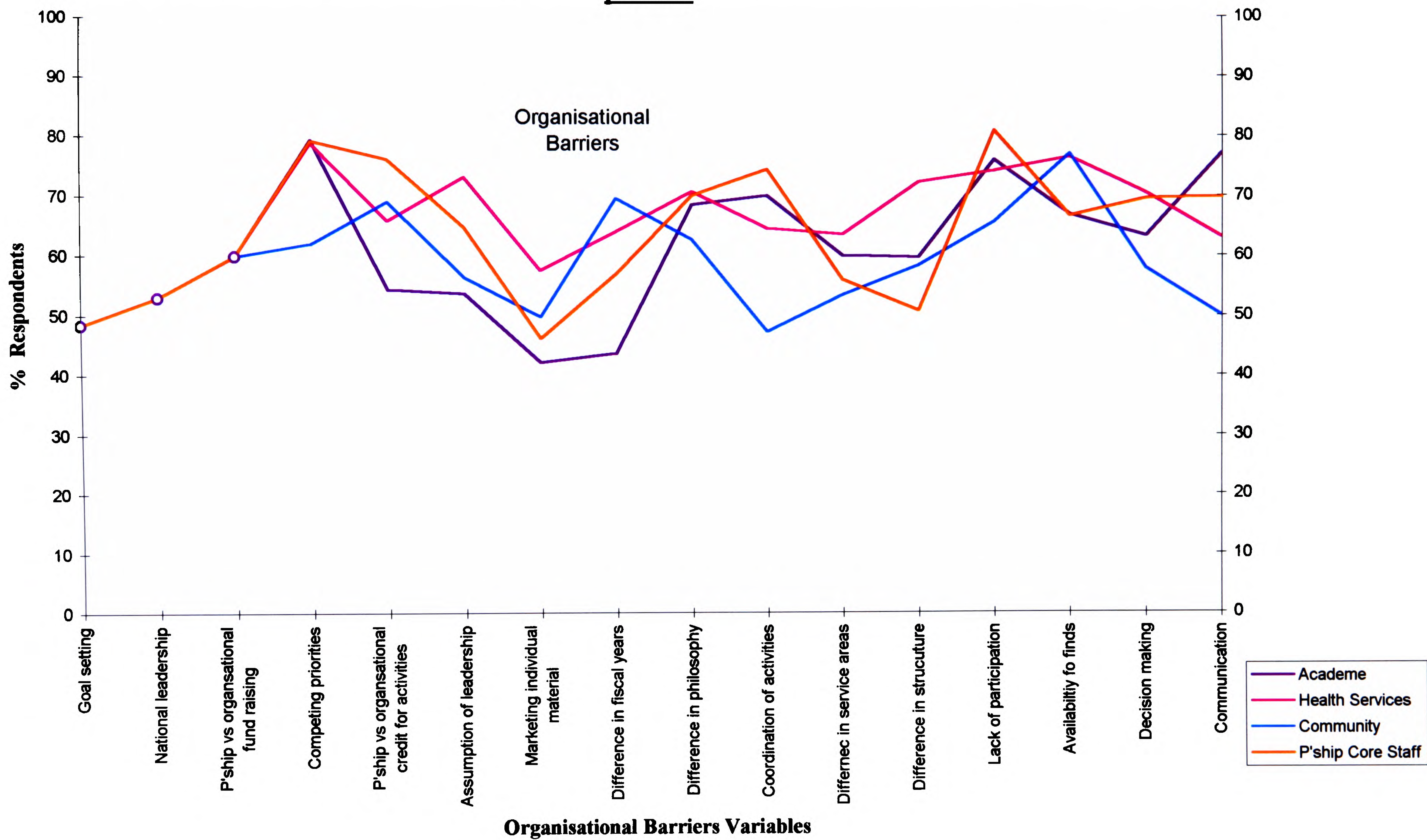


Figure (55). Stakeholders' perceptions of Organizational Barriers (Percentage of Whole Sample)

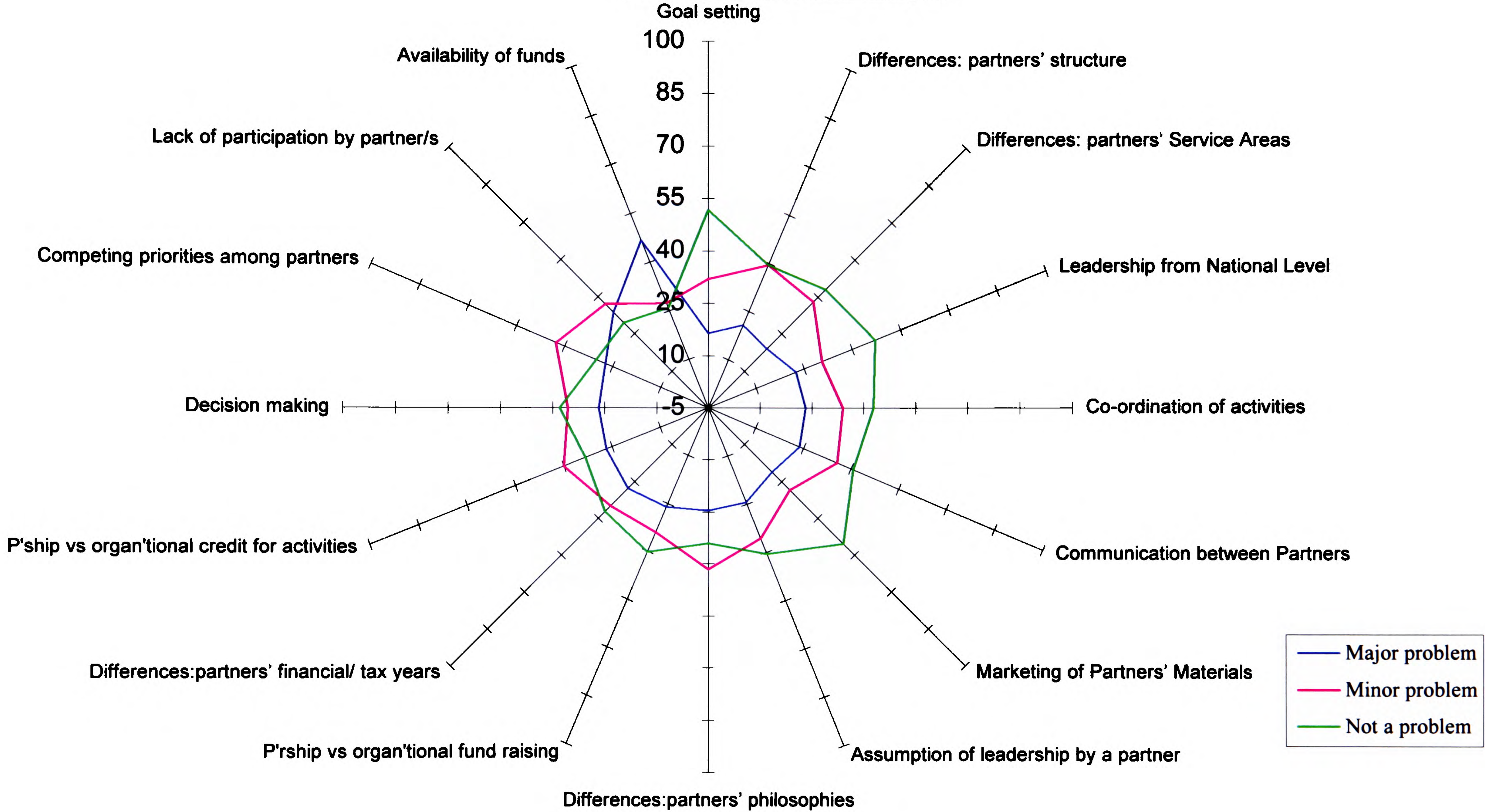


Table (34). **Stakeholder Groups' views on the Perceived Effectiveness in their Partnerships**

Differences in participants' perceptions of effectiveness in their Partnerships (summaries of the percentages of respondents of comparison groups who reported the aspect to be be either "effective" or "extremely effective")

Variable	AI	HS	CM	CS	*P* Level
1. Communication between the partners	61.6	78.3	73.8	57.7	0.00000*
2. Goal setting	82.8	73.6	71.6	74.1	0.00000*
3. Making decisions	76.8	72.1	72	69.5	0.0001*
4. Focus on primary health care	90.2	80.6	77.2	85.7	0.002*
5. Training community health workers	75.3	59.9	67.9	78.6	0.00000*
6. Volunteer co-ordination	65.4	60.2	58.9	36.4	0.0001*
7. Fund-raising	60.6	46.4	58.2	61.8	0.00005*
8. Public relations/ media	61.8	59.8	58.5	45.7	0.00001*
9. Involve minorities in P'ship activities	65.8	48.6	53.9	56.4	0.0005*
10. Evaluation of its performance	75	67.6	66.6	63.8	0.03*
11. Make health planning community responsive	77.4	73.3	71.6	74.5	0.00000*
12. Help comm. emerge as force on health issues	86.1	69.2	64.5	63.8	0.00001*
13. Improving the quality of local health services	81.4	81.3	76.1	77.6	0.00001*
14. Increasing accessibility of health services	81	77.6	72.2	78.5	0.00002*
15. Raising awareness of health issues/ planning	84.5	82.3	73.5	81	0.00000*

* Significant

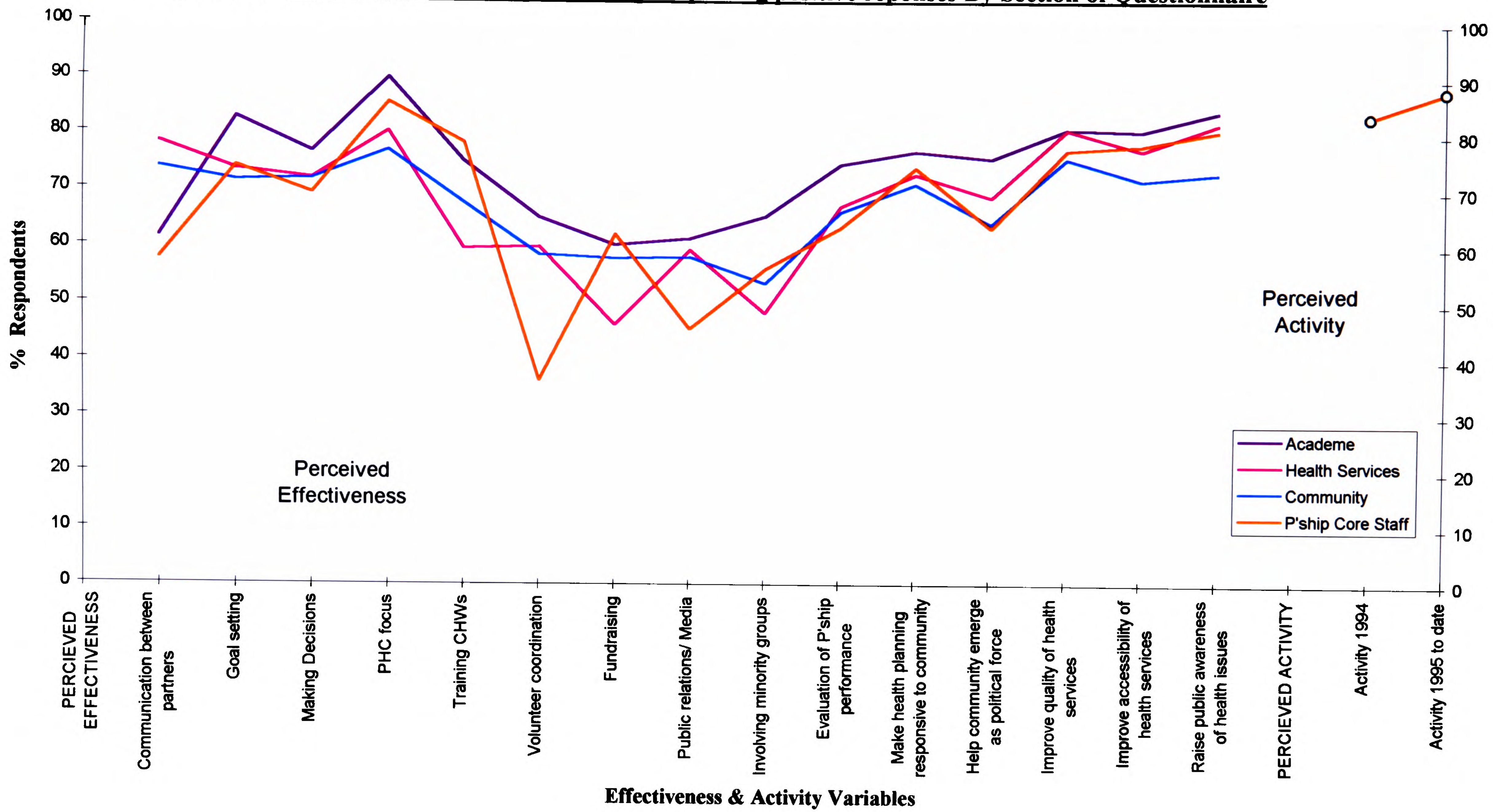
Table (35). **Stakeholder Groups' views on the Perceived Activity in their Partnerships**

Differences in participants' perceptions of activity level in their Partnerships (summaries of the percentages of respondents of comparison groups who reported partnership aspect to be be either "active" or "very active")

Variable	AI	HS	CM	CS	*P* Level
1. Perceived activity in 1994	91.2	80.7	81.8	86	0.18 (NS)
2. Perceived activity: 1995 until point of study	89.6	84.3	86.5	87.7	0.86 (NS)

* Significant

Figure (56). Percentages of Participant Groups reporting positive reponses By Section of Questionnaire



Summary of Findings: Sections With Categorical Scales; Radar Graph

Table (36) and Figure (57) summarize the data emerging from the variables with categorical scales. A composite score for each of the four comparison groups for each of the questionnaire sections was computed by averaging the scores for each stakeholder group across all the questions of the section [Annex (14)]. This was done by computing the total number of respondents from each group who answered in a *positive* sense to the questions asked in a particular section (expressed as a percentage of that group). In doing this computation it is assumed that positive responses to the statements are a "good thing" (e.g. for statements on operational understanding, only respondents who answered 'Yes' were counted; or for statements on CPs effectiveness, respondents who answered either 'Effective' or 'Extremely Effective'). Exceptions to this rule were two sections, namely organisational barriers and personnel barriers, where the calculation done here was reversed. Only the numbers of respondents who answered in the *negative* sense were counted (e.g. percentages of respondents who viewed the queried statements as being either a 'Major' or 'Minor' problem in their Partnerships.

In this sense a larger web with more radius would generally indicate a 'good thing' (e.g. more respondents answering 'Yes' to statements regarding roles and procedures as 'does your Partnership have written mission statements'; or operational understanding 'do you know the Partnership's organisational structure and staffing'; or leadership 'the Partnership's leadership provides me with a lot of good information') except in the two arms of the barrier sections mentioned above (where a wide radius would indicate more people complaining of the queried barriers). Thus the figure summarized the responses of 668 respondents from four comparison groups commenting on about 82 variables divided into sections or parameters with categorical scores which represented the arms of the radar graph.

A Bird's eyeview

What emerged from the figure was the following:

1. In general, for all the four comparison groups, their scores (webs) seemed to fall within the range of 50 - 75 % i.e. sometimes well above average. This was usually in the form of an affirmative response to positively phrased statements about rules and procedures (e.g. 'Does your Partnership have written mission statements'); or about operational understanding (e.g. 'Do you know how new members are chosen'); or about leadership skills in the Partnership (e.g. 'The Partnership's leadership provides me with a lot of good information'); or communication mechanisms (e.g. 'Written reports from own P'ship's

staff '). An exception warranting attention is the scores of the groups on the arm on perceived activity where more than 75 % all the groups reported that their CPs were either moderately active or very active over the last years.

2. Within the above mentioned range where the four webs fluctuated smoothly, three "bulges" (or areas of non overlap) and one "dip" were noted; one related to the CS, the second to the AI, the third to the HS, and the fourth to the CM:

2.1 The web of the CS group seemed to bulge out in right half of the graph: significantly more respondents from the CS group reported positive responses when asked to comment on positive statements regarding about leadership skills, communication mechanisms, role clarity, rules and procedures and operational understanding in their CPs.

2.2 The web of the AI group seemed to bulge out in the left half of the graph: significantly more respondents from the AI group exhibited positive responses when asked about perceived effectiveness and activity of the CPs and more of this group viewed a benefits to difficulties ratio of their involvement in their Partnerships as equal or more benefits.

2.3 The web of the HS group seemed to bulge out on two arms in the lower half of the graph. In general, the least numbers of respondents reporting positively to the statements posed were the HS group. They seemed to score the lowest group on about 60% of the (sections) arms of he graph. This was supported that when it came to statements about the organisational and personnel barriers in the CPs, where the percentage of respondents from the HS group who complained of barriers quickly soared to the highest or second highest and accordingly their curve displays a sudden bulge out of contour of their normal radius.

2.4 The web of the CM group seemed to narrow down in two areas: significantly less CM respondents reported positive responses to statements about the communication mechanisms in their CPs (e.g. 'regularly published newsletter' or 'verbal reports from staff at own Partnership meetings'). A similar picture also emerged when respondents were queried abut their authority to make decisions on behalf the organisations they represent at their CPs meetings. The percentage of the CM who indicated that the could make a decision whether it is immediate or after consulting other people or board of membership of their organisations was significantly lower than the other three groups. This relatively low percentage was computed taking into account that in the CM group, as opposed to the other three, many participants were solo members i.e. not representing an organisation but rather themselves. These solo members were

excluded before computing the percentage for the CM that was plotted in the radar graph. Including this 'solo community members' group that was excluded from the calculation can only bring the percentage of the CM even lower, confirming that not much CM respondents could actually take binding decisions in their CPs.

Table (36). Differences in participants' perceptions on aspects of their Partnerships. Sections with Categorical scales

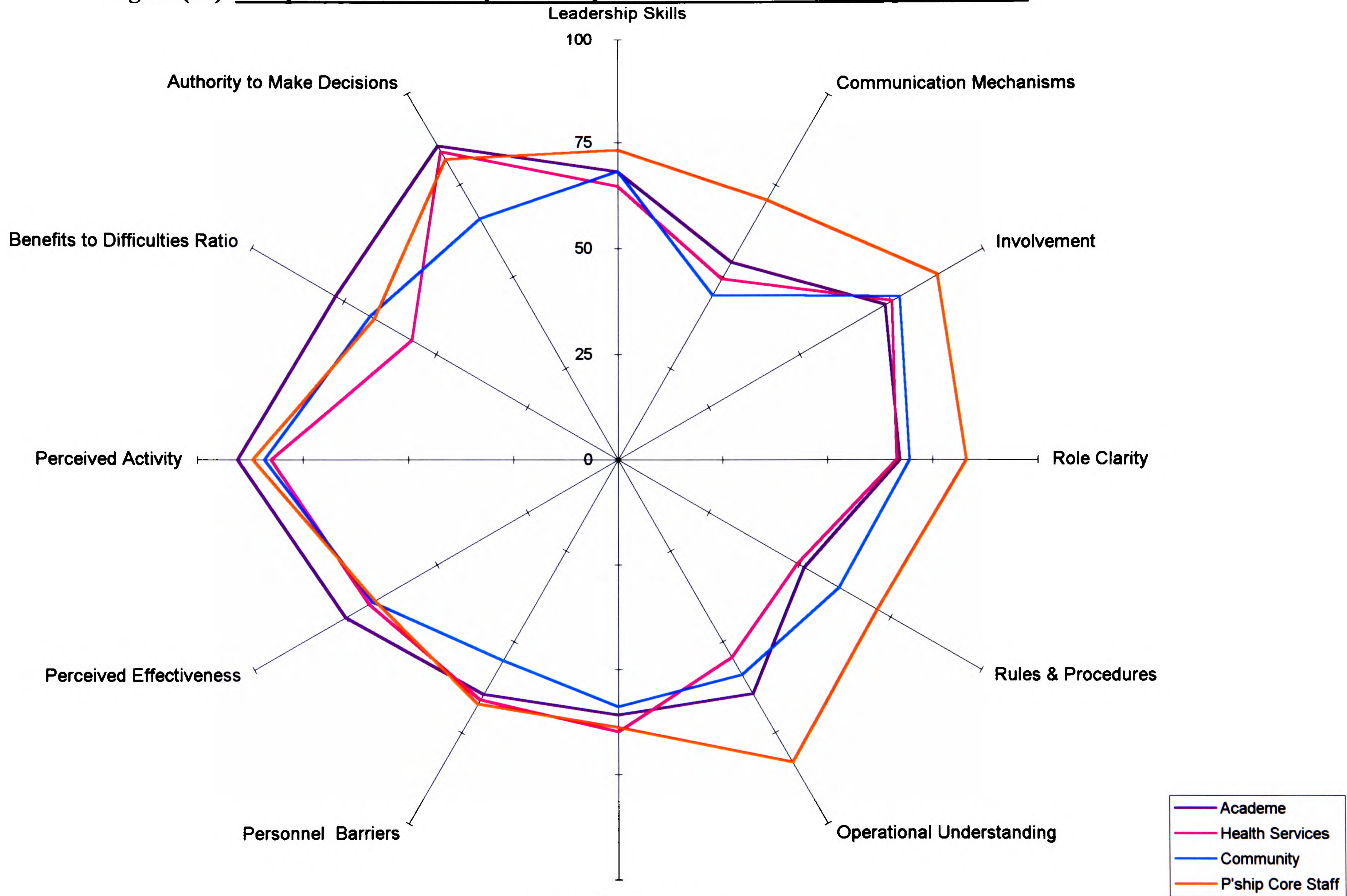
Differences in Percentages of participant groups reporting positive responses on the various aspects of their Partnerships. Sections with Categorical scales
(Comparison of percentages, Chi- Squared Test, *Pearson, Significance Level: P ranges from < 0.05 — < 0.00000)

Section	Areas of Agreement	Areas of Significant Disagreement*
1. **Formalised rules & procedures**	1. Engage in strategic planning	2. Have written mission statements 3. Have written by-laws/ operating principles 4. Review its by laws/ operating principles 5. Have long-range funding plan 6. Have written objectives 7. Reviews mission, goals and objectives 8. Clear procedures for selection of leaders 9. Provide orientation for new members
2. **Operational Understanding**		1. How new members are chosen 2. How committees/ task forces are formed 3. The P'ship's organisational structure/ staffing 4. The P'ship's mission and clearly understand it 5. What your role in the P'ship is
3. **Involvement**		How involved are you in the Partnership: 1. Moderately or very involved
4. **Authority to make decisions**		1. Authority to make decisions on behalf the organisation you represent in the Partnership: yes
5. **Benefits/ Difficulties Ratio**	Overall, how would you compare the benefits with the difficulties of being a member in the P'ship?	
6. **Role Clarity**		Any role (advise, develop, recommend, approve) you typically have in: 1. Setting P'ship's programmes budget 2. Designing program goals & objectives 3. Selecting local subcontractors 4. Developing P'ship's overall plans
7. **Personnel Barriers**	1. Expertise of Professional Staff and Volunteers 2. Volunteer availability 3. Keeping volunteer interest	4. Professional Staff availability 5. Professional Staff turnover 6. Professional Staff interest 7. Professional Staff priorities* 8. Volunteer turnover 9. General interest in Partnership activities
8. **Leadership Skills**	1. Reports achievements through newsletters, etc. 2. Offers group activities to P'ship members 3. Provides continuing education opportunities 4. Gives praise/ recognition at meetings 5. Listens to opinions and comments during meetings	6. Makes me feel welcome at meetings 7. Provides me with a lot of good information 8. Seeks out and welcomes my views 9. Holds social gatherings for P'ship members 10. Seeks views of people outside the P'ship 11. Asks me to assist with organisational tasks

Table (36). *contin'd* **Differences in participants' perceptions on aspects of their Partnerships. Sections with Categorical scales**

Section	Areas of Agreement	Areas of Significant Disagreement*
9. **Communication Mechanisms**		1. Regularly published newsletter 2. Written reports from own P'ship's staff 3. Written reports from other SA P'ships 4. Verbal reports at own P'ship's meetings 5. Verbal reports outside own P'ship's meetings 6. Opportunities to talk with other SA P'ships at meetings 7. Opportunities to talk with other SA P'ships outside of meetings
10. **Organisational Barriers** (*Contin'd*)	1. Goal setting 2. Leadership from the national level	4. Competing priorities among partners 5. P'ship vs. organisational credit for activities 6. Assumption of leadership by a lead partner 7. Marketing of individual partner's material 8. Differences in partner's financial/ tax years 9. Differences in partner's philosophy 10. Co-ordination of activities between partners 11. Differences in partner's service areas 12. Differences in partner's structure 13. Lack of participation by partner/s 14. Availability of funds1 5. Decision making in the P'ship 16. Communication between partners
11. **Perceived Effectiveness**		1. Communication between the partners 2. Goal setting 3. Making decisions 4. Focus on PHC 5. Training CHWs 6. Volunteer co-ordination 7. Fund-raising 8. Public relations/ media 9. Involve minorities in P'ship activities 10. Evaluation of its performance 11. Making health planning more responsive to community needs 12. Helping community emerge as political force on issues of health 13. Improving the quality of local health services 14. Increasing the accessibility of local health services 15. Raising public awareness of health issues and planning
12. **Perceived Activity**	1. Perceived activity in 1994 2. Perceived activity: 1995 until point of study	

Figure (57). Comparison of 4 Participant Groups: 12 Parameters with Categorical Scales



4.1.5. Bivariate Correlations

4.1.5.1. Predictor variables with intermediary measures

(Tables 37 - 40)

Personnel predictors and Personnel Barrier predictors; Comparison groups

Table (37) shows the correlation between personnel and personnel barrier predictors and intermediary measures for the comparison groups.

In general for the PS, CM and CS groups, the two personnel predictors, past and present experience, did not show any correlation with all the intermediary measures except for educational activity. Educational activity was correlated with both predictors for the three groups (Pearson's correlation coefficient ranged between 0.35 - 0.58). These two predictors were thus excluded when reporting the correlations of each group individually.

PS & CM groups

The six intermediary measures were correlated with all the personnel predictors and the personnel barrier predictors (Pearson's correlation coefficient ranged between 0.11 - 0.78). However, for the CM there were three exceptions: outcome efficacy was not correlated to costs of participation; and effectiveness was not correlated to expertise, whether it was expertise of professional staff or of community members.

CS group

Satisfaction was correlated to all the personnel predictors and the personnel barrier predictors except operational understanding (Pearson's correlation coefficient ranged between 0.36 - 0.64).

Commitment was correlated only to the expertise of professional staff or of community members, operational understanding, sense of ownership and benefits of participation (Pearson's correlation coefficient ranged between 0.30 - 0.39). There was no correlation between commitment and the rest of the personnel predictors and the personnel barrier predictors.

Outcome efficacy was correlated with all the personnel predictors and the personnel barrier predictors except costs of participation (Pearson's correlation coefficient ranged between 0.32 - 0.78), while

effectiveness and activity level were both not correlated with any. Finally, educational activity was correlated to all the personnel predictors but not the personnel barrier predictors except role clarity (Pearson's correlation coefficient ranged between 0.44 - 0.66).

Organisational predictors and Organisational Barrier predictors; Comparison groups

Table (38) shows the correlations between organisational and organisational barrier predictors and intermediary measures for the comparison groups

PS & CM groups

The six intermediary measures were correlated with all the organisational predictors and the organisational barrier predictors (Pearson's correlation coefficient ranged between 0.14 - 0.59). However, there was one exception for each group. For the PS effectiveness was not correlated to involvement, and for the CM activity was not correlated with decision making.

CS group

Satisfaction was correlated with all the organisational predictors and organisational barrier predictors (Pearson's correlation coefficient ranged between 0.31 - 0.68) except for formalised rules and procedures and involvement, both of which were not correlated with satisfaction.

Outcome efficacy was correlated with all the organisational predictors (Pearson's correlation coefficient ranged between 0.31 - 0.82) but not to organisational barrier predictors. Effectiveness was correlated only with community representation and interaction (0.31 for both), while commitment correlated only with community representation (0.31) and flow of information (0.32). For both intermediary measures, no correlations were found with the rest of the variables. Activity was not correlated with any of the organisational predictors or organisational barrier predictors. Finally, educational activity was correlated with all organisational predictors or organisational barrier predictors (Pearson's correlation coefficient ranged between 0.36 - 0.66) except involvement and communication mechanisms.

Personnel predictors and Personnel Barrier predictors; Whole Sample

Table (39) shows the correlations between personnel and personnel barrier predictors and intermediary measures for whole sample. The six intermediary measures were correlated with all the personnel

predictors and with the personnel barrier predictors (Pearson's correlation coefficient ranged between 0.13 - 0.59). Two exceptions existed: past CPs experience was not correlated to any of the intermediary measures, and present CPs experience was correlated only with activity level and educational activity.

Organisational predictors and Organisational Barrier predictors; Whole Sample

Table (40) shows the correlations between organisational and organisational barrier predictors and intermediary measures for whole sample, where the six intermediary measures were correlated with all the organisational predictors and with the organisational barrier predictors (Pearson's correlation coefficient ranged between 0.16 - 0.58).

Table (37). Correlations between personnel and personnel barrier predictors and intermediary measures: 3 comparison groups

variables	Intermediary Measures																	
	Satisfaction			Commitment			Outcome Efficacy			Effectiveness			Activity Level			Educational Activity		
	P. Staff	C. Members	C. Staff	P. Staff	C. Members	C. Staff	P. Staff	C. Members	C. Staff	P. Staff	C. Members	C. Staff	P. Staff	C. Members	C. Staff	P. Staff	C. Members	C. Staff
Personnel Predictors																		
Past Experience	- 0.13	0.05	0.72	0.15	0.14	0.40	0.08	0.11	0.90	0.22	0.10	0.27	- 0.07	- 0.20	- 0.27	0.43***	0.50***	0.58***
Present Experience	0.04	0.07	0.12	0.11	0.10	- 0.07	0.07	- 0.03	0.01	- 0.01	0.02	- 0.21	- 0.10	0.15*	0.03	0.35***	0.43***	0.47***
Staff Expertise	0.51***	0.54***	0.64***	0.52***	0.63***	0.36*	0.55**	0.57***	0.78***	0.55***	0.41	0.27	0.40***	0.39***	0.15	0.39***	0.28***	0.18
Community Expertise	0.49***	0.40***	0.53***	0.41***	0.60***	0.38*	0.52***	0.52***	0.67***	0.53***	0.36	0.17	0.37***	0.25***	0.09	0.34***	0.29***	0.48***
Operational Understanding	0.31***	0.30***	0.25	0.31***	0.40***	0.34*	0.31***	0.40***	0.30*	0.31***	0.19**	0.23	0.32***	0.36***	0.20	0.45***	0.41***	0.44**
Sense of Ownership	0.69***	0.58***	0.66***	0.54***	0.66***	0.39*	0.58***	0.57***	0.67***	0.37***	0.35***	0.28	0.43***	0.13**	0.18	0.30***	0.49***	0.46***
Role Clarity	0.28***	0.36***	0.36*	0.51***	0.39***	0.15	0.35***	0.35***	0.32*	0.22**	0.20**	0.04	0.19*	- 0.23***	0.17	0.34***	0.15**	0.24
Participation Costs	- 0.44***	- 0.11*	- 0.36*	- 0.36***	- 0.13*	0.00	- 0.35***	- 0.10	- 0.25	0.41***	- 0.20**	0.00	- 0.32***	0.33***	- 0.13	0.38***	0.41***	0.53***
Participation Benefits	0.54***	0.48***	0.55***	0.61***	0.55***	0.30*	0.55***	0.43***	0.64***	0.46***	0.27***	0.15	0.36***	0.27***	0.03	0.52***	0.53***	0.66***
Costs/Benefits comparison	0.57***	0.29***	0.58***	0.40***	0.37***	0.06	0.43***	0.33***	0.33*	0.53***	0.23***	0.06	0.35***	0.25	- 0.02	0.50***	0.39***	0.46***
Resource Allocation satisfaction	0.56***	0.50***	0.47***	0.44***	0.36***	0.18	0.47***	0.40***	0.45**	0.42***	0.20**	0.18	0.44***	0.30***	0.17	0.43***	0.49***	0.44**
Personnel Barrier Predictors																		
Personnel Barriers	- 0.27***	- 0.43***	- 0.37*	- 0.33***	- 0.30***	- 0.08	- 0.36***	- 0.37***	0.39*	- 0.37***	- 0.32***	- 0.06	- 0.41***	- 0.41***	0.11	- 0.17*	- 0.38***	- 0.24

* $P < 0.05$; ** $P < 0.005$; *** $P < 0.000$

Table (38). Correlations between organisational and organisational barrier predictors & intermediary measures: 3 comparison groups

variables	Intermediary Measures																	
	Satisfaction			Commitment			Outcome Efficacy			Effectiveness			Activity Level			Educational Activity		
	P. Staff	C. Members	C. Staff	P. Staff	C. Members	C. Staff	P. Staff	C. Members	C. Staff	P. Staff	C. Members	C. Staff	P. Staff	C. Members	C. Staff	P. Staff	C. Members	C. Staff
Organisational Predictors																		
Management Capabilities	0.54***	0.63***	0.68***	0.42***	0.45***	0.02	0.49***	0.57***	0.66***	0.47***	0.30***	0.11	0.34***	0.40***	0.07	0.43***	0.50***	0.58***
Rules and Procedures	0.42***	0.46***	0.21	0.43***	0.49***	0.20	0.41***	0.53***	0.53***	0.43***	0.32***	0.27	0.39***	0.29***	0.18	0.35***	0.43***	0.47***
Involvement	0.19**	0.22***	0.13	0.26***	0.28***	0.22	0.20**	0.22***	0.31*	0.14	0.16*	- 0.07	0.26***	0.17**	0.07	0.39***	0.28***	0.18
Community Representation	0.38***	0.40***	0.35*	0.45***	0.44***	0.32*	0.44***	0.45***	0.47**	0.45***	0.17**	0.31*	0.34***	0.14*	0.23	0.34***	0.29***	0.48***
Staff-Community Communication	0.48***	0.55***	0.65***	0.44***	0.47***	0.03	0.48***	0.55***	0.59***	0.39***	0.28***	0.20	0.36***	0.33***	0.07	0.45***	0.41***	0.44**
Comm. Members Communication	0.45***	0.39***	0.47***	0.44***	0.41***	0.13	0.48***	0.39***	0.52***	0.44***	0.23***	0.19	0.19*	0.32***	0.22	0.30***	0.49***	0.46***
Communication Mechanisms	0.35***	0.22***	0.31*	0.39***	0.28***	0.15	0.38***	0.34***	0.39***	0.28**	0.22***	0.06	0.22**	0.26***	0.17	0.34***	0.15**	0.24
Flow of Information	0.53***	0.45***	0.48***	0.36***	0.52***	0.31*	0.53***	0.59***	0.58***	0.38***	0.26***	0.25	0.39***	0.36***	0.00	0.38***	0.41***	0.53***
P'ship Interaction	0.65***	0.55***	0.54***	0.53***	0.55***	0.28	0.57***	0.59***	0.82***	0.59***	0.31***	0.31*	0.52***	0.38***	0.12	0.52***	0.53***	0.66***
Decision Making	0.60***	0.38***	0.54***	0.51***	0.41***	0.18	0.55***	0.43***	0.53***	0.54***	0.20**	0.13	0.40***	0.21***	0.12	0.50***	0.39***	0.46***
Leadership Skills	0.45***	0.49***	0.49***	0.28***	0.46***	0.16	0.28***	0.45***	0.36*	0.42***	0.21***	0.16	0.32***	0.30***	0.09	0.43***	0.49***	0.44**
Organisational Barrier Predictors																		
Organisational Barriers	- 0.52***	- 0.53***	- 0.51***	- 0.43***	- 0.51***	- 0.55***	- 0.38***	- 0.37***	0.03	- 0.52***	- 0.32***	- 0.13	- 0.46***	- 0.41***	- 0.24	- 0.35***	- 0.46***	- 0.36*

* $P < 0.05$; ** $P < 0.005$; *** $P < 0.000$

Table (39). Correlations between personnel and personnel barrier predictors and intermediary measures for whole sample

variables	Intermediary Measures					
	Satisfaction	Commitment	Outcome Efficacy	Effectiveness	Activity Level	Educational Activity
Personnel Predictors						
Past Experience	- 0.08	0.18	- 0.01	0.11	- 0.10	0.08
Present Experience	0.04	0.08	0.01	- 0.00	0.13**	0.17***
Involvement	0.20***	0.29***	0.24***	0.13**	0.18***	0.31***
Staff Expertise	0.53***	0.58***	0.59***	0.44***	0.36***	0.55***
Community Expertise	0.46***	0.52***	0.55***	0.38***	0.24***	0.43***
Operational Understanding	0.27***	0.37***	0.36***	0.21***	0.28***	0.28***
Sense of Ownership	0.64***	0.61***	0.60***	0.33***	0.35***	0.35***
Role Clarity	0.30***	0.42***	0.34***	0.18***	0.16***	0.16***
Participation Costs	- 0.22***	- 0.19***	- 0.19***	- 0.25***	- 0.25***	- 0.25***
Participation Benefits	0.50***	0.57***	0.50***	0.29***	0.30***	0.30***
Costs/Benefits comparison	0.41***	0.34***	0.35***	0.28***	0.27***	0.27***
Resource Allocation satisfaction	0.49***	0.38***	0.42***	0.27***	0.31***	0.31***
Personnel Barrier Predictors						
Personnel Barriers	- 0.38***	- 0.30***	- 0.36***	- 0.34***	- 0.33***	- 0.29***

*** $P < 0.000$

Table (40). Correlations between organisational and organisational barrier predictors and intermediary measures for whole sample

variables	Intermediary Measures					
	Satisfaction	Commitment	Outcome Efficacy	Effectiveness	Activity Level	Educational Activity
Organisational Predictors						
Management Capabilities	0.62***	0.42***	0.56***	0.32***	0.33***	0.46***
Rules and Procedures	0.42***	0.46***	0.50***	0.33***	0.31***	0.41***
Community Representation	0.39***	0.44***	0.45***	0.25***	0.20***	0.31***
Staff-Community Communication	0.54***	0.44***	0.54***	0.30***	0.31***	0.42***
Comm. Members Communication	0.42***	0.40***	0.44***	0.27***	0.26***	0.42***
Communication Mechanisms	0.21***	0.31***	0.34***	0.19***	0.23***	0.25***
Flow of Information	0.48***	0.47***	0.58***	0.28***	0.33***	0.40***
P'ship Interaction	0.58***	0.56***	0.64***	0.36***	0.35***	0.50***
Decision Making	0.36***	0.39***	0.41***	0.16***	0.16***	0.32***
Leadership Skills	0.48***	0.38***	0.39***	0.26***	0.28***	0.45***
Organisational Barrier Predictors						
Organisational Barriers	- 0.52***	- 0.37***	- 0.48***	- 0.42***	- 0.41***	- 0.40***

*** $P < 0.000$

4.1.5.2. Intermediary measures with themselves

Tables (41 - 42) shows the correlations between the intermediary measures of performance for each comparison group separately and for the whole sample.

The six intermediary variables (satisfaction, commitment, outcome efficacy, effectiveness, activity level and educational activity) were correlated with each other for each comparison group separately and for the whole sample. In general, for the PS and CM groups, the intermediary measures were all significantly correlated to one another with r lying between 0.32 and 0.58 for most of the correlations. An exception was, for the CM group, where a significant but relatively low correlation between satisfaction and effectiveness ($r = 0.26$, $P < 0.000$). Table (41) revealed a large number of statistically significant relationships for each comparison group and for the whole sample. As for the CS group, Table (41) also reveals that the significant correlations between the intermediary measures are generally fewer for the CS than for the PS and CM.

Professional staff & Community members

All the intermediary measures were correlated with each other and with the two barrier variables and formality of structure (Pearson's correlation coefficient ranged between 0.17 - 0.66).

Core staff

The two barrier variables were correlated with each other (0.46). They were also correlated to formality of structure, satisfaction and outcomes (Pearson's correlation coefficient ranged between 0.36 - 0.63). Barrier variables were, however, not correlated with commitment, effectiveness or activity level. For educational activity, personnel barriers were not correlated with it.

Satisfaction was correlated with the two barrier variables and outcomes and educational activity (Pearson's correlation coefficient ranged between 0.37 - 0.63). For the rest of the intermediary measures or with formality of structure, no correlation was found.

Commitment was correlated with outcomes, effectiveness, activity level and educational activity (Pearson's correlation coefficient ranged between 0.49 - 0.56), whereas with the barrier variables, formality of structure and satisfaction, there was no correlations.

Outcomes efficacy was correlated with both the barrier variables, formality of structure and all the intermediary measures except effectiveness (Pearson's correlation coefficient ranged between 0.39 - 0.63).

Effectiveness was only correlated with commitment, activity level and educational activity(Pearson's correlation coefficient ranged between 0.34 - 0.63). For all the rest it was not correlated to any of them.

Activity level was correlated with commitment, outcomes and effectiveness (Pearson's correlation coefficient ranged between 0.31 - 0.63). With all the other variables and intermediary measures, no correlation was found.

Finally, educational activity was correlated with formality of structure and organisational barrier variable and all intermediary measures except personnel barriers and activity level (Pearson's correlation coefficient ranged between 0.34 - 0.73).

Whole sample

Table (42) shows that educational activity was not correlated to any of the intermediary measures or with the two barrier variables or formality of structure. Otherwise, all the intermediary measures were correlated with each other and with the two barrier variables and formality of structure (Pearson's correlation coefficient ranged between 0.31 - 0.64).

Table (41). Pearson correlation matrix for organisational and personnel barriers, formality of structure, and intermediary measures of accomplishment & Impact: Each comparison group separately

A. **Professional Staff**

	Organisational Barriers	Personnel Barriers	Formality of Structure	Satisfaction	Commitment	Outcomes Efficacy	Effectiveness	Activity Level	Educational Activity
Organisational Barriers	1.00	0.61***	- 0.43***	- 0.52***	- 0.38***	- 0.43***	- 0.52***	- 0.46***	- 0.35***
Personnel Barriers		1.00	- 0.26***	- 0.27***	- 0.33***	- 0.36***	- 0.35***	- 0.31***	- 0.17*
Formality of Structure			1.00	0.42***	0.43***	0.41***	0.43**	0.39***	0.35***
Satisfaction				1.00	0.50***	0.58***	0.52***	0.49***	0.47***
Commitment					1.00	0.52***	0.43***	0.36***	0.48***
Outcomes Efficacy						1.00	0.54***	0.35***	0.47***
Effectiveness							1.00	0.45***	0.43***
Activity Level								1.00	0.37***
Educational Activity									1.00

*** $P < 0.000$

B. **Community Members**

	Organisational Barriers	Personnel Barriers	Formality of Structure	Satisfaction	Commitment	Outcomes Efficacy	Effectiveness	Activity Level	Educational Activity
Organisational Barriers	1 .00	0.66***	- 0.44***	- 0.53***	- 0.37***	- 0.51***	- 0.32***	- 0.41***	- 0.46***
Personnel Barriers		1.00	- 0.39***	- 0.43***	- 0.30***	- 0.36***	- 0.37***	- 0.41***	- 0.38***
Formality of Structure			1.00	0.46***	0.49***	0.53***	0.32***	0.29***	0.43***
Satisfaction				1.00	0.45***	0.42***	0.26***	0.29***	0.43***
Commitment					1.00	0.60***	0.34***	0.33***	0.50***
Outcomes Efficacy						1.00	0.45***	0.34***	0.40***
Effectiveness							1.00	0.48***	0.32***
Activity Level								1.00	0.36***
Educational Activity									1.00

*** $P < 0.000$

C. **Core Staff**

	Organisational Barriers	Personnel Barriers	Formality of Structure	Satisfaction	Commitment	Outcomes Efficacy	Effectiveness	Activity Level	Educational Activity
Organisational barriers	1.00	0.46**	- 0.38*	- 0.51***	0.03	- 0.55***	- 0.13	- 0.24	- 0.36*
Personnel barriers		1.00	- 0.36*	- 0.37*	- 0.08	- 0.39*	- 0.06	0.11	- 0.24
Formality of Structure			1.00	0.21	0.20	0.53***	0.27	0.18	0.47***
Satisfaction				1.00	0.22	0.63***	0.17	0.17	0.53***
Commitment					1.00	0.55***	0.56***	0.56***	0.49***
Outcomes Efficacy						1.00	0.29	0.31*	0.73***
Effectiveness							1.00	0.63***	0.34*
Activity Level								1.00	0.05
Educational Activity									1.00

* $P < 0.05$; ** $P < 0.005$; *** $P < 0.000$

Table (42). Pearson correlation matrix for organisational, personnel barriers and formality of structure, and intermediary measures accomplishment & Impact: Whole sample

	Organisational barriers	Personnel barriers	Formality of structure	Satisfaction	Commitment	Outcomes Efficacy	Effectiveness	Activity Level	Educational Activity
Organisational Barriers	1.00	0.64***	- 0.42***	- 0.52***	- 0.37***	- 0.48***	- 0.42***	- 0.41***	- 0.40
Personnel Barriers		1.00	- 0.34***	- 0.38***	- 0.30***	- 0.36***	- 0.34***	- 0.33***	- 0.29
Formality of Structure			1.00	0.42***	0.46***	0.50***	0.33***	0.31***	0.41
Satisfaction				1.00	0.45***	0.50***	0.33***	0.34***	0.43
Commitment					1.00	0.58***	0.37***	0.34***	0.49
Outcomes Efficacy						1.00	0.45***	0.33***	0.44
Effectiveness							1.00	0.48***	0.34
Activity Level								1.00	0.34
Educational Activity									1.00

*** $P < 0.000$

4.1.6. Multivariate Regression

Many of the predictor personnel and organisational variables and barrier variables were inter-correlated, and the intermediary variables were also inter-correlated. For these the data was analysed looking at each intermediary measure separately.

Multiple stepwise regression with hierarchical entry was used to examine the relationships of the predictor variables (personnel and organisational variables and barrier variables) to the intermediary variables (satisfaction, commitment, outcome efficacy, effectiveness, activity level and educational activities). The regression was used to identify the independent predictors of the intermediary measures separately for the professional staff (AI + HS), community members, and core staff groups. Personnel and organisational variables and barrier variables were included in the regression for each group. Stepwise regression was chosen to assist in the process of identifying a 'best' set of independent variables while addressing the problems caused by collinearity (Neter and Wasserman, 1974). The results are reported for each of the comparison groups separately and then for the whole sample together. The tables present all factors in the order entered into the model through forward selection (alpha to enter the model was set at 0.05).

Tables (43 - 46) and Figure (58) show the predictors of the intermediary measures for the individual comparison groups and for the whole sample. For each cell, the number denotes how much of the variance of that intermediary measure is explained by the linear combination of the variables in that cell. In any cell, the significance levels of the contribution of each of the variables to the explanation of the intermediary measures varies from $P < 0.05$ to $P < 0.0000$. The variables in each cell were arranged in descending order of the significance level.

By Stakeholder Group

Professional Staff (AI + HS)

In general for satisfaction about 60 % of the variance could be explained, while for commitment, outcome efficacy, effectiveness and educational activity about 50 % of the variance could be explained. For the activity level about 40% of the variance could be explained.

Community Members

In general, for 50 - 60 % of the variance of the satisfaction, commitment, outcome efficacy and educational activity could be explained by the explanatory variables, while for effectiveness only about half that variance (27%) could be explained.

Core Staff

In general, for 60 - 85 % of the variance of the satisfaction, outcome efficacy and educational activity could be explained by the explanatory variables. Only 15 % of commitment could be explained, and for effectiveness and activity level no explanatory variables were able to explain them for the core staff group.

Whole Sample

In general, for 45-60 % of the variance of the satisfaction, commitment, outcome efficacy and educational activity could be explained by the explanatory variables. For effectiveness and activity level explanatory variables were able to explain about 25 % (range 23 - 27 %) of each.

By Intermediary Measure: Correlates of performance

Table (47) and Figure (58) depict the significant predictors of the six intermediary measures for each stakeholder group. For each partner, the contribution made by the independent variables to the intermediary measure is shown and the factors responsible for that contribution are listed together with their corresponding P values. It need be cautioned, however, that the arrangement of the independent variables in each cell is in order of descending significance level and not in order of the relative contribution of the factors.

Satisfaction

For instance, Table (47) indicated that with the intermediary measure of satisfaction, for the professionals, 62 % of the variance in their satisfaction was explained by the combination of the variables sense of ownership ($P < 0.0000$), interaction ($P < 0.005$), difficulties to benefits ratio ($P < 0.005$) and staff-community member communication ($P < 0.05$). The reader need note that these variables were not necessarily the same set of factors that explained the satisfaction for the other stakeholder groups. For example, 51 % of the variance in the satisfaction of the community members was explained by the combination management capabilities ($P < 0.0000$), sense of ownership ($P < 0.0000$), organisational barriers ($P < 0.05$) and resource allocation satisfaction ($P < 0.05$). Still, for the core staff

group, 63 % of the variance in their satisfaction was explained by sense of ownership ($P < 0.005$), staff - community member communication ($P < 0.05$) along with a contribution from management capabilities which was close to reaching statistical significance ($P = 0.06$).

Commitment

For the professionals, 51 % of their commitment was explained by the combination of the factors benefits of participation ($P < 0.0000$), role clarity ($P < 0.005$), expertise of PS ($P < 0.005$) and community representation ($P < 0.05$). In contrast, for the community, the combination of the factors sense of ownership ($P < 0.0000$), expertise of CM ($P < 0.0005$), expertise of PS ($P < 0.005$) and benefits of participation ($P < 0.05$) contribute to 58% of the variance in their commitment. For the core staff, however, only 13 % of the commitment was explained by the section on sense of ownership ($P < 0.05$).

Outcome Efficacy

Fifty two percent of the variance in the views of the professionals on outcome efficacy is explained by the combination of the variables expertise of PS ($P < 0.005$), flow of information ($P < 0.005$), benefits of participation ($P < 0.005$), sense of ownership ($P < 0.05$) and personnel barriers ($P < 0.05$). On the other hand, for the community the combination of expertise of CM ($P < 0.0000$), flow of information ($P < 0.005$), organisational barriers ($P < 0.005$), staff - community member communication ($P < 0.05$). communication mechanisms ($P < 0.05$)and community representation ($P < 0.05$) explained 54 % of the variance in outcome efficacy. For the CS, an exceptionally high (85) percentage of the variance was explained by the combination of the sections on interaction ($P < 0.0000$), expertise of PS ($P < 0.0005$), formalised rules and procedures ($P < 0.0005$) and community representation ($P < 0.05$).

Effectiveness

For professional staff, 53 % of the variance of their views of the effectiveness of their partnerships' operations is explained by the joint contribution of the sections on leadership skills ($P < 0.005$), costs of participation ($P < 0.005$), resource allocation satisfaction ($P < 0.05$), community representation ($P < 0.05$), expertise of both CM ($P < 0.05$) and of PS ($P < 0.05$). In contrast, only 24 % of the community's views on effectiveness was explained by personnel barriers ($P < 0.005$), expertise of PS ($P < 0.05$), expertise of CM ($P < 0.05$) and costs of participation ($P < 0.05$). As for the CS, none of the independent variables made any significant contribution to explaining the variance.

Activity Level

The levels of prediction for the activity level were rather low for all the stakeholder groups. Thirty seven percent of variance in activity level for the professional staff was explained by the combination of the factors interaction ($P < 0.0005$), organisational barriers ($P < 0.005$), CM communication ($P < 0.05$), involvement $P < 0.05$) and expertise of CM ($P < 0.05$). As for the community, 25 % of the variance was due to a combination of communication mechanisms ($P < 0.005$), organisational barriers ($P < 0.05$), personnel barriers ($P < 0.05$) and costs of participation ($P < 0.05$). Again, for the CS group, none of the independent variables made any significant explanation to the variance.

Educational Activities

For professional staff, 45 % of the variance of their views on the educational activities in their partnerships was explained by the combination of the factors on interaction ($P < 0.0005$), organisational barriers ($P < 0.005$), CM communication ($P < 0.05$), involvement ($P < 0.05$) and expertise of CM ($P < 0.05$). In contrast 49 % of the community's variance is explained by expertise of PS ($P < 0.0000$), CM communication ($P < 0.0005$), benefits of participation ($P < 0.0005$), leadership skills ($P < 0.005$) and communication mechanisms ($P < 0.05$). Further still, for the core staff 59 % of the variance was due to joint contributions from formalised rules & procedures ($P < 0.05$), expertise of PS ($P < 0.05$), community representation ($P < 0.05$) and a contribution from interaction ($P = 0.055$) which was close to statistical significance.

Table (43). Relative contributions of the Predictors of Intermediary Measures for Professional Staff

Dependent Measures/ Predictors	R^2	ß	P
Satisfaction with Partnership	**0.63**		
(1) Sense of Ownership		0.40	< 0.0000
(2) Interaction		0.13	< 0.005
(3) Difficulties to Benefits Ratio		0.20	< 0.005
(4) Staff - Member Communication		0.13	< 0.05
Commitment	**0.53**		
(1) Benefits of Participation		0.35	< 0.0000
(2) Role Clarity		0.23	< 0.005
(3) Expertise of Professional Staff		0.22	< 0.005
(4) Community Representation		0.16	< 0.05
Outcome Efficacy	**0.53**		
(1) Expertise of Professional Staff		0.22	< 0.005
(2) Flow of Information		0.21	< 0.005
(3) Benefits of Participation		0.22	< 0.005
(4) Sense of Ownership		0.22	< 0.05
(5) Personnel Barriers		- 0.14	< 0.05
Effectiveness	**0.55**		
(1) Leadership Skills		0.20	< 0.005
(2) Costs of Participation		- 0.19	< 0.005
(3) Resource Allocation Satisfaction		0.19	< 0.05
(4) Community Representation		0.17	< 0.05
(5) Expertise of Community Members		0.17	< 0.05
(6) Expertise of Professional Staff		0.17	< 0.05
Activity Level	**0.39**		
(1) Interaction		0.37	< 0.0005
(2) Organisational Barriers		- 0.26	< 0.005
(3) Community Members Communication		- 0.25	< 0.05
(4) Involvement		0.18	< 0.05
(5) Expertise of Community Members		0.20	< 0.05
Educational Activities	**0.47**		
(1) Involvement		0.25	< 0.0005
(2) Benefits of Participation		0.26	< 0.005
(3) Interaction		0.23	< 0.05
(4) Expertise of Professional Staff		0.19	< 0.05

Table (44). **Relative contributions of the Predictors of Intermediary Measures for Community Members**

Dependent Measures/ Predictors	R^2	ß	*P*
Satisfaction with Partnership	**0.53**		
(1) Management Capabilities		0.33	< 0.0000
(2) Sense of Ownership		0.27	< 0.0000
(3) Organisational Barriers		- 0.16	< 0.05
(4) Resource Allocation Satisfaction		0.13	< 0.05
Commitment	**0.59**		
(1) Sense of Ownership		0.33	< 0.0000
(2) Expertise of Community Members		0.23	< 0.0005
(3) Expertise of Professional Staff		0.21	< 0.005
(4) Benefits of Participation		0.16	< 0.05
Outcome Efficacy	**0.55**		
(1) Expertise of Community Members		0.25	< 0.0000
(2) Flow of Information		0.22	< 0.005
(3) Organisational Barriers		- 0.17	< 0.005
(4) Staff - Member Communication		0.16	< 0.05
(5) Communication Mechanisms		0.13	< 0.05
(6) Community Representation		0.12	< 0.05
Effectiveness	**0.26**		
(1) Personnel Barriers		- 0.23	< 0.005
(2) Expertise of Professional Staff		0.19	< 0.05
(3) Expertise of Community Members		0.17	< 0.05
(4) Costs of Participation		- 0.13	< 0.05
Activity Level	**0.27**		
(1) Communication Mechanisms		0.19	< 0.005
(2) Organisational Barriers		- 0.22	< 0.05
(3) Personnel Barriers		- 0.21	< 0.05
(4) Costs of Participation		- 0.15	< 0.05
Educational Activities	**0.51**		
(1) Expertise of Professional Staff		0.32	< 0.0000
(2) Community Members Communication		0.23	< 0.0005
(3) Benefits of Participation		0.23	< 0.0005
(4) Leadership Skills		0.21	< 0.005
(5) Communication Mechanisms		- 0.13	< 0.05

Table (45). Relative contributions of the Predictors of Intermediary Measures for Core Staff

Dependent Measures/ Predictors	R^2	ß	P
Satisfaction with Partnership	**0.66**		
(1) Sense of Ownership		0.40	< 0.005
(2) Staff - Member Communication		0.33	< 0.05
(3) Management Capabilities		0.25	< 0.06 (NS)
Commitment	**0.15**		
(1) Sense of Ownership		0.39	< 0.05
Outcome Efficacy	**0.86**		
(1) Interaction		0.43	< 0.0000
(2) Expertise of Professional Staff		0.36	< 0.0005
(3) Formalised Rules & Procedures		0.26	< 0.0005
(4) Community Representation		0.15	< 0.05
Effectiveness			
Activity Level			
Educational Activities	**0.63**		
(1) Formalised Rules & Procedures		0.25	< 0.05
(2) Expertise of Professional Staff		0.31	< 0.05
(3) Community Representation		0.23	< 0.05
(4) Interaction		0.21	< 0.055 (NS)

NS: Non-Significant

Table (46). Relative contributions of the Predictors of Intermediary Measures for Whole Sample

Dependent Measures/ Predictors	R^2	ß	P
Satisfaction with Partnership	**0.59**		
(1) Sense of Ownership		0.34	< 0.0000
(2) Organisational Barriers		- 0.15	< 0.005
(3) Management Capabilities		0.16	< 0.005
(4) Resource Allocation Satisfaction		0.14	< 0.005
(5) Staff - Member Communication		0.13	< 0.05
(6) Operational Understanding		- 0.10	< 0.05
(7) Communication Mechanisms		- 0.09	< 0.05
(8) Leadership Skills		0.09	< 0.05
(9) Benefits of Participation		0.09	< 0.05
Commitment	**0.56**		
(1) Sense of Ownership		0.22	< 0.0000
(2) Benefits of Participation		0.19	< 0.0005
(3) Expertise of Professional Staff		0.20	< 0.0005
(4) Management Capabilities		- 0.16	< 0.005
(5) Role Clarity		0.10	< 0.05
(6) Expertise of Community Members		0.12	< 0.05
(7) Interaction		0.13	< 0.05
(8) Community Representation		0.10	< 0.05
(9) Formalised rules & procedures		0.09	< 0.05
Outcome Efficacy	**0.59**		
(1) Expertise of Community Members		0.19	< 0.0000
(2) Interaction		0.19	< 0.0005
(3 Flow of Information		0.16	< 0.005
(4) Sense of Ownership		0.14	< 0.005
(5) Staff - Member Communication		0.11	< 0.05
(6) Community Representation		0.08	< 0.05
(7) Communication Mechanisms		0.08	< 0.05
(8) Formalised rules & procedures		0.08	0.065?
Effectiveness	**0.27**		
(1) Organisational barriers		- 0.22	< 0.0005
(2) Expertise of Professional Staff		0.20	< 0.005
(3) Expertise of Community Members		0.15	< 0.05
(4) Costs of Participation		- 0.10	< 0.05
Activity Level	**0.23**		
(1) Organisational Barriers		- 0.24	< 0.0000
(2) Sense of Ownership		0.15	< 0.05
(3) Expertise of Professional Staff		0.13	< 0.05
(4) Costs of Participation		- 0.10	< 0.05
Educational Activities	**0.46**		
(1) Expertise of Professional Staff		0.29	< 0.0000
(2) Benefits of Participation		0.22	< 0.0000
(3) Leadership Skills		0.10	< 0.0005
(4) Involvement		0.13	< 0.005
(5) Member - Member Communication		0.13	< 0.05

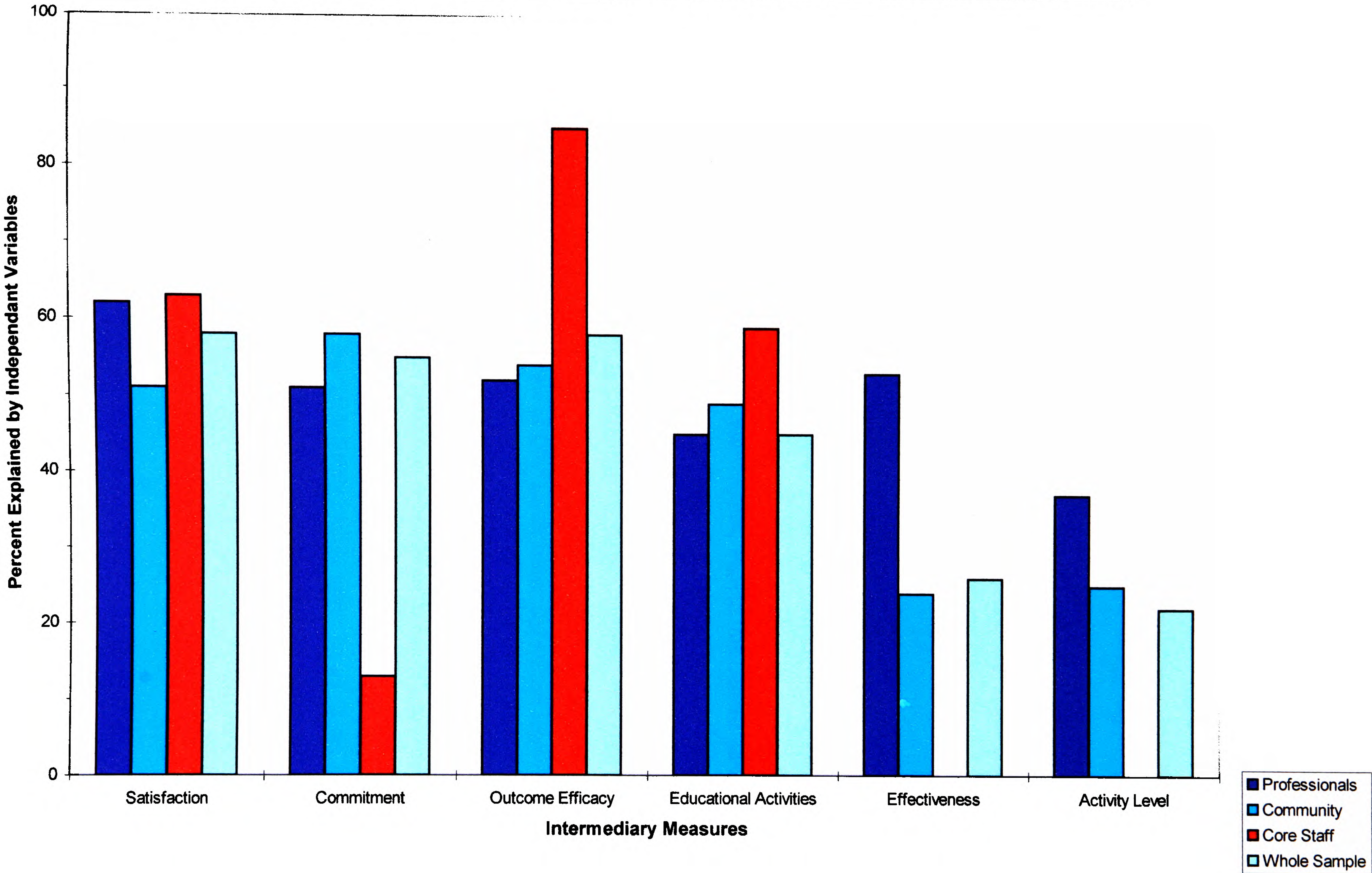
Table (47). Comparison of predictors of the intermediary measures for comparison groups and whole sample

	Predictors of Intermediary Measures Adjusted R^2			
Intermediary Measure	**Professional Staff (AI +HS)**	**Community Members**	**Core Staff**	**Whole Sample**
Satisfaction	**0.62** Sense of Ownership Interaction Difficulties to Benefits Ratio Staff-Member Communication	**0.51** Management Capabilities Sense of Ownership Organisational Barriers Resource Allocation Satisfaction	**0.63** Sense of Ownership Staff - Member Communication Management Capabilities	**0.58** Sense of Ownership Organisational Barriers Management Capabilities Resource Allocation Satisfaction Staff - Member Communication Operational Understanding Communication Mechanisms Leadership Skills Benefits of Participation
Commitment	**0.51** Benefits of Participation Role Clarity Expertise of PS Community Representation	**0.58** Sense of Ownership Expertise of CM Expertise of PS Benefits of Participation	**0.13** Sense of Ownership	**0.55** Sense of Ownership Benefits of Participation Expertise of PS Management Capabilities Role Clarity Expertise of CM Interaction Community Representation Formalised rules & procedures
Outcome Efficacy	**0.52** Expertise of PS Flow of Information Benefits of Participation Sense of Ownership Personnel Barriers	**0.54** Expertise of CM Flow of Information Organisational Barriers Staff - Member Communication Communication Mechanisms Community Representation	**0.85** Interaction Expertise of PS Formalised Rules & Procedures Community Representation	**0.58** Expertise of CM Interaction Flow of Information Sense of Ownership Staff - Member Communication Community Representation Communication Mechanisms Formalised rules & procedures

Table (47). *contin'd.* **Comparison of predictors of the intermediary measures for comparison groups and whole sample**

	Predictors of Intermediary Measures Adjusted R^2			
Intermediary Measure	**Professional Staff (AI +HS)**	**Community Members**	**Core Staff**	**Whole Sample**
Effectiveness	**0.53** Leadership Skills Costs of Participation Resource Allocatn Satisfaction Community Representation Expertise of CM Expertise of PS	**0.24** Personnel Barriers Expertise of PS Expertise of CM Costs of Participation		**0.26** Organisational barriers Expertise of PS Expertise of CM Costs of Participation
Activity Level	**0.37** Interaction Organisational Barriers CM Communication Involvement Expertise of CM	**0.25** Communication Mechanisms Organisational Barriers Personnel Barriers Costs of Participation		**0.22** Organisational Barriers Sense of Ownership Expertise of PS Costs of Participation
Educational Activities	**0.45** Interaction Organisational Barriers CM Communication Involvement Expertise of CM	**0.49** Expertise of PS CM Communication Benefits of Participation Leadership Skills Communication Mechanisms	**0.59** Formalised Rules & Procedures Expertise of PS Community Representation Interaction	**0.45** Expertise of PS Benefits of Participation Leadership Skills Involvement CM Communication

Figure (58). Percent Prediction of the Intermediary Measures for the Stakeholder Groups



4.2. Qualitative Findings

4.2.1. Qualitative findings: Purpose, content and context

The Purpose

In order to supplement and complement the questionnaire findings and analyses, qualitative data using semi structured interviews were employed to answer questions of "how" and "why". These involved probing into the concerns of the respondents. The interviews were exploratory with the purpose of obtaining reactions and comments relating to the various aspects of the CPs that were of concern to the interviewees. They also contributed to the gain of insight into the dynamic relationships of attitudes, opinions, motivations and problems. The interviews provided a context for the understanding of the experiences of respondents and the meanings they make of that experience. The major task was to build upon and explore the interviewees' concerns.

The Content

Due to the multiplicity of the qualitative themes emerging from the interview data, they are reviewed in a clustered manner in order to complement, supplement and provide a more holistic context for the content and dynamics of the particular findings. Within each cluster, various but related sub-themes were aggregated together for a more comprehensive overview. Where appropriate, the sets of findings related to each stakeholder group were matched, contrasted or complemented. Additional salient themes that emerged from the interviews and possessed scarce quantitative data on them were also reviewed and inserted in their appropriate places. Where applicable to the cluster, further participant observation impressions or documentary data from the review of CPs' publications and reports were drawn upon to help verify or corroborate the findings.

It was the intention of the study to cast the data collection net as broad as possible to the respondents at the functional periphery of the CPs. The data was completed by members of varying degrees of involvement, rather than focusing only on the immediately visible upper layers of the CPs' involved members. This is supported by the survey finding that indicated that 70 % of respondents rated themselves as either not very involved or moderately involved in their CPs. This has the implication that the views expressed in the discussion are fairly representative of what is actually happening on the ground.

The Context

As was foreseen at the design stage of this study, the multi faceted nature of P'ship fostering and the intertwining, interacting and fluid nature of the related variables under study draws no distinct boundaries between the miscellaneous aspects of P'ship functioning. This characteristic thus dictated that the views and opinions of the comparison groups on various issues and factors need not be looked at in isolation, but rather holistically in a 'whole system approach`.

Two broad issues characteristic of the South African study setting need to be clear in the background. Both have to do with the meeting the challenges of the past:

1. *Lack of appropriate health care services, usually with lack of appropriate infrastructure.* Due to the lack of provision of adequate basic health and PHC services, a high percentage of patients in need of basic health care use the services of tertiary referral teaching hospitals. Appropriate PHC facilities were not readily available, and the community was generally negative with regard to the accessibility of services. Rapid urbanisation was taking place after removal of regulations restricting the free movement of 'black' people and was contributing to population influxes and increase in informal settlements which resulted in increased demand for health care services. Furthermore, due to inappropriate training of health care professionals, where training was primarily hospital-based, students had little experience of PHC services or of meeting the total health care needs of patients.

2.1. *Past discriminatory policies which excluded 'black' students from most universities until the late eighties.* In addition to restriction, the language of tuition was Afrikaans, which in the case of 'black' students was their third language. Besides, most of the 'black' children came from disadvantaged schools background and therefore were not equipped with the selection criteria of universities. In parallel, apartheid policies had created a situation in which mutual understanding between race groups and communities was lacking. Both the AI and HS, as well as disadvantaged communities required development.

4.2.2. Description of Sample

Table (48) and Figures (59 - 64) provide a description of the sample.

4.2.2.1. Demographic characteristics of whole sample

A total of 46 interviewees were interviewed. Interviews were semi structured, tape recorded and were between 25 to 45 minutes duration. Figures (59 - 60) indicate the percentages of interviewees by CP, and by participant group. Table (48) shows the actual numbers and distribution of the informants as regards their P'ships and their participant group. The detailed description of each participant group was reserved to when reporting the themes emerging from the concerns of the individual participant groups. For the whole sample, the average age of interviewees was 38.8 years, about 65 % were females, participating for an average of just under 3 years (range 4 months to 5 years) [Figures (61-64)].

4.2.2.2. Individual Stakeholder Groups

Academic Medical, Nursing and Other Training Institutions (*N* = 8)

A diverse group of faculty members, tutors and nurse educators, some of which were members on the CPs boards or management committees and sub-committees, while others were simply academic participants. Except for one interviewee who was from the sociology department, most of the academic interviewees belonged to nursing or medical training institutions or colleges. Their professions varied from lecturers/senior lectures to clinical instructors. The age range of the interviewees from the academic participant group was from 29 to 57 years (average 42.5 years), and at the time of the interviews, they had been participating in their CPs in some capacity for a period of between 1 and 4 years (average 2.5 years). All this group were females.

Health Services staff (*N* = 11)

A varied group of HS respondents, some of which were members on the CPs boards or management committees and sub-committees, while others are simply health services participants. Their professions vary from a nurse manager to senior professional nurses, a nurse in charge of a CP health centre to a medical superintendent of a participating hospital, nurses responsible for the local health centres/ clinics, to a physician in family medicine. Administratively, some respondents were municipality-based while

welfare provincial administration. The age range of the interviewees from HS group was from 30 to 55 years (average 42.5 years), and at the time of the interviews, they had been participating in their P'ships in some capacity for a period ranging from under a year to just under 5 years (average 3 years). Females represented 80 % of this group.

Community Members (*N* = 13)

A disparate group of CM, several of which were members on the CPs boards or management committees and sub-committees. Professions of the interviewees ranged from a lawyer, a business man, a government servant, a chairman of the board, an experienced teacher, a church reverend, a village health worker, a factory worker who is an executive and board member, and two relatively younger people, one was the chairperson of the youth program and the other working in a similar development project in the CP's catchment area. Several of the community members were participating in their CPs via civic structures that they belonged to, as participants or representatives (e.g. South African National Civics Organisation, SANCO). One could not speak fluent English and was interviewed via another interviewee who acted as an interpreter. The age range for the CM was from 27 to 55 years (average 43 years), and at the time of the interviews, they had been participating in their CPs from 4 months to 5 years (average 2.5 years). About 25 % of this group were females.

Core Staff (*N* = 14)

These were full time paid employees who were employed by and had no other responsibility. This group consisted of CS involved in the different programmes run by the CPs. The range was wide, comprising of two HS co-ordinators from the CPs, an education co-ordinator and an education facilitator, a researcher/ evaluator, a community development projects manager, a CP's director, assistant co-ordinator and other administrative staff, core staff from the evaluation department and local government programme section of the CPs. The age range of the interviewees from the CS group was from 24 to 55 years (average 35.5 years), and at the time of the interviews, they had been participating in their CPs in some capacity for between 1 and 4 years (average 2.5 years). About 80 % of the sample were females.

Table (48). Distribution of Interviewees by Partnership and Respondent Group

Respondent Group	Academic Institutions	Health Services	Community Members	Core Staff	Whole Sample
P'ship No.1	2	3	3	3	11
P'ship No.3	5	2	8	1	16
P'ship No.4	1	2	1	4	8
P'ship No.5		4	1	6	11
Totals	8	11	13	14	**46**
Age (years)	*M* = 42.5 Range: 29 - 57	*M* = 42.5 Range: 30 - 55	*M* = 43 Range: 27 - 55	*M* = 35.5 Range: 24 - 55	*M* = 38.8 Range: 24 - 55
Gender (females)	100%	80%	25%	80%	65%
Duration of Participation (years)	*M* = 2.5 Range: 1 - 4	*M* = 3 Range: 1 - 5	*M* = 2.5 Range: 0.25 - 5	*M* = 2.5 Range: 1 - 4	*M* = 3 Range: 0.25 - 5
Strategic position	Several respondents of each group are P'ship/ program chairs or Board/ management committee/s members, others are more situated at the peripheral end of the P'ships				
Examples	faculty: tutors, nurse educators, lecturers, senior lectures & clinical instructors. One interviewee from sociology Dept., rest from nursing/ medical training institutions/ colleges	nurse manager, senior professional nurses, nurses in charge of/ responsible for P'ship's health centre & local clinics, hospital's medical superintendent, physician in family medicine	lawyer, business man, teacher, government servant, factory worker, church reverend, village health worker, chairman of the board, chair of youth program, development worker of similar development project in the catchment area. Some Reps participate via their initial civic structures (e.g. South African National Civics Organisation, SANCO)	two HS co-ordinators, education co-ordinator & facilitator, P'ship's director & assistant co-ordinator, researcher/ evaluator, community development projects manager, CS from administration & evaluation Depts. & local government programme sections of the P'ships	

Figure (59). **<u>Spread of Interviewees Sample Across Partnerships</u>**
(N = 46)

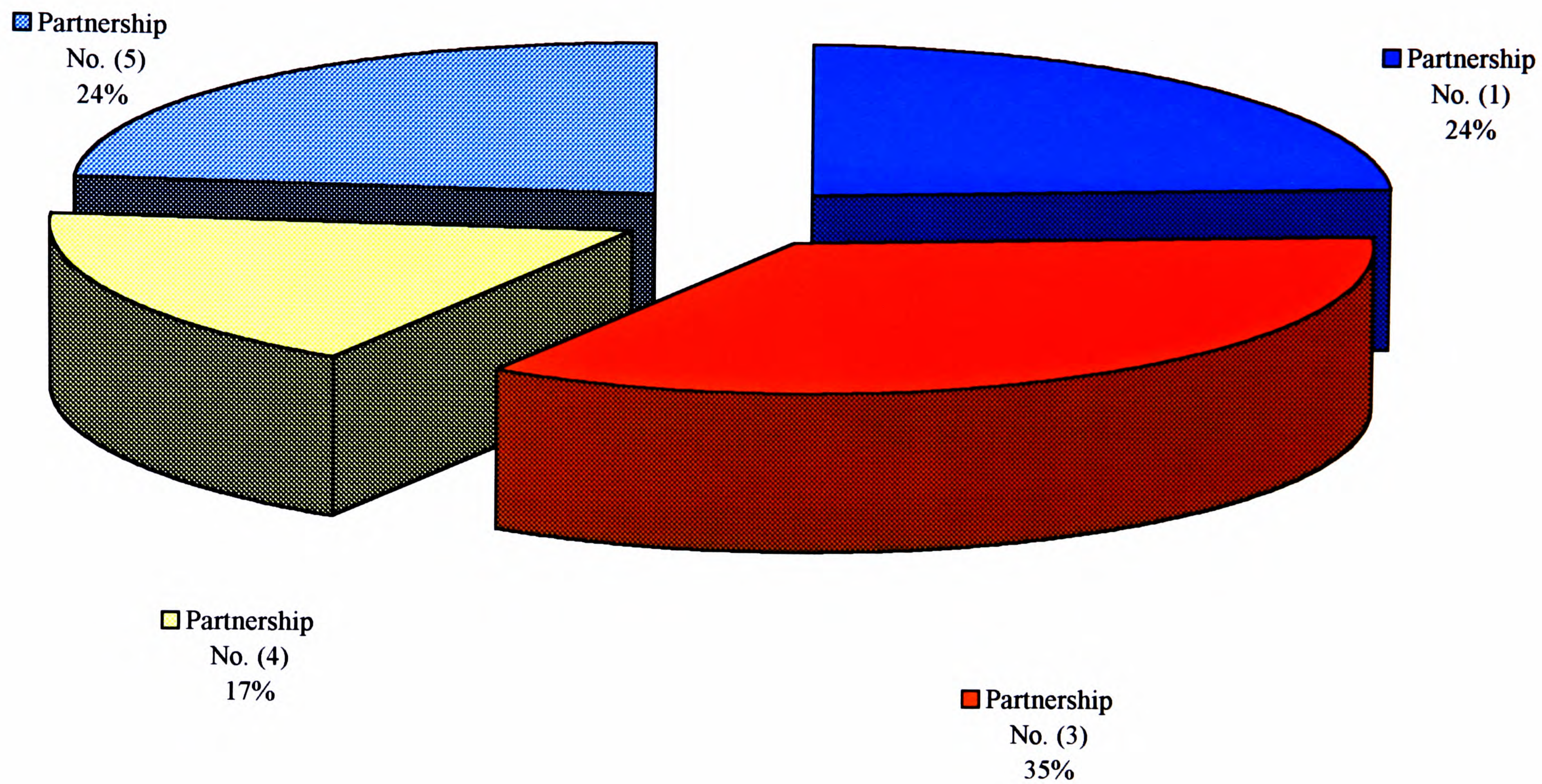


Figure (60). Spread of Interviewees Sample Across Stakeholder Groups
(*N* = 46)

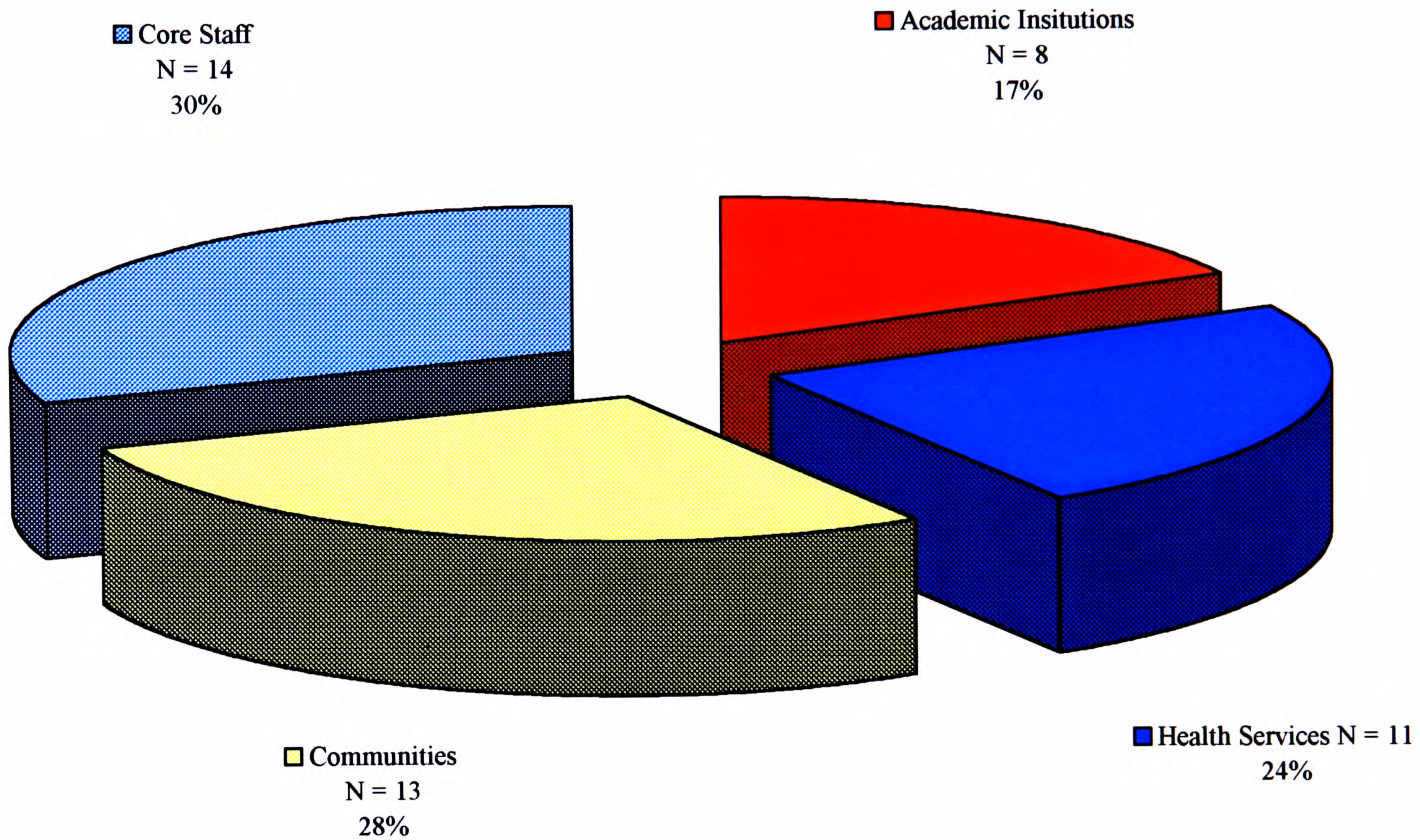


Figure (61). Age Distribution of Interviewees

(N = 46)

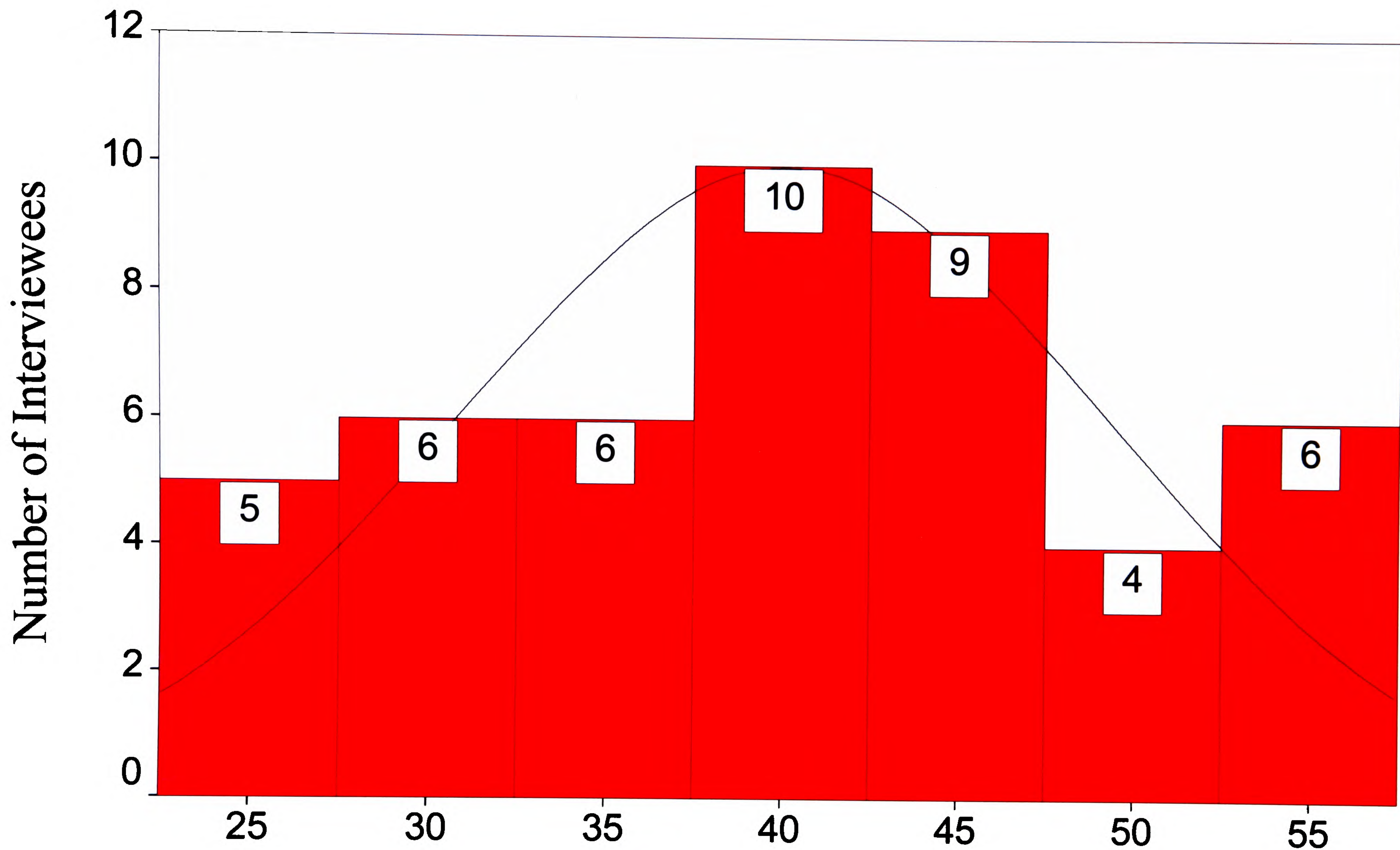


Figure (62). Gender of Interviewees by Age & Stakeholder Group (N = 46)

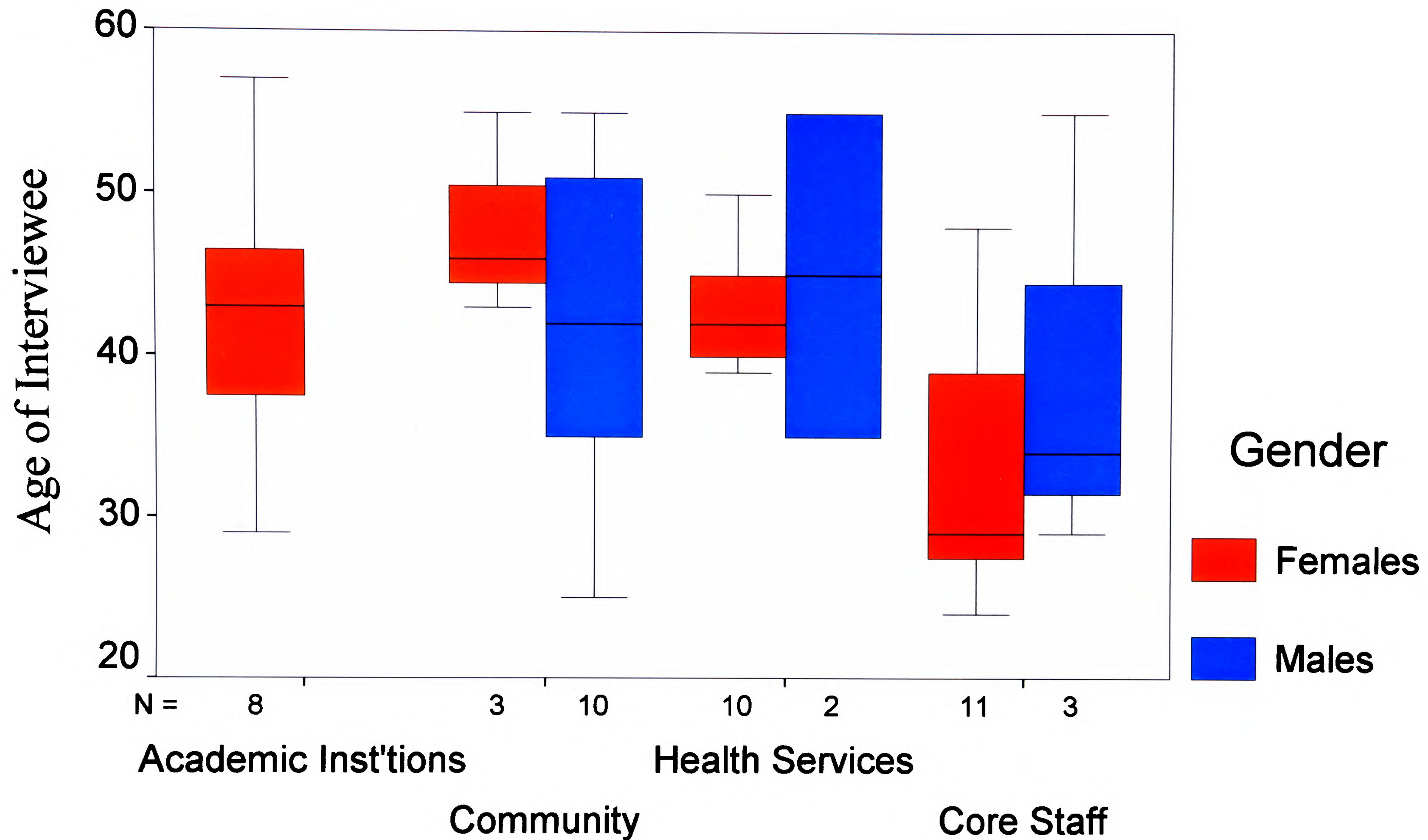


Figure (63). Duration of Participation of Interviewees

(N = 46)

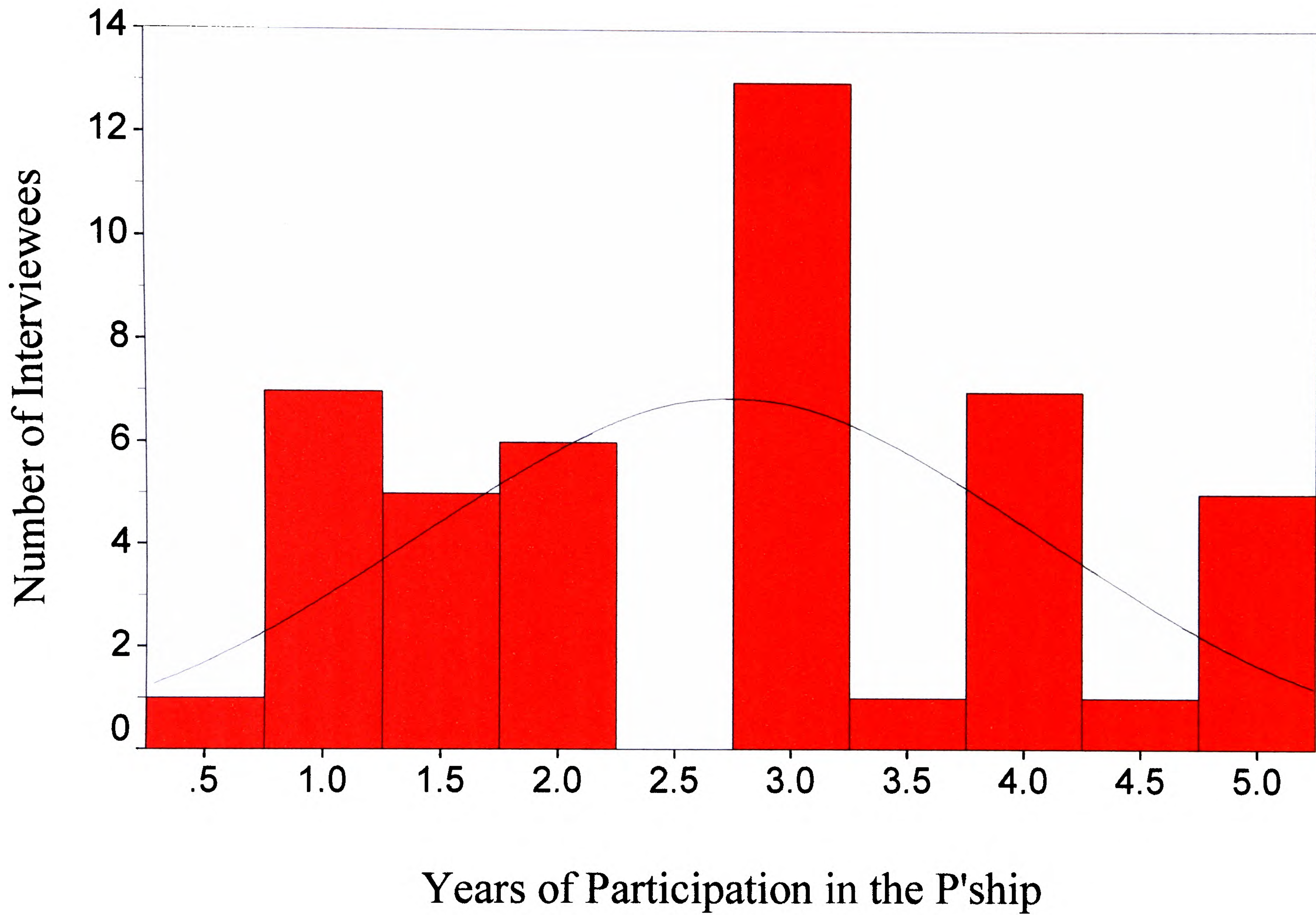
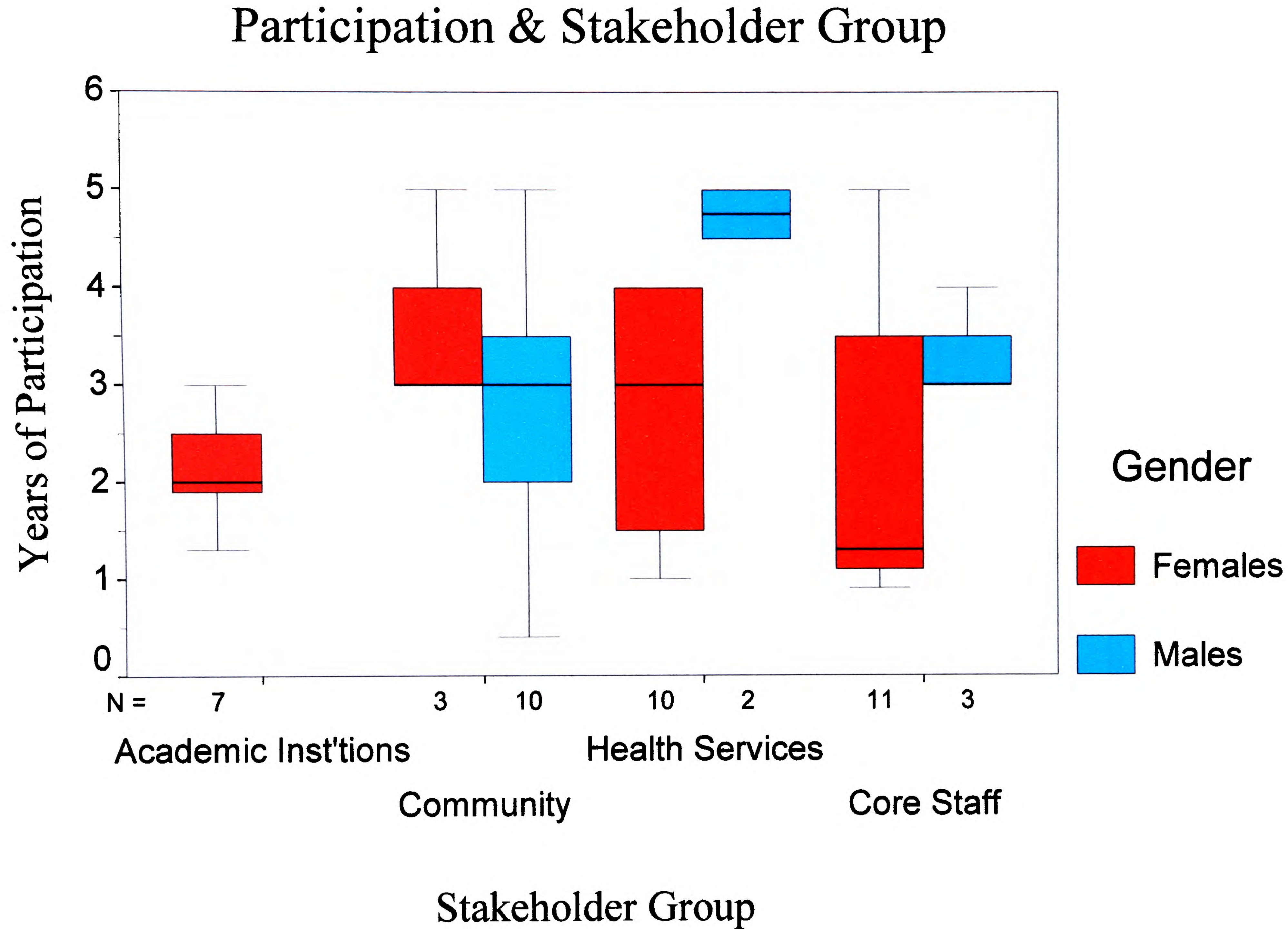


Figure (64). Gender of Interviewees by Years Participation & Stakeholder Group



4.2.3. Emerging Themes

The summaries of concerns that emerged from the interviews with participants from the partner groups were as follows:

4.2.3.1. Cluster I: Clarity

Clarity of Concepts: Partnerships, Empowerment & Development

One of the issues raised in the interviews related to the early *vision* stage of the CPs' initiation. Shared vision from the initiation seem to contribute to long term sustainability later down the road. The sub-themes that emerged related to the need for understanding and an agreed upon interpretation of the CP concept as well as for a balance between the short term and long term objectives. They also related to the broader definition of health within the context of development and the operationalisation or practicalisation of the concept:

> AI: community development has task [job opportunities & address basic needs] & process objectives [need to empower people to solve their own social problems], need balance between short term poverty alleviation vs. long term empowerment, CS doing the work for the community vs. self help.
>
> HS: P'ship concept is poorly understood, what are they ultimately trying to achieve, do not understand the goals.
>
> CM: I foresee progress, actually something is taking place within the P'ship, no matter the many problems, people learnt to realise what is collecting consensus & requesting funds; convincing a funder, funder is teaching aid to our people, illiteracy is gradually breaking off, people learnt to know if we bring together, if we request funds not for personal but for community use, it is possible, to work together aiming at gaining something for everyone, it is possible, that is what I think P'ship is busy making, teaching within our environment.
>
> CS: CPs are new area for everybody; health needs be looked at in its broader sense, understand the concepts; P'ship concept has complexity of construct, affects the interpretation by different partners who also have their own agendas, this gives rise to unpleasant situations; it is a new concept, with not enough reference on its operationalisation & practicality, there is too many people involved, is difficult to work together, each stakeholder has different needs.
>
> **Qte [1.1]**

The *empowerment* of the communities was a learning process that required clarity, time and pace:

> CS: show community that they are also leaders, think creatively, think about problems before you bring them to P'ship committees, suggest solutions, feel good about oneself, the interim measure of the need to empower people first is a long process.
>
> CS: do not rush and then find that you are doing things that are not making sense, think first, get more clarity on the issue, get honest opinions, do not expect donor to show you everything.
>
> CS: develop a culture of positive energy flow, do not focus on pitfalls and convey a positive message; sometimes even gamble with the issues, some trial and error business, do not brush mistakes away, expose and learn from them.
>
> **Qte [1.2]**

Development was a lengthy process and HPE was not a community priority. Peoples' needs were to guide the CPs programmes:

> CS: community management is a spin off of the P'ship, it is not the P'ship, the P'ship is about reorientation the training of our HPE, therefore it is in domain of academics, the community development happens as a result of that, so in the short term the communities benefit through these projects & hopefully in long term they are going to benefit when people who are training now graduate & go into service they will have a different perspective of PHC focus etc., for communities, perception is that community is only interested in what they can get now, this long term thing is not their interest.
>
> CS: first thing is needs of the people, then work portfolios or programmes relevant to the needs, then matrix it, all portfolios going through same sort of different activities.
>
> **Qte [1.3]**

Review of CPs documentary data goals confirmed that the CPs goals were to establish, strengthen and structure partnerships between the AI, the HS and the beneficiary communities. These CPs were for interdisciplinary community based training and education, to strengthen the community base of the HS in the context of effective PHC, and to further the understanding, support and facilitate community development activities and programmes that improve health in the communities. This in turn has led to three general key programme areas but with a wide ranging variety and spectrum [Annex (4)]. These encompassed (1) HPE development; (2) community development, and (3) health services development.

Clarity of Roles, Responsibilities, Rules, Procedures & Operational Understanding

Role clarity linked to the clarity of understanding of the CP concept, communication, involvement and formalised rules and procedures.

Interview findings suggested that generally, clarity of roles, procedures and responsibilities needed attention:

> AI: role clarity must be increased.
>
> HS: P'ship management & procedures are unclear.
>
> CM: there are not clear guidelines as to how many people must constitute the committee & what are criteria for inviting new members.
>
> CS: Responsibility is not clear: role clarity lacking, always asking the director seems to be always needed, no financial devolution in P'ship.
>
> **Qte [1.4]**

The need for clarity appeared to effect all the *stakeholder* groups to various extents. The CS were not clear about who they were attempting to service in their CPs. Their primary focus seemed to shift:

> CS: who exactly is the CS servicing? staff seems to be shifting more to servicing the community partner; how are costs to be covered in future? role clarity is needed, lack of clarity has de-motivating effect on CS, nobody sees what they are doing, the vision of the P'ships is sometimes interpreted differently by various CS [e.g. a staff member thought the more departments on board the P'ship the better, while the director was not motivated for many academic medical departments to join on board].
>
> CS: it could be our mistake that we concentrated on this specific partner because we thought it was a disadvantaged partner amongst the other partners.
>
> **Qte [1.5]**

A subdivision of the CS, the co-ordinators of the various CPs' programmes appeared to be in the middle of many subgroups. They would appreciate more clarity on their roles and a sense of belonging, lines of accountability seemed not very distinct:

> CS: role clarity of co-ordinators of programmes that the P'ship is running, I feel there is no clear clarification of the role of each of core staff or facilitator, do community fully understand what my role is as education facilitator, do HS or AI understand? I put a question mark about whether they understand that.. I think it is a process that you have to continually inform people, make them understand, but sometimes it is, influences how you eventually feel about your work., because you are doing a little bit with a lot of different people, at the end they only see that little bit, and they say I wonder what else this person does, I think that is a common problem with CS.
>
> CS: there is no sense of belonging of the co-ordinators, this hinders their work & has negative effects; there is no clear line of accountability & multiple accountabilities frustrates, we as co-ordinators don't know where we belong because we don't belong to the community, we don't belong to the professionals, in the process we could really loose our ego and that will have a very negative effect on us, can easily say I have enough of this, I can rather leave and go and work where I know I am answerable to Walid, he is the director, but not be answerable those partners & this partner & this partner as it is here, role of the co-ordinator is to facilitate the process. Even if you are facilitating the process you need to have a sense of belonging.
>
> **Qte [1.6]**

As regards the CM group, their views were that there was space for clarity:

> CM: most of people participating in community meetings & programs are actually not clear where program is going to, only few people have knowledge of what is happening, because of the lack of knowledge there has been from the AI side, one cannot (hide) the fact that P'ship is a research program of the university, it should be an interventionist approach, unfortunately if there is an intervention, it is to a certain limit, to the benefit of the AI, not to the benefit of the community, community is not too much involved as they would be expected to, only come to meetings, listen to the big tanks [AI] who have recommendations & just rubber stamp them, no process of empowering community to be part & parcel of decision, it is perceived that AI knows everything, whatever is decided by AI cannot be challenged, when other people challenge it, they appear as opponents, there is no other time allocated for people who understand what is happening within the community groups to say this is wrong or right, if we can begin this approach, it can be a way forward.
>
> CS: community needs more role clarity, are they there for the governance or the management of the P'ship.
>
> **Qte [1.7]**

In relation to the AI, the impression was that some of them felt a lack of clarity and view their role as restricted to the deployment of students in the community:

> AI: nursing colleges do not feel they know, I do not think they know their role, only thing AI are aware of is deployment of students in the community, other than that there is nothing else, they utilise the P'ship for students which is basically for them, the AI; even sending students to the community is not happening full blown, only one nursing college in this P'ship is sending students.
>
> **Qte [1.8]**

As for the HS, the finding that they were the group that was least clear about their roles seems to reinforced:

> AI: HS role in the P'ship & HPE lacks clarity; no clarity on role specifics, we know we got this HS partner, but no clarity what do they bring into the P'ship, only the community & the nurse educators that utilises the HS, the HS representatives, there is nothing really that they are doing, need to identify specific roles for each partner; there is no direct communication so I do not know what the HS are doing and how we can utilise them.
>
> HS: role clarity is lacking, HS do not know where they fit in, were not included in the teaching to students posted in health centres that they run; role of HS is not only passive receptacle for students but also teaching; we [HS] perceive antagonism towards us, maybe it was due to our attitude, because we did not really know where we fit in the P'ship; now there is improvement of communication between us, I think we have to play an important role because if P'ship want to reach its goals, they have to be with us, because they come in with the students and I think that we should be playing an important role. in the P'ship
>
> HS: Lacking & ill defined, my role [hospital doctor] in the P'ship was poorly defined, I arrived at the place, was not told what is expected of me, seems very ill defined, I was working in one area & P'ship wanted me to be involved in another health area, the health workers of that area never appeared at meetings so I could not communicate, I was putting input into an area I never seen, a clinic I do not know & never communicated with the staff there, needed to actually see the staff and size of the clinic but I never went there, so much of the input was really wasted, I was talking but was not getting to grips with what we are doing, could be due to lack of clarity & not communicating with the clinic staff, I do not know of them coming to the meetings, that is one big problem.
>
> **Qte [1.9]**

The suggestions for *possible roles* of the HS so that missed opportunities could be minimised included their involvement in the tutoring process at workshops, in the actual running of the P'ship and getting more involved in the community, in the clinic upgrading, in the training of health workers or lay people, or in the supervision of the health-related aspects of the programmes the CPs were running e.g. after care groups, crèches, day centres for the young or STD awareness clinics for the youth etc. :

> HS: I am well trained in community health & fully committed, I just felt that they could have used me much better than what they did, they did not involve me, could have involved me in the workshops at the clinic, you talk & plan but never seem to get there & actually do the work, I was used as an advisory, my contribution could have been more.
>
> HS: participation is related to role being defined, whether the P'ship wanted us from point of view of introducing students, we were also at that stage running the only PHC training courses for students, or do they see us only as a vehicle to bring students into CBE & not really want us to put in, and that again was never really defined; we could do much more, be involved in running the P'ship & get involved in the community, involving students is one sphere, other contributions could be clinic upgrading, training of health workers or lay people, run workshops which community has requested, also bring in the students to have days to work at rural clinics.

HS: e.g. home based care group where children stay at day mothers, day mother makes no visits to health centre or contact clinic sisters or refers cases needing professional attention; I do not know what is going on, I think they do not know that they should come to the clinic, since we are a P'ship I feel that the P'ship & we should know what is going on in these houses, are they safe, is the hygiene good, can the day mother look after them.

Qte [1.10]

The CPs' executive boards too could benefit from more clarity:

AI: board is gradually starting to understand its role, for the few years in the P'ship, one has been not so clear about one's role.

CM: in short, there is no direct policy which is revealed to us [board members] to know our field where we can remark or where we can supplement, by the time you start asking, the manager [acting director], to show that there is no transparency, you are not given up to which level should you monitor the use of vehicles, but by the time you start remarking in a meeting that vehicles are going up and down for no strong reason, and they are not driven by the people we thought have got the authority to use these vehicles.

CS: when it's comes to governance & management, who manages the P'ship, director or the board? If it's the board is the board aware of their roles, of what expected of them, what their contributions to their communities & also to us as CS, how much support are they suppose to give - who suppose to give us support if we suppose to get any support? director does not have enough time to do that.

Qte [1.11]

Miscellaneous *examples* indicated the lack of clarity on the policies relating to decision making, conferences and budget:

AI: partners not feeling as part of decision making, might be misconception or misunderstanding, people think if they are not representatives on the management committee, they are not involved in decision making, but there is the strategic planning which makes decisions & every member can attend the strategic planning, not only those of the management committee, this needs to be clarified, in the minds of people there may be two different things, awareness & understanding of what we mean when we say every institution is part of decision making is needed.

HS: P'ship approached me to go to conference, it surprised me, they could not tell me exactly what was it, person who called me did not know why they were going to send me.

HS: we heard that Kellogg has brought some money to P'ship, but with the community of Newlands, then we thought budget was for community, that is where the community disagreed, they thought budget should be in their hands & use it for their own, they understood when we clarified to them what is this money made for.

Qte [1.12]

<u>Clarity through Formality & Visibility</u>

As regards to the *formality* of links or agreements between the stakeholders:

CS: the P'ship has no formal links or agreement to any of the faculties they work with, how P'ship structure and meetings articulate with university structures; not much advocating and networking was done, no links to the RDP, although a pioneer the P'ship has not strategically placed itself within the policy framework of the restructuring process.

Qte [1.13]

The qualitative data further supported that visibility needed attention. The data also suggested various *strategies* for increasing the visibility of and clarity about the CPs include more advertising, marketing, popularisation and communication, literacy, and advertising through various promotional media channels, otherwise nepotism could develop:

HS: it is not clear who leadership is, they do not attend meetings, there is lack of communication & commitment; not clear who leader is in the P'ship, need a more dynamic person to interact more with HS at grass roots level, even in our area here, sometimes did not even know who the leader is, with leadership I think about the chairperson, the person in the P'ship's office, perhaps I know who the leaderships are because I attend meetings, but I do not even know if my staff here at grass levels know who leaderships is; chairperson or director does not come to the clinic, even at P'ship's meetings, chairperson does not attend regularly, in important meetings, the person is not there; this is causing confusion between P'ship & people at grass roots, if they are not here, not attending their meetings, how can they expect us to take P'ship seriously, that is a problem with the other partners also, because they are not taking the P'ship seriously.

CM: leadership should be open to people, I mean management or staff must be open to everyone, so that they [community] may see her/ him as a good person who can do things for them, do not think leadership is open because people do not know whether this person is director or co-ordinator, do not know his portfolio, e.g. you have got a director at [P'ship], but many people do not know that director, they should call community meeting to inform & tell people, introduce the leadership to them, but as I told you that there is no representation at all, so few people will know then but majority of them do not know.

HS: P'ship not well advertised in external environment, extend invitations; use local radio for advertising.

CM: P'ship not known to entire environment, within 30 Kms radius you find a certain portion where P'ship is not known, I think it is not well advertised, not well marketed, people who were supposed to be helped know nothing, means P'ship is for few people who know it, make a living & job creation there, go looking for relatives to come & work there.

CS: visibility of the P'ship to the outside environment is very little, in terms of visibility, P'ship is only visible to those who sit on the board & to staff in the community development projects & perhaps P'ship is most visible to CS because they're the engine, to a large extent very few community people actually know or have heard about the P'ship, that role was originally assigned to the community fieldworker, part of their fieldwork is to mobilise, publicise & make community structures aware of P'ship, I don't think that has happened; I think that what should have happened in the beginning of the partnership is that there should have been a lot of publicity, we should have engaged departments from onset of sharing the vision and mission, once again it was elite and a cemented few I think we are beginning to bear the fruits of having been selected in the beginning, I think the one is lack of publicity.

CM: nepotism might be base of the P'ship, whereby the project can turn to a family thing, run by brothers, cousins, it is not well marketed, they [community] know nothing, I confirm this as a school teacher, other principals 30 kms. away know nothing about P'ship, yet P'ship has useful education programmes.

CM: not only geographical, but informing them [community] that there is this P'ship & it is doing this and this, people cannot realise what P'ship is doing now because they don't know where is P'ship, you see,. ways of communicating is to visit most effected areas where we have got illiterate people, maybe establish a centre where people be taught about P'ship & other structure, or pamphlets notifying that you are free to come & read books in P'ship, people come & ask where is P'ship? they do not know the place.

CM: I have a serious problem, only the people involved within the P'ship know about it, not whole [location] knows about P'ship, should advertise in magazine or a community newspaper, publication & advertising at various points, libraries & police station, would be much better if whole [location] is aware of what P'ship is all about, am talking about the magazine but feel that it is not enough, it helped to certain extent but is not enough.

Qte [1.14]

Clarity through Transparency

The qualitative findings from the interviews lent themselves to the fact that clarity between the partners required transparency as to what each was doing and access to each others agendas. Generally, transparency was a complex domain and a mixture of various levels of satisfaction seemed to exist:

AI: transparency does not need hidden agendas, otherwise people loose trust, they do not understand why decisions are taken; personally happy with transparency; am satisfied with transparency.

HS: little, not much; transparency much needed, honesty is transparency; transparency is lacking.

CS: transparency is problem; some are satisfied with transparency levels in their P'ships; levels of transparency are not much, examples of things that were done before consultation with the community; I cannot say I am not happy or happy about it because there is sometimes some issues that you find are not transparent and have been done already; it is not that good, it is not very poor, but it is not that good, but it is better than it was 3 years ago.

CM: very little that is happening, transparency is still a problem, transparency is not there totally, lots of decisions are taken without knowing exactly what was rational, idea & issue, you did not hear about this issue but some decision is still taken, transparency is a big problem; they [P'ship] are transparent, nothing is being done under hand or behind scenes, management are very transparent, do not have comments because the transparency is there.

CS: transparency is lacking, there is hidden agendas, power issues are involved; lacking.

Qte [1.15]

Causes that contributed to the lack of transparency included the 'personality' and vested interests of the partners, the unwillingness to share, fear, suspicion, illiteracy, blocking by the CPs director or simply the lack of constitution and policy, of time, information or interest:

HS: I do not think that it is particularly transparent, particularly when you see AI come together, there was a lot of conflict between the nursing colleges, and some of it was a personality problem but a lot of it obviously everybody is trying to be the superior nursing college.

CS: transparency is complex, usually people have vested interests e.g. a builder looking for a contract; it is difficult to talk about transparency with large groups of people, people go through the process of being afraid, think there is transparency between CS, sometimes we have heated debates, discussions on issues, I think that is because to an extent people are transparent, a heated debate shows that people are saying their say; otherwise in the P'ship it is okay.

CS: you would sit with half the information and I don't think that there is willingness for people to share openly, think that transparency amongst CS is the most difficult thing because we have certain people that can put policies in place, put systems in place but who deliberately contravene, overstep, ignore.

CS: a member of CS will come to me as chairperson & complain about the director, I tell them, write that complaint, address it to director and a copy to me, I will attend to that problem of yours, they refuse to do that, my response is I do not subscribe to that kind of behaviour because it creates tension; as far as I am concerned I would not complain about it.

HS: suspicion between the community *vis-à-vis* the other two partners.

CM: no transparency, usual reason is that budget need to be submitted quickly to Foundation & there was 'no time'; we have spoken about illiteracy problem, that people cannot read figures, cannot understand accounting language being used there, in order for that [them to understand] the accounting language to happen, people whom I am talking about should be explained how this went on.

CM: the director does not want us to know more about what is taking place in P'ship, have discussed it with one other CM & we had common view that acting director actually does not want us to put more feelers into his way of planning, that is why I say things that I do not like about transparency within the P'ship is attitudes of acting director, is intimidating us by way of reaction.

AI: there has been problems in understanding objectives & benefits of what P'ship is trying to achieve, but co-ordinators are trying their best to circulate funding proposals, discuss the P'ships activities in the community forum or to the board and to circulate information like annual report, these are all attempts to make issues transparent, am hoping this will continue.

AI: constitution important for transparency; we are operating without a constitution but working on it, have identified that we need improve transparency, am quite satisfied with transparency, when we have a constitution, then everybody knows each other's roles, it tells you whole purpose of the organisation so every member is aware of utilisation of Moines, equipment & actual running, things which are still not clear to P'ship members etc.., the constitution will help transparency because it states there are these & that committees, like a watch dog & will report to the committee etc.

CS: selection of information passed on is against transparency.

AI: you are dead right, this is a very big challenge, e.g. if you have not spent time on the health budget, you would not know who has been appointed on the health programme because it is not your interest, it depends on interest of the person to follow up the information, that is why we are asking that when people come to attend community forum for example, that those people have an interest in what they have been delegated to do, do not simply delegate a person because he comes from a certain constituency.

Qte [1.16]

The *consequences* of the lack of transparency were 'gossip networks', jealousy and the formation of sub-alliances within the individual CP:

CM: until such time that people learn to be transparent & have no hidden agendas then there will be problems, yes gossips go out and change everything, this was the complaint, that was highlighted by a member of the community who is on the board

CS: transparency is lacking, creates a lot of jealousy between staff, alliances are then formed in between core staff making it difficult to be open and easy to be victimised; transparency then depends on where one is in the hierarchy of the organisation & if one is connected to the gossip network;

CS: now I don't believe that there's transparency in the project. I'm talking about, from government structures down to management, to CS and then from staff to community and the other way from the bottom right up, think that there's a lot of jealousy among staff, I think that many CS know that knowledge & information is power and the least that they share the more in control they are, the more they can also blame the other partner when things go wrong because, and what has happened is that certain staff have formed certain alliances with senior people in the project which makes it very difficult for people to be transparent and open about what they do.

Qte [1.17]

Areas of lack of transparency embraced the filling of the P'ships' vacant posts and salary levels of the CS. Special emphasis was placed on the financial and budgetary issues and human resource development in terms of educational trips nationally or internationally:

AI :transparency means coming up front regarding challenges or problems that P'ship is facing, P'ship is attempting very clearly to indicate how many vacant posts they have, how they are intending to fill, what problems they have encountered in terms of staff or advertising or appointing, so those will be regarded as transparency of the organisation.

HS: level of transparency is not satisfactory, how did the board of trustees come to be, people were interviewed, who appointed the people who are the interviewers of the board members who are now appointed, what mechanism did they use, are they legitimate, because if it is the P'ship's management, then I have got problems, they can appoint interviewers who they can influence and so appointment of the final candidate will be in their favour, that is a burning point, that is why I say there is no transparency.

HS: again who determines the salary of the CS, no CM was invited for the determination of employees' salaries, I do not know their salaries, I have never seen it so far.

AI: as P'ship grows we need understand how much the funder has given & how money has been spent, this will through P'ship's board, one is not clear that one should be looking at how much they have received & have spent, so transparency around financial matters is also crucial.

HS: HS input into the budget was only in 1996; transparency was lacking, 1996 was the first time to give a budget input, there was no nurses then on P'ship's board, maybe due to poor communication & co-operation with the HS, it is better now; transparency is only happening now, for example AI takes all the interest on money donated by funder; transparency is big problem in P'ship, or was big problem, because there was no transparency regarding the budget, previously there was no nurse on P'ship's board, when a nurse got on the board we really started to interact with the P'ship, it was only last year (1996) that we sat in on the budget, previously only doctors on the board and they were who allocate the funds, that was a real big problem, previously we did know what we receive from P'ship; I am comfortable, unless there are other issues I am not aware of.

HS: the solution is to be honest, management as a whole, they [P'ship] are not transparent, definitely due to lack of honesty, we are told that money arrived from Kellogg, how & when .. we are not involved, only the leaders meet Kellogg people, we would prefer grass roots people be given a chance to go to Kellogg's office, we have no chance to express such thoughts, you shall then be victimised if you put something that is not satisfactory to the leadership, they will avoid you in meetings, somewhere, somehow they can attack you (Physical?), they feel you are stumbling block to their success, I am afraid of such things.

CM: But because of pressure from donor they had to sit down & make your financial report and a budget & submit it to the funder, then the funder has brought the money and then you do not know how much that money is all about, these are some of the frustrations we are meeting within P'ship, chairperson of board suppose to be signatory to cheque account, but this is not the situation here.

HS: transparency is improving but not clear regarding attending national & overseas conferences, always AI who attend, AI get preference, there is need for more nurses to go, also need to save money that is spent on these activities & spend it where it is really needed, for more 'on the ground' activities, e.g. this year because HS had input in budget, we asked money to develop this PHC site.

CS: Transparency firstly when it comes to finance is that you see what's in your budget and then what else is not written there you don't know what's happening. So not to frustrate myself I have decided to keep my eyes and my mentality within what I do, within my budget; No, you can see the other sectors as well... but like what's happened with the remainder of the money, maybe from last year... you know, some sort of communication, to me it is if you select whoever you feel comfortable to understand you and to say yes to what you want to bring up. And then to me that's not openness, that's not transparency, because how do the others also know what's happening. And also sometimes things that are actually done.. you find are never communicated e.g. conflict resolution workshop; e.g. they want access to money & it is my job for example to control budget & when I say that we are not allowed to say.. cross items or things like that, I become the problem.

CM: there is no transparency as regards the trips abroad or the method of selection.

Qte [1.18]

Levels of transparency seemed to be related to the participant's *administrative tier* in the P'ships, whether it was board members, CPs' programmes and the university-linked peripheral units involved in the CPs:

AI: as a board member transparency is good, each nursing institutions have representative on the board who in some cases reports back; I am aware of this information because I am a board member, am very involved & interested since inception.

CM: you [B. member] are going to be stopped as if you have jumped into field of another person to control, but you are a B. member, I do not see any transparency because you do not know where the limit of your control as B. member. As a B. member, you are an eye & ear to control that things should be well happening within the P'ship. I do not see any transparency if you are stopped instead of being, we must be first sure which are our field or sphere to complain or control, so if you are stopped, it means there is a hidden agenda, there is no transparency, and that is what I do not like about the P'ship, about transparency in the P'ship as such.

CM: things are not as transparent as one may think, am having fear of maybe some other things within P'ship, more especially in central office, we [board members] only get there as a board once a month, we are told or get some reports of certain things, there are some other things that you would like them revealed to you but, you cannot say what because at some other meetings you or one B. member might ask a question, maybe he has information about something else & you find that, when this B. member now talk about this & then they all think that it is being told to us, then you wonder why this thing has not been said before, if somebody is asking questions concerning certain point, then you find there are some hidden things maybe within this thing, there are other CM who feel transparency is not way it should be.

AI: in a programme involving Dept of social work, community meetings largely contribute to developing & promoting transparency, there is open agenda & decisions are not made before hand, alternative solutions are invited, yes there is enough transparency & cards are all open on the table; income generating projects have own action committees.

HS: HS do not know what is happening, I do not know where this thing (P'ship) is going to, there is no clear direction of P'ship's sub programmes e.g. home based care group where children stay at day mothers, day mother makes no visits to health centre or contact clinic sisters or refers cases needing professional attention; I do not know what is going on, I think they do not know that they should come to the clinic, since we are a P'ship I feel that the P'ship & we should know what is going on in these houses, are they safe, is the hygiene good, can the day mother look after them.

AI: yes there is transparency within the university-linked projects, there is clear vision of what objectives & benefits are as compared with main campus who are very far & might not be clear about objectives & benefits of P'ship; lack of involvement of AI & HS maybe because of transparency, things are not very clear, what are the P'ship's objectives & benefits, where is P'ship leading to.

Qte [1.19]

Transparency needed to be a multi-directional process between all the stakeholders involved in the CPs:

CS: transparency with community is good, but bad with the other the AI & HS partners, maybe due to them not being involved, so their people do not know what is going on.

HS: I do not think that it is particularly transparent, particularly when you see AI come together, there was a lot of conflict between the nursing colleges, and some of it was a personality problem but a lot of it obviously everybody is trying to be the superior nursing college.

HS: CM have serious concerns & reservations about P'ship, in meetings the were murmuring, saying it is better that the P'ship be closed, they are trying to air out their grievances, but seemingly their grievances are thwarted, they are being ignored, something like that, this happens often, community is not enough organised and not properly involved, so they are not strong enough to vent their grievances; I do not think we have that much transparency, everybody is looking after their own little hierarchy, they are all trying to improve their side of things.

CM: some transparency as there are CM on the board, decisions still unilaterally made, this violates transparency; lots of gossiping going on, community does not want to write their complaints down or go & air them directly to the director, so chairperson does not do anything about community concerns; who is representing who on the board, a member of staff may not be satisfied, will be simmering inside, this hampers progress & creates tensions.

Qte [1.20]

4.2.3.2. Cluster II: Representation of Stakeholder Groups

As regards the interviewees, the mean age of the informants was 38.8 years (range 24 to 55 years). Again there was no interviewee under 23 years of age and those under 28 years were about 8 % of the informants [Figure (61)].

Underrepresented groups

Regarding the under-representation of the *youth*:

> CM: we have problem with youth, they do not like to go & attend meetings, forums or whatever
>
> CM: youth should be given a very large slice in our budget.

Qte [2.1]

Also under-represented were the voluntary groups and community agencies. This was supported by the qualitative findings relating to the representation and turnover of the various stakeholders:

From the community side, more community representatives from the *lower social strata*, *community-based organisations, religious and other civic structures* were needed:

> AI: lower community strata not well represented, sustainability problem if lower strata do not participate; Grass roots need be represented, not only the elites, more representation of lower social strata are needed; P'ship management need to draw these socio-economic groups; there are CM in the field work, but at decision making level it is lawyers & teachers who represent community; there is need that P'ship elites motivate people from lower strata to be represented in their structures.
>
> HS: no religious structure represented, consultation with & feed back to structures is poor; need more grassroots people; not satisfied with participation level, many people & organisations are not reached; I am happy with the representation of the community.
>
> CM: more representation needed, there are few community structures, need from P'ship to have many community organisations represented, also like to see whether people are participating or not, CBOs need be involved so they can report to their constituencies how P'ship is run, P'ship is pulling forums where people should come & attend & you'll find CM are represented, only few structures are represented there, it is a problem because P'ship have to send many invitations to these people, so they can report these matters to constituencies or to their executive committees, so that they can choose people who are going to represent them, all that I am saying is that P'ship should get new mechanism of informing people to come & represent their own structures.

Qte [2.2]

From the health services' side, more HS representation especially from the *central health department* was advocated for:

> AI: if they [HS] attend, they are not representing government, maybe only their personal departments.
>
> HS: we feel under-represented on P'ship's board; feedback from HS representative on the board was not regular, so we would discover important decisions already made without coming back to us.

Qte [2.3]

From the academic institutions' side, more representation of various AI *departments* was reported to be needed:

> CM: Many [AI] departments are not represented, so implementing decisions becomes problematic.
>
> AI: distance between the main university and beneficiary communities is 500 kms; peripheral university linked units not funded from the main university are those who wrote the proposals and are involved. P'ship's initiation in terms of mainstream university was by remote control, main university is not founding member, did not participate in pioneering.
>
> **Qte [2.4]**

Reasons behind under-representation

The interviewees suggested that *reasons* behind the biased under-representation of groups in general could be tribal, geographical, political or educational considerations or combinations thereof:

> HS: all people & organisations invited at meetings are from the North [particular tribe], middle & southern parts of beneficiary location are not well informed, people from the south are very narrowly represented; people take it that the P'ship belongs to a certain group, P'ships invitation mechanism not proper, too much racism, CS at the P'ship needs to invite us, three quarters of CS are from that tribe.
>
> HS: again a certain political party has just joined the P'ship, you see from the initial stage that political party was not there, for your information I am not from that political party, I just want to cite practical examples, people are marginalised because of their political affiliations.
>
> CM: teaching them [CM] to read & write, most people are illiterate, when we tell them about [P'ship] they do not listen [understand], if education [literacy] be given to them, maybe they will come & attend the forum, if we can teach this people, then we will have more representation, would suggest that we have offices next to most effected areas, P'ship may establish such centre where people be taught by CS or employing new staff to be there.
>
> HS: definitely politics might be a contributing factor, maybe it is because they [P'ship management] want to personalise the P'ship to be more specifically for the people of the North, they are the ones who are side lining other groups.
>
> **Qte [2.5]**

Expertise and decision making authority of the representatives

Related to representation were the issues of skills and power of the delegated representative. A fair amount of *expertise* as well as *decision-making authority* of the representatives was advocated for:

> AI: delegation only to interested relevant persons, not simply because coming from certain constituency; only nurses are involved, no really senior personnel.
>
> HS: expertise of the delegated representatives, skills are needed and also the authority to make decisions rather than only attending and reporting back; which is better to be on the board, HS senior vs. junior members who give better feedback & have better feel of problems on the ground, top person is not always the person that is actively involved at grass roots; need for top representatives from HS, I wonder if top most people from hospitals are coming to P'ships meetings, top levels in hospitals are missing, you find a younger person, they cannot take binding position as regards the HS, he will have to go & consult somebody who has authority, so it is difficult.
>
> **Qte [2.6]**

The need for skilful top management level representatives appeared to be controversial:

> HS: HS representative in the P'ship was a doctor from top management & was not in touch with us, there was very little nurses, now a nurse represents HS at the P'ship, she is trying to overcome that, she worked in the area; top level is not aware of what is happening in the community.
>
> CM: community people are elected because they represent, not because of good management skills.
>
> **Qte [2.7]**

Thus the balance between the skills, extent and level of representation seemed difficult but desirable:

> HS: management level mix complements each other & improves feedback; invite management levels mix, representing central administration & peripheral clinics: she [HS representative from middle management] might be good to sit in the P'ship for the budget, but if we need to motivate for some office services, we [clinic nurses] will motivate better; let a representative from each community & from HS sit in on board meetings, even just sitting there, listening & contributing when needed, but not part of decision making, like an ex officio or observer so that the feedback will not come via via via, it will come directly for me.
>
> **Qte [2.8]**

4.2.3.3. Cluster III: Communication

The communication cluster included professional staff - CM communication, communication in-between the CM, flow of information, communication mechanisms with emphasis on meetings as a mechanism and the management capabilities of the groups as regards the CPs meetings. These sections were interlaced with the survey responses on selected questions from other sections relating to the effectiveness of communication and communication as an organisational barrier. This cluster contributed statistically significant explanatory power to the intermediary measures of satisfaction, outcome efficacy, activity level and educational activities of the various stakeholder groups [Table (47)].

Communication, communication mechanisms & flow of information

The qualitative data added several dimensions to the complicated and central process of communication in the CPs. The major sub-themes that emerged related to the timing and characteristics of inadequate and adequate communication, the dynamic and evolving nature of the phases and levels of communication, the need for multi- directional direct communication and the effect of the organisational structure of CPs on communication. Communication was again intertwined with the information on the meetings, role clarity, ownership, visibility and transparency.

Generally, time needed to be made for communication, as it contributed to visibility and seemed to need improvement:

> CS: health committees of beneficiary localities are very loaded, with not much time for P'ship issues, feedback to constituencies is incomplete & lost.
>
> CM: because there is no communication, people do not know what is happening in P'ship, what is P'ship, what is it doing, would suggest that P'ship management or CS recruit people to visit & see what is happening in P'ship, maybe not for people staying around the P'ship, people who are staying far, if people know & used to P'ship premises they will not have problem to attend P'ship forums.
>
> AI: communication is not 100%, needs be improved, presently we communicate through minutes of meetings & workshops reports, this does not ensure inclusivity, need that each member is communicating with each & every person.
>
> HS: communication is poor, late notifications, agendas, minutes etc., some partners never saw the beneficiary location, or were not involved in developing a community profile or running needs assessment; meetings had jargon, meeting times & places sometimes inconvenient, long hours, last minute notices, better with a junior partner; previously reports, newsletters etc. were lacking, now these last two years, they sent newsletters to us & also reports, budget report, we never got that, but now they send it also.
>
> **Qte [3.1]**

The *timing* of communication appeared to be a sensitive issue. The interviews suggested that communication needed to be unconditioned to particular problems and be before the event and not after it i.e. more proactive rather than reactive. The examples where CM were not timely informed or consulted included the appointments of CS or CHWs, salary changes or educational trips and tours abroad:

> CM: communication with P'ship officials, unless there is a problem then they will communicate with us, they will be discussing the issue that was discussed already [at the P'ship], if there is no problems they will not communicate, it is very wrong; communication is poor, e.g. after someone was employed or after increasing the salary, community is not aware of this at time of its happening; suggest that in their plenaries or forums, they have to inform all people by letters, pamphlets or whatever, that people should attend those meetings.
>
> CM: people who might not be qualified that much but more qualified than only CM working at P'ship, CM were very concerned, why is this lady being taken, they could have applied if they were told that if one does not posses qualifications one can still apply & be taken if one is from [beneficiary location], so they did not apply, otherwise they would have applied, people from the [beneficiary location], people like me, we know people in [beneficiary location]who are more qualified, whom we can approach of which I have not done in the past; selecting & training CHWs, no communication with community was done, several CHWs not from immediate beneficiary area, gives impression that the P'ship is going out of [beneficiary location].
>
> CM: frequently told late about things e.g. job application, trips abroad, etc., community needs communication before decisions are made or implemented; committee members may change every two years with no orientation for the new ones who come on board; only days later, minutes might reflect what was said; because most of them [CM] they are not educated, maybe this is the problem that makes them not comnunicate with each other; would say most of the time it, was not too early, you are just told about it when 3 weeks are left, there is a trip that is going to such a place, now they [director] will say we have chosen those people to go because of time factor, names have to be submitted by certain date, no communication made effectively for people from [location] to apply for certain jobs.
>
> **Qte [3.2]**

Characteristics of inadequate communication

Characteristics of *inadequate communication* included the information being deficient, filtered, twisted or inconsistently flowing leading to "gossip" networks, or a bias could result from geographic, person, language or educational considerations. Related issues were that communication of the stakeholders with the beneficiary location and communities needed to happen early and that information was power:

Interviewees reported instances of twisted or inconsistent information:

> CM: but there is tendency for twisting information as it is taken back to the communities, there was a question of some members of central CS who attend our meetings & take minutes, issue came up where a CM said she was afraid to talk because of tendency here to twist information after each meeting, then they would go out there & find something they said in the meeting twisted, but then they said somebody or some people from the meeting go out there & change the context, so there was a suggestion that because at meetings sometimes we talk about staff, it was unwise of us to have staff taking minutes.
>
> CS: also I'm sure its consistency, consistency in information, such things that the budget says this and this, OK you interpret the budget that way and you go and find out what's actually happening, it is not the same information for the next person as to what's happening, so consistency also in information, if you say that what will happen to so much money needs to be the same, I need to know same information as you know what's available in the project, what will be happening in the project, what other future plans of the project. that

information differs between the different groups of people, because of that inconsistent and all that you find there is a lot of gossip. Because you find out that there's this information ...now I take you and say are you aware of this? so there's such an increase of gossip; communication is not developed, is beginning to be responding; communication is poor, right information is not given to the right people, leads to poor interpretation of vision; no consistency of information with various people, as a result small teams are formed and a gossip network develops.

Qte [3.3]

The reported instances of filtered information could result in too little information on important topics being shared among the partners:

CS: the way communication is filtered through in this organisation leaves a hell of a lot to be desired, nobody takes responsibility to make sure that everybody gets the same information, what happens is there is huge skinner [gossip] network, if you not linked into gossip network you often find out that you do not know what is going on.. like last week when the director went off somewhere, none of us knows where she is going and where she is going to, it is courtesy to tell people that you work with that you are not going to be in there.. so that is just one incident of lack of information.

CM: sometimes this thing has been decided by the last sub committee, or something has been said or agreed upon between a sub committee, the board as it is knows nothing about what has been decided in the sub committee, question of transparency, you will not get full report of what has been agreed on by sub committee except what has been done only by the management.

Qte [3.4]

Bias —geographic, person, language or educational considerations in communication:

HS: communication to certain locations, unsatisfactory with structures from other locations so they know very little about P'ship; we did not communicate, besides with the team leader [director], we did not communicate very much with other CS, so you do not know them & what their function is, we got to the P'ship half way through, were not there at inception, we did not understand the working or actual staffing, besides the director.

CM: communication channels limit information dissemination to the northern part of [beneficiary location]; many CM do not speak English but rather Xhosa, this deters many CM from attending meetings; because the people are illiterate, written communication is useless, verbal communication need to be used instead.

CS: communication & information is power, sometimes when it is filtered this leads to gossip network; on the other hand, premature dissemination of information maybe destructive [e.g. information was disseminated that donor funding is going to end when it is not].

HS: what frustrated me more than anything else is going to the meetings & talking about something I never ever saw, instead of workshops at big hotels, shouldn't we have one of those meetings in the area we are trying to uplift, most people also from two nursing colleges have never been in the area that everybody keeps discussing, yes nobody goes to the beneficiary locality & see what it looks like, you have never been there, do not know the road, would be nice to see where you are trying to plan, no managerial level meeting took place there, CS seem to go to the location, but rest of us do not, means it is very difficult to participate, have not been sent reports or involved in community profile or needs assessment, merely met community at two of the weekends that we had.

Qte [3.5]

Characteristics of adequate communication

On the other hand the characteristics of *adequate communication* as reported by the interviewees were: communication needs be meaningful, relevant, information sharing and be as a part of an attitude:

AI: we meet the partners at meetings but have not really started talking to each other, if this happens we will be able to share problems, resources & experiences; communication is better in smaller groups over extended periods of time; sharing of information needs be more.

CM: because only a tiny fraction of those people attending there [committee] participate in meetings, at end of the day they get their 50 Rands, we can do without about 50% of people who go there, some go there for sake of 50 Rands, this is terrible, only a tiny fraction, a third of the whole committee are involved in discussions

HS: communication now is much better, it was something to do with attitudes, we HS did not know what the P'ship was about & I think they also, am not blaming the core office, HS are also to blame, we were never really interested in what is going on in the P'ship, we did not know what the mission & goals are, did not know what the P'ship was about, I always see them as people who come here & demand, that maybe was the problem.

Qte [3.6]

Communication seemed to improve with presence of a HS *co-ordinator*:

HS: communication was poor with HS, improved after HS co-ordinator was employed [at the P'ship], especially that co-ordinator was a nurse with health background, she seems to draw us all together & get us involved, that seems to have improved things.

Qte [3.7]

Communication needed to be *dynamic*, as the CPs moved from initiation to implementation, phases and levels of communication differ:

CS: it has to take phases and different levels. We could not call them all at go, we had to convince those at authority that the ideology is good and then only come down, we still have to go further down; communication with top management in structures for ideology support, need to move on to the second level and prepare them as the P'ship moves from ideology to implementation, so it is not new to the workers when you get there; when we started we were dealing with administrators within different Depts.., within AI we were dealing with rector & deans, within HS we dealing with rectors, those people know about P'ship, they have been involved from inception, now we are at phase of implementation, dealing with people like lecturers, HS providers, we need to start fresh again, communication to all these people is not very easy, creates problem, you think people there know about us, they should have told their people about existence of P'ship program, only to find that few people interested in listening to whole ideology, because they were not involved literally with whole idea of P'ship, communication is always very difficult & creating number of problems, when they started with community health centre were we are rendering HS, people who have involved all along, the directors etc., when we had to start the functionality of the centre, we had to come down now to assistant directors, chief professional nurses & those people took it that we want things to happen tomorrow, because they were not involved from 1991, we are talking to them now when we are saying the centre is about to start & they think we are telling them just now, see what I mean with problem in communication.

Qte [3.8]

All along, d*irect, multi-directional* communication between the partners was desired:

AI: there is no direct communication so I do not know what HS are doing & how we can utilise them, we only communicate in meetings, would prefer a newsletter or short reports, something communicating information; two way communication is needed, through the P'ship's office, communication take all modes, partner to partner, partner to P'ship, P'ship to programme to community, it need be sharing information;

CM: informing people not well implemented; knowledge not shared; communication not satisfactory as it is indirect between the partners, sometimes filtering first through core office; communication is poor & information is little.

CM: communication within P'ship, we [partners] do not know each other, that is No. 1, people heading these programmes [P'ship programme heads] never visited us, we never spoken to them, all of us as board, no direct communication to P'ship programmes leaders, we hear so & so who was leading certain programme is leaving, but he never brought any problems to the board, even progress he is doing, not only problems, never reports it.

> If everything is running smoothly, & I do not think the way things are taking place, they can be smooth running, even if things are running smooth, it is needed to have a congregation so we hear what type of person are you, communication there is breaking, feel we should have direct communication with these people, the leader of that very programme never came to us, that is where there is communication breakdown, somebody [director] is reporting for them, communication is not satisfactory, his way of answering is that of stopping you not to dig more.
>
> **Qte [3.9]**

The *direction* of communication included 'in house' communication or communication between the pairs of stakeholders. This needed to be ample so that the CS can transfer information to the partners:

> CS: in house communication is a problem leading to further problems, if I'm not fully communicated with anything then its not easy for me to communicate with HS people, involving them in anything because I'm ill informed, and because of no clear job descriptions it actually leads to overlapping of other people doing what is not theirs, I think not poor interpretation of the vision and each one understanding mission statement your own way and interpreting it your way, also interpreting your activities the way they suit your partner which then becomes a problem because now its not properly communicated that why I think its not easy to maintain this whole P'ship. Like CM, HS & AI. Because I'm more interested in my own partners that I'm co-ordinating - that's the services.
>
> CS: within the CS communication is good, from the project [P'ship] is good
>
> **Qte [3.10]**

The multi-directional *vertical* and *horizontal* communication process encompasses communication in between the AI (AI - AI) for pacing, especially if there were several AIs involved in the CP. Paired relations might benefit from strengthening are in the directions of (CM - HS), (P'ship - CM) and (P'ship - CM/ HS) communication, communication between the CP programmes or general communication between the partners:

> AI: [AI - AI] communication need be increased to the AI that are moving slow so they get more information & become more educated; there were reporting back in my nursing college, but reporting back does not mean stimulating activities.
>
> CM: [CM - HS] they communicate with the community... I am having a problem with community to communicate all the time with HS, then they do not have enough communication with HS, if P'ship can push to have the workshop to participate with the people to make them understand what is good or wrong about P'ship, if P'ship can try to go to the people around here.
>
> CM: [P'ship - CM] people are not used to visit P'ship to communicate with CS or management, there is no communication between P'ship and the community, P'ship will advertise jobs maybe around our area, only to find that we don't have qualified people who will be selected for those posts.
>
> CM: [P'ship - CM/ HS] Communication not enough with the community & HS, could be due to illiteracy or how interested is traditional chief with the P'ship.
>
> CS : programmes are separated, not mutually informed [vertical intra-P'ship programmes].
>
> CS : the information flow going into the project from the partners is bad, need to be improved, more reports, newsletters etc., ensuring that the right person got the letter; communication is bad with several academic institutions and with health sciences institutions are not in one body, even within the mainstream university; joint planning committee does not feed back information to the constituencies.
>
> **Qte [3.11]**

The *organisational structure* and its effect on communication: satellite site office/s in beneficiary location/s

> HS: communication is irregular, worst after site office was formed, as the clinic was then on mailing list of core central office & we [clinic at the health centre] used to get information directly, but it does not come directly as it used in the past before site office started [site office & health centre are a bout 500 meters apart], sometimes there is a problem with them in the satellite office, when they are not there or when they are busy, there is certain information that does not get through e.g. sometimes they know that students are coming here but they themselves are not here, so site office might know about it but we might not know about it.
>
> CM: the peripheral site offices at beneficiary locations are suggesting that they need better communication with central core office, they feel they are alone.
>
> CS: the organisational structure in P'ship inhibited communication between P'ship's main office & satellite offices at beneficiary sites, communication is bad & there is no administrative backup from central office to site offices, this is not conducive of functioning as a team with the other sites, CS from the site offices do not feel welcome in central office & are told to write reports instead of coming, site offices are small with too many people functioning autonomously, not as an extension of the main office, they have to create their own working conditions, this has a negative impact on the work.
>
> **Qte [3.12]**

<u>Meetings as a means of Communication</u>

The qualitative findings further indicated that notifications, invitations and agendas of meetings were delivered late, resulting in members sometimes not being able to attend:

> HS: there is poor notification of meetings, no agenda until we get there, often no written agenda, so you do not know direction of the meeting; seems to be coming okay, problem when we get last minute notices; when there is a workshop they [P'ship] will come & say just before the workshop, maybe late afternoon of day before & tell you that you must attend, then you cannot because you have things to do & have not planned for the workshop, so it is all part of a communication problem; we never know normally until the meetings about half an hour before the meetings, sometimes we get a fax, most of the time we do not know what is going on; the invitation mechanism to meetings is selective, involves top [management] layer only, additional observing members are needed.
>
> CM: if certain task are asked from certain people [CS], it is never to satisfaction, I mean if someone from the office[P'ship] must contact people, they don't do it, they either mislay that file or something, for instance when meeting is scheduled for a certain time & all the members that has been presented need to be informed timeously, that does not happen; people should be informed in advance, so that they can prepare themselves for that meeting, some are getting the invitation early, but some do not get them early, because maybe you find the invitation today, tomorrow is the meeting.
>
> CS: we are not working in a situation where there is organised management activities, there is always something that crops up at specific intervals, you find that we are having a definite date for meetings but it is not everybody who is able to attend, we have really tried to say on those dates we must attend the meetings, something urgent crops up, here, the needs outside most of the time easily outrule your need for be in the meeting because you need to decide can I loose this chance of presenting my case to these [other] people.
>
> **Qte [3.13]**

A related issue was the minutes of the meetings. The groups differed in their level of agreement if minutes correctly reflect the meetings where the CM agreed the most and the AI agreed the least. Interview data suggested that *minutes* were not delivered in time, not typed and in some instances might

not reflect the meetings. It was not clear, however, if the minutes were twisted or if some members attending disseminated imprecise information in the community:

> HS: minutes arrive late, at times by the time you get the minutes it is too late, cannot even have an input, so you get to meeting without having enough pervious information, might even get the minutes after the second meeting has happened, so you miss a meeting, but if minutes arrive on time, one can give more input or inform P'ship that there are points that need immediate attention, then the input would be stronger even in an informal manner.
>
> CM: some times do not get minutes at all about the last meeting which says next meeting will be in such a date, minutes come perhaps a week after that meeting has been held; minutes taken should be typed up, that also does not always happen; only days later, minutes might reflect what was said but there is tendency for twisting information as it is taken back to the communities, the tendency here to twist information after each meeting.. then they would go out there and find something that they said in the meeting twisted, but then they said somebody or some people from the meeting go out there and change the context, so there was a suggestion that because at the meetings sometimes we talk about staff.. it was unwise of us to have staff taking minutes you know.. although the person really who took minutes is our administrative manger.. we thought she was relevant .. we thought it was proper for her to be there to take minutes.. because she is involved in the administration of the organisation.
>
> **Qte [3.14]**

Participant observation revealed that a considerable proportion of the meetings were at the CPs site. In addition, most of the CS had varying access to and could utilise the CPs vehicles or they already owned their own vehicles, so it might be easier for them to get to the location/s. However, this must be portrayed in the context of the amount of non-tarred roads to the beneficiary locations. But the interview data suggested that meetings hardly ever took place at the beneficiary locations. In fact, as regards the *location* of the meetings the AI and CM suggested that meetings need to take place in the beneficiary locations as opposed to the CP's office:

> CM: some [meetings] must be held at [location] because at [location] you get the benefit of some of the CM coming, yet here [at P'ship] you only have people who are regular committee members coming, in fact half the number is coming.
>
> AI: I am not aware of any other [P'ship] meeting that has taken place in [beneficiary location], no, not that I know of, the actual [P'ship] CS seem to go into [location] but the rest of us [partners] do not seem to go there.
>
> **Qte [3.15]**

Regarding the starting and ending of CPs meetings, the impressions of participant observations where the researcher participated in several management, strategic or joint planning meetings and community forums across the CPs was that meetings rarely started or stopped on time. The interview data supported this finding. *Times* of the meetings were reported not to kept and meetings were reported to be too long:

> HS: meetings start & stop not as scheduled; meetings are too long.
>
> CS: in meetings there is a need to stick to the times & agendas advertised beforehand .
>
> CM: board meetings take so long, when we part we are also frustrated, tired & must rush home, it is so late; I believe an effective meeting should not last more than two hours, you must not go to two or three or four hours; would not like to spend long hours in this meeting, at certain time I must be home, then you feel no let me not raise more issues otherwise we are going to waste more time.
>
> **Qte [3.16]**

The interview data also offered explanations relating to the *interaction* in the meetings, *language* between the members and stakeholder groups that might have an inhibitory effect on attendance, the *agendas* and the *turnover* of members which was further discussed as a separate issue below:

> HS: conversant persons dominate the discussions, there is repetition unless there is a strong chairperson who can control the contributions, sometimes people tend to capitalise the meetings so you find that some of the people are really a bit uncomfortable because they feel that they sort of not accommodated, so some people might be intimidated and step back and at the end of the meeting there may not be any good results because one point has been repeated and we have been concentrating on it because of the same person.
>
> CM: tendency at the P'ship is to accommodate one person at expense of the people, if one person does not understand [local language], we will all speak English, people who have problem with English then will not understand exactly what we are saying, it has driven some people away from the meetings, it is because the people at P'ship are learned people, tendency is to forget those people[CM], now they [CM]are feeling not good, decided to stay away from meetings, & you wonder why they do not come, problem is communication, if we could so simplify ourselves, we, have lay community people, it is those who will be able to convey whatever we say here in terms of people in their communities.
>
> CS: in meetings there is a need to stick to the times & agendas advertised beforehand; partners come with hidden agendas which is very destructive for the meetings.
>
> **Qte [3.17]**

Analysis of the interviewees' responses revealed that the *turnover* of members and representatives attending is high resulting in repetition and low continuity:

> HS: people coming to meetings are different every time, different people come the following times, this is very disruptive, people ask questions that previous ones knew, a new person does not know what is going on; no stable attendance, turnover is high, continuity of those attending needed.
>
> CM: also you get people coming to meetings now then they do not come then they come back in 2 or 3 months time again then you got to go through the whole thing again; it is disrupting to us, you do not feel that that particular AI is really represented, because there are people who are there on day to day basis, like certain AI & the community also, they are there on day to day basis as opposed to once from the other institutions where you find that this is just a token that this person is representing the institutions but there is no continuity in terms of activities; turnover of members is high.
>
> CM: if you are representing your structure in this forum, you must not skip any meeting, when you skip a meeting then there is no feedback that they are going to give your constituencies, they must encourage them [reps] that they must report back when they come from meetings, people are just going there, some because there will be lunch,, after that they go home, forgetting they must compile a report & give it to other members; people are afraid to participate in the community forum, they are afraid to participate, because you may find that she comes once then after three months she comes again & attend that forum, that person cannot be able to participate, because he never understand the whole question, but that person cannot know what is happening in that forum, he is going there being blank, but if those structures that I am talking about are well represented & those people who will come knowing that they are going to participate in P'ship community forum.
>
> CM: because of continual habit of taking on new members you loose track of where we are supposed to be, how many of us are supposed to be here, you loose tracks of essential issues in terms of basically what are the goals that P'ship is there to achieve, it often comes across as, so long as they are devoted to nursing interests, they (new members) are from the services and the training colleges.
>
> **Qte [3.18]**

The qualitative data also suggested that the *follow up* and *feedback* after the meetings might be inadequate:

> CM: is incredibly poor, everybody speaks but no follow up; follow up is bad, you get nothing unless we sort of pursue it, I think I am representative of members of the hospital I represent; everybody writes lists & we never ever hear from them again, I think if there had been follow up I was willing to get involved, but you never get minutes after a meeting, we had one weekend on the budget but never heard of it again, incredibly poor follow up, then you loose momentum, you do not get involved in it, am not happy with amount of reports or feedback, could be improved a lot, sister at my clinic also has same problem.
>
> CS: no follow up on issues raised or invitations or reports send back to constituencies.

Qte [3.19]

4.2.3.4. Cluster IV: Ownership, Commitment, Involvement & Contributions

Ownership issues were in close relations with commitment, involvement and contributions

Ownership and Commitment

Interview data revealed that in general, the sense of ownership might need strengthening as regards the CM:

> CM: people must see that this building [P'ship] is for other people whom they do not know. They must feel that this [P'ship] is for them
>
> CS: community does not feel ownership, views are not welcomed or truncated early
>
> **Qte [4.1]**

Ownership needed to be spread out and be a *collective* ownership rather than individual one, a stronger but limiting sense of ownership was felt about the "old" members of the CPs who also had an unequal distribution as regards the CPs resources:

> CM: ownership by the 'old few' is intimidating, there is perpetuation of self interests; a problem that CM who began with this P'ship before us, they have the habit of telling everybody, staying on top of the mountain that it is them who began this project, this brings perception to community that if this people can go out, then this project will collapse, that is very dangerous for community, (the impression) is for as long as they are retained, for as long as they are there, then we [P'ship] will see prosperity in this project, that brings trash to the people, if we can move from a situation of individual ownership to collective ownership then this P'ship will be one of the best in the country & international, stop individualising & personalising the P'ship, and they have attitude of liking to occupy all powerful positions, to be board chairperson or in the management committees or administration management. But over each and every powerful position that maybe he/she thinks that is going to peruse his/her self personal interest, they want to be in that particular position, it effects the process of ownership in the sense that the people begin to have a feeling that this project is not theirs, that this project belongs to certain people & is only going to survive if those people are still there & for as long as we threaten the position of those people, then you bugger everything and then you are going to mess everything up.
>
> CS: community is active, but mainly the "old" group who joined the P'ship from the beginning, those have a strong sense of ownership, but this might lead to the exclusion of newcomers, there is need to identify new community members and perhaps use the older community members to bring the new ones in thus sharing ownership; most CM who come to meetings & are active are people who have been there from initial stage, seems that they are not open to have new member coming in, would like to see new members coming here, they just make it no to share, maybe feeling of ownership is so strong that it is theirs, they are not ready to share yet, need to go further inviting those communities who do not come, they must come to meetings & attach them to the programme, can do this by using old members to go & invite & bring new blood, has got to be them to go & open hands & visit these people, in order to go & call people to come here, we have not raised their interest yet enough, so far nothing, would have liked to see it happening, more invitations extended to all or most members of community, maybe because they are not known, the people to the P'ship, that the project has not identified various CM or groups that can come and participate, I think so yes, recommendation is sharing of ownership, yes allowing new members to come in, extended invitations, & raising interest of other people & groups, using old members to go out to people & also the people who are working in P'ship to invite more.
>
> CS: [resource distribution].. the "old" members seem to have unequal distribution of the resources of the P'ship e.g. constant use of P'ship transport and vehicles, telephones etc.
>
> **Qte [4.2]**

The interview data also revealed that generally, more commitment of the AI and HS could be a promising strategy:

> AI: commitment is lacking especially HS and partly the AI; involvement is minimal, there is some lethargy, the nursing colleges done little to educationally uplift the P'ship, minimal student deployment to the clinics.
>
> HS: no volunteers, community involvement somewhat spoiled, need to sort out committed people now.
>
> CM: some AI & HS, commitment is rather slack, particularly day to day commitment to P'ship activities, mostly you find problems within that particular institution itself, they would just rob in somebody to present that institution and you find there is a problem that maybe that person is committed somewhere else, would recommend that such AI & HS sit down in a consultative way instead of robbing people in, so the person they send is a committed person up to date with activities of P'ship.
>
> CS: more commitment is needed.

Qte [4.3]

<u>Involvement & Contributions</u>

As regards involvement, the views of the stakeholder groups suggested the following:

<u>Health Services/ Department</u>

> AI: HS is not very involved, not visible, not much participation, not pushing the P'ship; need to draw HS in & enlighten them, get them to lobby amongst themselves.
>
> HS: involvement is not satisfactory, CS say HS are not participating, whereas on the other hand they [P'ship] are not open for us; our representative on the board is not afraid of the director.
>
> HS: health centre's nurses are seconded from & under authority of HS, but no or minimal central support from health department, we do not think that they (central) appreciate the kind of work that we are doing.
>
> CM: the community, they can't know nothing because they [health services] have people they can go to the community & tell them about the HS, solution is if the P'ship can work with the health services to go to the community, but I am sure they need to pull hard because they start but in another villages, they do not know about the P'ship, maybe I can talk about the HS, maybe they do not have the chance or enough time to go to community, it is a few villages where the P'ship is touching the community.
>
> CS: HS are not very involved, just sit in the P'ship meetings; participation by HS is low, only 1 hospital,; the health services are not very involved, just sit in the P'ship meetings.

Qte [4.4]

Several *causes* seemed to have contributed to the lack of involvement. Apart from the lack of clarity discussed earlier (section 4.2.3.1.), the causes included the lack of time, administrative authority and hierarchical considerations, times of meetings, transport problems and lack of support:

> CM: The health people [HS] do not have enough time with the community.
>
> CS: there is a communication problem; very little transformation, judgmental attitude
>
> HS: very difficult for us HS to participate, P'ship seem to be for AI, they can go straight ahead, we [HS] are with the government, have to ask permission, the Dept. must give us the go ahead, because of the time we consume to go to meetings, also transport problems, CS are also paid overtime but we are not & sometimes

meetings not in working hours, hospital authorities give us a problem sometimes, matrons usually give go ahead but no transport.

HS: there is lack of appreciation from central health department

HS: senior HS people pay no visits to health centre, only the nurses' direct supervisor, if you have not been to the place or the area, even if I indicate I have a problem, my problem will not taken seriously because you do not know the exact situation; if I talk about personnel but every day patients at the clinic are seen, then you do not think this is serious; as long as health centre's clinic is running, indirectly means that nurses there are managing, there is lack of transfer of their problems to higher levels of central HS administration for a solution, people at the top need come down to grass roots levels at the clinic

HS: whatever you are doing you are not doing it correctly or efficiently because you want to finish those clients as they cannot be returned, as the community itself expects us to do something for them, we hardly have enough time to do health talks with our clients.

Qte [4.5]

Academic Institutions

Generally, academics were seen to be busy people with a high turnover at meetings:

AI: AI participation not much and do not show up in many meetings

CM: participation of AI is low, there is a high turnover of representatives, disruptive as everything has to be explained again.

Qte [4.6]

The administrative level, commitment of individual players such as the heads of departments of various faculties seemed to be important:

AI: major committed individual players are more important than institutions.

AI: dean is not interested, a partner will come and see the transformation, the site, he [dean] does not know where the students are; he only came 2 years after P'ship started, even if it is no fun the vice chancellor was forced to come.

CS: first there is heads of departments, I think these are the people who could be showing interest & taking lead so other people should follow, but there is no more or much involvement from that point of view, there is no enough involvement at level of heads of Depts, if these key figures get involved, their departments will definitely follow, although necessary not only the heads of departments need be targeted.

CS: not all faculties are involved, the nursing dept, Dept of agriculture, unit of behavioural sciences - psychology Dept., now slowly Dept. of education is coming on board, they have been here several weeks ago telling us how they want to be involved, I would have liked to see the medical Dept taking the lead, this partnership is a health service, yes they started not very long ago, but they are coming now, I recommend that keep on inviting them on board and to meetings, not just the heads of the Depts. but everyone.

CS: not all faculties are involved, not ready yet to take part, the P'ship is advertising itself, but academia do not come to meetings, the medical department is lacking, academics do not attend the meetings, health services are a bit better; Academic sector needs two pronged approach of the senior and junior staff, there has been no real attempt to involve entire departments.

Qte [4.7]

Example:

> AI: Community entry process whereby stakeholders get together and look at community & available structures, none of the four nursing colleges were involved & process was left to P'ship's director; how can you actually start anything without nobody knowing who you are and where you come from; impact is, to develop a curriculum, a philosophy, you cannot do that without knowing the community, need to interact & see before you sit & theorise, information need be first hand from the community instead of from the P'ship office, you cannot set objectives for people you have not seen; we do not know what community would expect from a professional nurse
>
> **Qte [4.8]**

The *reasons* attributed to lack of involvement fell broadly under un-readiness, communication, clarity, resistance, lack of lobbying and joint planning, and the 'minor' importance of the CPs. They embraced the un-readiness yet of the AI to take part, lack of publicity, advertising and information, resistance to change or taking risks, AI did not want to show their ignorance, overloaded faculty, position of the CPs which sort of sits out on the periphery, lack of advocating, lobbying academics, lack of joint planning, transparency and clarity as well as the relation between change and benefits:

> CS: reasons could be that there was not enough publicity, or academics do not see themselves as the P'ship, they do want to make change or take risks, maybe lazy because of presence of CS, need more invitations to & response from academics; not all faculties are involved, not ready yet to take part; AI do not want to get involved, may then show their ignorance.
>
> CS: my concern is not all partners are fully involved in P'ship, in the universities not all faculties are involved, maybe because that they do not know much about P'ship, they are not ready yet to take part, maybe they are not well informed with programmes that are going on in P'ship, advertising as far as I know done enough in form of newsletter, discussion documents, videos or open meetings, where they are invited to meetings & most of them do not come, maybe they are not ready enough or just not interested, need to keep on inviting them to meetings, keep on giving them information.. in the form of newsletters etc. those are few things that one can do.
>
> CS: P'ship sort of sits out on the periphery, kinds of demands that P'ship then makes is something in addition to the work of any departmental head or lecturing staff be it junior or senior, on more than one occasion its been intimated that P'ship is more of a nuisance than it than it has actually been a benefit because it demands extra meetings, demand extra times.
>
> CS: I don't think we've done enough in terms of advocating, lobbying academics in terms of community based education & curriculum development, taking ownership of the partnership, in a way academics have also come to realise that having CS is more convenient because in a lot of ways CS takes the responsibility of what should have been the academics responsibility.
>
> AI: overloaded faculty, very busy, no time to spend in community, would love to give more but cannot, student numbers increasing, need more faculty.
>
> AI: in this transition period nursing college overburdened with old curriculum, cannot focus on new way of doing things or on P'ship in general, also overburdened with teaching & administration, faculty shortage and not enough staff to attend/ extend a hand to the P'ship, more faculty = more liaison = more activities; the backing we get from the government is study leaves to be able to attend workshops etc.
>
> AI: as nursing institutions, we did not sit together & plan; at a workshop, each of the nursing institutions gave their own report and not together as an institutions partner; on the other hand without involving enough communities on board there are not going to major benefits of the P'ship with regards to the spread of PHC.
>
> AI: Maybe because of transparency, things are not very clear, what objectives & benefits are, where is the P'ship leading to; distance; university linked peripheral units are the only ones on the board.

AI: AI has not changed & is holding the strings; involved faculty seem to be those who had benefits, people want something first & then participate.

Qte [4.9]

An important *consequence* was the dispersion of energies of the AI:

AI: AI looking at other communities & doing community entry to their own areas that are nearer to them than the beneficiary community, it is a dispersion of energy, this dispersed energies separates us all together as partners, now nobody knows who is doing what where; everybody is going somewhere and implementing their philosophy; to bring these energies to bear on one problem we have to go to step one and that is the philosophy.

Qte [4.10]

Community

HS: community participation is a problem, unstable attendance & many political affiliations, P'ship can quickly become personalised or politicised, excluding many from participating.

HS: participation of community grass roots levels in P'ship's projects, like brick laying project, would like community to respond more eagerly & actively than at the moment [CM complain that no projects have started except paraffin project & that sewing project has been stopped/ dropped].

CM: participation quality is low, community rubberstampers on decisions already made by others especially AI, people are presently still dis-empowered; lack of continuity.

Qte [4.11]

4.2.3.5. <u>Cluster</u> V: <u>Power Issues & Consultation</u>

<u>Suspicion, Groups, Struggle, Agendas & self interests</u>

The qualitative findings indicated that generally, suspicion between the partners could be a hampering factor to the advancement of the CPs. Power struggles in the form of hidden agendas, win-loose situations, caucus meetings, mistrusts and conspiracy could be signs of an underlying feeling of suspicion:

> AI: a hampering factor between partners, thinking that each has a hidden agenda, a win-loose situation which we try to overcome, we need to be all in this so that communities can benefit.
>
> HS: the professionals & CM suspicious of each other, CM have caucus meeting meaning that there is suspicion, partners must sit & discuss openly; also mistrust in appointment of the P'ship's director, CM not satisfied with the board of trustees, what method used to appoint those members, who appointed the panel, lots of questions; CM were not given chance to select a person for that post; there are too many subgroups and 'little backyards' to look after; who is the important partner.
>
> CM: especially the CM, they feel sometimes there is a conspiracy to push them out, but again it is difficult to push them out because that is a community project.
>
> **Qte [5.1]**

The *Reasons* for suspicion appeared to be ascribed to a variety of factors. These embraced issues related to the different paces of the stakeholders, the individual partner's 'personality', competition for resources, inadequate interpersonal relationships or simply the history of the place and the accompanying political ideologies:

> AI: one college is moving faster than the others, may seem that it has its own agenda or treated by the P'ship in a special way; if there was less suspicion then maybe we can work together as institutions; this has not to do with transparency but rather that the colleges have been apart, now in an amalgamation process, got to know each other to be able to trust each other, that is just human.
>
> AI: source of suspicion could be from institution's personality, we committed ourselves, maybe other colleges did not, some benefits went to those fully committed; we can break down suspicion in small groups, to know each other more as individuals and to communicate, more social and begin to talk about things; getting together is one thing and having a curriculum, sharing students & everything.
>
> CS: problems may create competition for resources, inputs may become negative and political.
>
> CS: people are insecure, if you say that it would mean that you are stupid, I am extremely simplistic now but that is how it is perceived, within the P'ship core office e.g. we have different levels of education., I do not go around telling people what degrees I have, because if it is important on the one hand, I think it is what I do that is important, but other staff do not perceive it like that, so they would for example, this issue that I have a masters degree from wherever and I work with academics, it happens at CS level & at different levels in the organisation, you know this issue is interpersonal relations it is very important.. how you relate to other people.
>
> CS: within the P'ship, [location] had history of being problematic, it is still problematic, lot of the [P'ship] politics in [location] is politically based, different political ideologies, also personality based, the personalities bring the political baggage with them along, that complicates things, in one project the chairperson of the management committee had a bit of a fall out with other board members in [location], he is not on the board, so other board members, Mrs A etc., they started their own management committee of the project, because if you could access funding of the project, therefore they own the project & he should not own the project.
>
> **Qte [5.2]**

The existent *power relations* seemed also to be a function of the size and structure of the CPs, centralisation of authority, politics and political agendas, information power, and personality:

> CS: numerous partners, too many structures centrally & in periphery, becomes unmanageable, not clear who is accountable to who, board needs to be smaller, it is an octopus that just gets bigger and bigger all the time it is very difficult to hold it together, to hold the centre is very difficult.
>
> CS: power structure is as such that the director is only one who controls CS, there is need to decentralise power, information not shared equals power not shared.
>
> CS: politics/ political agenda: much involved in decision making e.g. appointment or firing of incompetent fieldworkers.
>
> CS: communication and information is power, sometimes when it is filtered leads to gossip network; on the other hand, premature dissemination of information maybe destructive e.g. donor funding is going to end when it is not.
>
> CM: this personality or friction we had in [location] caused serious problems amongst other [community] constituents because as a whole they must be included, no way we can go ahead & leave them [community] behind, we spent time trying to solve that problem, hell of an impact because it hampered our progress, we did not really be a progressive project & were lacking behind, because of this friction & personality, they were not involved enough, & also there was a power struggle there.
>
> **Qte [5.3]**

As a result of the power relations and struggles, the *power-retaining strategies* employed included a 'divide & rule' system, bribery in the form of opportunities, struggle fights and faction groups, the underlying 'know how' of the AI, and the retention of information:

> CM: past political system has used divide & rule system, even in this P'ship that system still apply & is very effective, at benefit of university, if there is something that will block the decision of university, only option left is to divide the community, immediately when you fight this un-united force, it's (not) easy to win the battle.
>
> CM: comes to situation where people are given certain opportunities to forget challenging things, others are not given those opportunities because they are talking too much, at the end they become alienated, this is the whole situation, you may challenge it, but it depends on the capacity that you have to challenge decisions & influence them, trips abroad or opportunities to outspoken people.
>
> CM who are concerned, when you become outspoken it becomes disadvantage, they begin to open (f*** all) opportunities for you, in order for you to keep quiet, bribery plays major role in this case, our people are not exposed, might be given opportunity to go overseas or promised a job in order that you be contained, cannot blame our people because most do not have resources to sustain own social life, then comes the question of how can you bite the finger that feeds you, when you become outspoken bribery takes place, that is the situation that happens here, why should I confront & destroy opportunities that I am getting, this happens from university because university is in control, it's in power.
>
> CS: so what happens is that the community board members are involved in this fights, their energies go into that and the contribution they can make in terms of the P'ship is solely lacking, in board meetings when it comes to any substantial kind of discussion about any issue, generally you find community board members do not participate.
>
> CS: there is a lot of this feelings that academics are in control, which they are, it is also about power & people, you also ascribe power to people so if you give them that power, then they will of course take it & do their thing, so there is this underlying dynamic about the academics know everything, they are ones who talk in board meetings and we shut up.

CS: I think that many CS know that knowledge & information is power and the least that they share the more in control they are, the more they can also blame the other partner when things go wrong; selection of information passed on is against transparency.

Qte [5.4]

Given the power tensions described above, the general impression was that the AI were in *control*. Their apparent control seemed to be due to their superior knowledge and education, the CPs' constitutions that gave them power to the financial administration, and sometimes the physical site of the CPs being on the university campus:

CM: AI is in power, P'ship constitution supports the university for financial administration, consultation is lacking; AI know where P'ship comes from & where they want to take it, they bought other people [HS & CM] into the P'ship, after they have put their proposals, discussed & understood them, are academically powerful compared to our 90% illiterate communities, gives them full power on decision making, sometimes they come with academic terminology people are not aquatinted with, & then they can sway our people with whatever they want, take them the way they [AI] want, the drafted constitution gives university more power than any other group, particularly financial administration, an article in the constitution gives university the power to administer P'ship money.

CS: academics are not there for the P'ship, but seen by partners to be in control, sometimes due to physical station of the project being on university campus, finances also administered by & through the university partner channels, but partners also decided that, this puts a good financial control system in place which is important for later sustainability; academics do not listen enough to community and are frightened; academics felt dis-empowered in the P'ship, as large amount of staff were recruited, and academics had not much power over them.

CM: once funding proposal is made, communities are not involved, when money comes or goes still community does not know anything, at the end community will be given audited financial statement & accountancy figures that our people are not aquatinted with, even that within the board community is a majority, point is majority of community does not make any difference, there are board CM who if you ask them what was discussed in the board, cannot even tell you, people get in the meeting up to it's end without saying any word or questioning what they do not understand, if chairperson is not signatory to the money how do you actually know how much is there & how much is going to be used in whatever.

Qte [5.5]

As regards the physical station where each individual CPs building/s were established and sometimes even constructed from scratch, the observation was that they exhibited a variety of stations in relation to their beneficiary communities. Of the five CPs under investigation, three are either on or related to university campuses. One was on the university campus proper with site offices that were established in the beneficiary locations. The second was on the university hospital grounds but linked to the beneficiary communities through the support, upgrading and enlargement of the health centres that were already established by the government in those locations. The third was in the same town and close to the AI, and again linked to the beneficiary communities through the support, upgrading and enlargement of the health centres that were already established by the government in those locations. The final two were not on university campuses but on separate 'neutral' lands, actually situated in the catchment area of the beneficiary location and communities that the CPs were supposed to be servicing. Of those two, the

station of one was strongly biased towards the northern part of the locality it was to be servicing. This had a direct implication on representation of geographical constituencies.

Self interest of stakeholders— the core staff, the community, and community board members :

> AI: CS need appreciate that they are working for NGO, does not look like people appreciate it, e.g. demands relating to salary increments, they are very unreasonable & all sorts of allowances like vehicle allowances, CS not sensitive enough to the fact that they are working for a non profit making NGO doing something for the community, at management level we are discussing the salary increases, CS demanded that these packages be back dated to the time when employment started in the P'ship, this sounds ridiculous, we are trying to make a collective decision with the management & sensitise CS that they are working for an NGO; CS getting valuable experience & nothing prevents them from moving to greener pastures; CS are overpaid & taking valuable jobs that should be done by community members
>
> CM: we have few black intellectuals within the community, not there for community interests, only for own personal interest, using name & flag of community to get where they want, the little who have good quality of education are serving their interests rather that the community; university was very clever, looked at influential people & respected figures within the community, put them in front, P'ship became more acceptable because these people command respect, a situation whereby same influential people co-opt their own people that come into the picture, and when you want to remove (the situation last year) this people as they do not represent us, told that legally, trustees give them 3 years period in the board, we decided we are giving them last chance to prove themselves, nothing changed, were told that certain percentage of our board representation will be changed, shorter periods than 3 years can be better.
>
> CM: The case is, decisions are taken in the university, unfortunately people in the board who are influential in community side are the people consulted to take decisions, they have their own self centred interest & those [CM] who immediately oppose whatever the university says then it's trouble for them, only thing is to cover up the university & cover themselves.
>
> CS: self interest of Individuals, particularly community board members, number of people, a few individuals really who participate on the board have only their self interest at heart, so they see it as a place where they actually can promote themselves, that has another dynamic within P'ship e.g. and I am not thinking about one of the people who were thrown off the board by [location], you could see he was a chancer, because here this person who you can see does not necessarily have the P'ship interest at heart, all he is interested in is getting things for himself, then that is promoted by the director, for me was very problematic, e.g. when it comes to using the [P'ship's] buses.
>
> CM: Community Board Members with own interests and agendas, no feedback or responsibility, not giving feedback to either side, some of them have their own agendas; yes & by their own word of mouth & own statements that they make, e.g. at signing of constitution, that is the only person out of all that has worked by cell [phone] than with the constituent community, we had particular B. member, whatever he did was for his own ends, using the community, then he goes back to the community, & community do not know anything about it, we have it inside board meeting, community is unaware of it, at the end you are not there to represent yourself, but to represent constituency that elected you there.
>
> CM: no individual is greater than the organisation it represent or community they serve, that is reality, what some board members do, they come with their own agendas.
>
> CM: I don't see the decline of the participation from now, but what I see it's more courage from the community side. The only decline that I see to some of the people [CM] who decided to stay at home are those who have their own personal selfish interest and because they could not achieve them and they decided to step back.
>
> **Qte [5.6]**

Consultative Decision making

Generally, consultation in decision making and co-operation seemed to be *lacking* with unilateral decision making taking place:

> HS: Co-operation & relationships were very poor between HS & P'ship but improving, student placements had no set criteria, clinic nurses did not know when students were coming, HS must be part of the placements; CS just come & demand & expect HS to do what they want to do.
>
> CM: more consultation is needed; consultation is lacking, unilateral decision making happens; they must consult, after we had these problems we consulted our people, then only we came right, we have got to tell the leaders about decisions made, there are leaders in the community used to be informed after the decision was made, if the decision is to be made by certain individuals, now it is coming right, because people are representing others, used to be serious & critical problem; we always feel that there are things that we do not have, we do not have access to P'ship, you get some information too late, you will hear that there was something done by the leadership, without not even consulting board, can cause conflict within board members & leadership or P'ship management, not often but happens sometimes.
>
> **Qte [5.7]**

Domination of the decision making process could sometimes happen by the CP's director or the AI:

> CM: decisions are not made by everyone on committee, instances where director & few members take decision that effect the projects and cause dissatisfaction among committee members, you do not know whether you belong here or someone has shown lack of confidence in you by not inviting you to particular meeting or passing point of view that you feel strongly about so long as that suits them, in terms of taking decisions unilaterally, very little has changed, certain members must not be invited to meeting because they come as being very much opposed to particular view proposed, emphasis has been on nurses, must be involved at all costs, also those very close & friendly to director have been included in all decision making.
>
> CS: Who is the running the P'ship that's one thing I'm not clear, one time you are told that decision are coming from the board but most of the time decisions come from the director, with authority when you find something going on you find that authority is vested, you know it is one person to decide on whatever needs to be happening in the project, being vested maybe in one or two people depending how do those one or two people interpret mission statement involving other people in achieving this, maybe I'm the one that's got power do it in such a way that I involve everybody or is it because I'm also involved in to many things it's not easy for me to decentralise or give this authority to other people or is it my own fears, it actually becomes a problem to me because when you find a place running like that, sometimes something you can change it but you can't change behaviours and attitudes.
>
> CM: there will be a decision taken somewhere in the university corridors & then they come to the community because everybody knows that if we've got the blessing of community in what you are to do, then everything is super, certain people take decisions in certain corridors without knowledge of others & when they come to the community they come as if they are suggestions.
>
> **Qte [5.8]**

Although a cause and effect relationship was difficult to verify, *causes* of the lack of consultation included the CPs culture, a perception that CM have a lack of knowledge, or simple organisational dysfunction that led to lack of teamwork:

> CS: co-ordination is defective, there is a project culture of 'do your thing'.
>
> CM: so that in a sense negates the whole democratic process of a community person cannot suggest a name of some one he or she knows because the community person is not supposed to know enough about who are the people who are helpful.

CS: although there is overlap of functions of the local health committees of the beneficiary localities with the functions of the P'ship's health services co-ordinator, the budget for the committees is with the community development co-ordinator, this is disruptive.

CS: only in 1996 was there joint strategic planning activities between the partners, we do not work well as a team. OK, that's the one aspect of organisational structure. I think the other aspect could be that the fact we have - even though we supposed to be all core staff - there's no, it's not a team, somehow the organisational structure does not allow us to function as team or it's management.. that does not allow us to function as a team.. and therefore it breaks up the communication even more between core staff. Because I think that core staff as facilitators of the partnership must always be aware what's happening in the partnership. If I just give an example of what I said that there is poor communication. Not everyone will be informed about the meeting or you get informed about the meeting you pitched up for the meeting and it will be cancelled.. right there.

Qte [5.9]

Consequences of the lack of consultation included missed opportunities and duplication of structures:

HS: [missed opportunities for].. using the skills & enthusiasm of some members, I am well trained in community health & fully committed, I just felt that they could have used me much better than what they did, they did not involve me, could have involved me in the workshops at the clinic, you talk & plan but never seem to get there & actually do the work, I was used as an advisory, my contribution could have been more.

CS: do not disrupt structures already present, but rather build on them

Qte [5.10]

Examples of the lack of consultation were numerous and in various domains. This included CS appointments at the CPs, salary increments of CS, selection of students for bursaries or CHWs for training or CM for educational trips abroad, and programme funding:

CM: within core office, would like executive committees/ officials to consult communities & committees when they employ, you just find the person in the office, that is strange, you do not know what he is doing but you will see that he is working, that is a major problem that we discover now these days, has happened twice, officials & director have no right to do this, chair person was not aware of it; this concern been not communicated to P'ship management because we are scared about talking all those things, we do not even know when you are right or are wrong, must remember, those are our bosses, I do not know how staff was employed, we only see that there is people now at P'ship, they do not use the same channels they are supposed to when they want to contact the people of [location].

CM: we find letters demanding CS increments in the benefits without informing us, not knowing where or to whom did they demand for that money, the director was the one demanding some of these benefits, they got them without consulting, they sat with themselves, discussed & came with the argument, they decided themselves on their demands.

CM: they never came to community telling the community that they are going to pick some students or CHWs (people to be trained) from other areas, they need to come to community, discuss first & tell community that we are going to jump out now, get some few people from other places, P'ship is originally only for [this location]; they will come & make a decision that students will come.. when we got these representatives maybe we should correct it the other way around, after that we make decisions, we find the problem that we cannot function, that P'ship cannot function, because those people are not representing the whole institutions.

CM: [when there are tours] CM are not always chosen, are informed within short time limits before function [conference etc.] abroad, reasons quoted by director is that names must be submitted to function committee by certain date & things were done in a rush, whenever there is urgent need for something, there can be special B. meeting that can be called; consult the partners; communicate before decisions made or implemented e.g. buildings, salaries etc.

CM: 2 professors from faculty came, decided with top management that their project is to be funded by the P'ship, but before it can be funded they get community approval, you see the way things were put there, to some people this was very complicated, the few who questioned them, they appear to be naive, at the end majority of people just accept & bless it, into the board & they are going to be funded, that is some things that happen in this P'ship, there is no proper consultation.

Qte [5.11]

4.2.3.6. Cluster VI: Capacity Building and investing in Social Capital

Human Resource Development

The interview findings also suggested that the development of the human resources is interlinked with development, feedback, accountability and transparency.

Qualitative findings indicated that the CPs concept was a relatively new one to all the stakeholders (the cluster on clarity). Given the history of the South African setting, and that the stakeholder groups had not traditionally communicated or collaborated with each other, an appropriate level of skills and expertise was needed for the various stakeholders, not only in the short term functioning of the CPs but also in the longer term process of the transfer of skills and the building of capacities as part of the community empowerment process.

As part of the inquiry on personnel barriers that might have presented as obstacles in the smooth functioning of the CPs, the stakeholders agreed as regards their views on the expertise of the professional staff and volunteers, where about 60 % of the sample expressed that, in their CPs, the expertise is either a minor or major problem [(Figure (47)]. This finding seemed to have found some echo and was matched with data from the interviews which suggested that generally, training and development appeared to be a main thrust of the CPs missions:

> AI: human resource development component, that was the main trust of the whole P'ship, even when you are trained in university you still need support afterwards on the job, the mission was that those who are in training will continue, but obvious that it should be in undergraduate study that students should be exposed to community.
>
> CS: training is needed to empower people in a slow developmental process.
>
> **Qte [6.1]**

Examination of the CPs documents and reports also confirmed the CPs' goals of training and development. As referred to earlier in the chapter on clarity, the aims and goals of the CPs were articulated in such a way that has led to the development of three key programme areas that were the focus of the attention and development of the three stakeholder groups: namely HPE development and training on educational strategies which is targeted at the AI, community development programmes aimed at the community and HS development directed at the HS.

This seemed appropriate, as with different backgrounds, educational levels and present and future tasks, the *type* of training might need to be different for the various stakeholders; the AI who were required to

implement PBL and CBE were themselves not trained on it, not as students in their undergraduate days nor as tutors and health educators in their post graduate careers. The AI needed to learn more about the educational process of community based education and problem based learning:

> AI: academics do not have enough information about changing to CBE, workshops & resource persons or consultants are helpful, but need an available resource person in the region, perhaps she can help amalgamate our efforts; need in service training; faculty from the nursing colleges that are moving slow need to learn about PBL and CBE; in order to initiate needed changes in curriculum etc., how much do you provide the needed training to the one who needs to do it.
>
> CS: We need to invest a lot more time and energy with academics and to acknowledge that if we want to bring them on board as a full partner there's a lot of development and training that's got to happen.
>
> **Qte [6.2]**

However, a balance seems necessary. Training for the AI needed not be completely directed at educational and curriculum development strategies, but also to embrace other domains of abilities that were expressed by the groups. Although the survey data suggested that for most of the skills that were inquired about, the stakeholders agreed on the above average to good abilities of the professionals, the survey data also suggested that the AI could benefit from more training on community-related issues, e.g. reaching target populations, community organising and bringing about change in the community, or training on how to bring about change in the HS/ department.

Community, on the other hand needed training that would increase the level of their understanding and skills in the field of CPs, income generation, meeting procedures, making statements, addressing meetings as well as illiteracy:

> HS : we have sent CM to training centre for skills training, but community's response is not as we would like it to be; reason why these income generating projects have not got off the ground is perhaps we have not got sufficient manpower trained in skills to start those kind of projects because those projects are labour intensive, cannot start income generating project when you do not have enough manpower, you have got to plan beforehand, we continue to encourage CM to come forward for training, we continue to do this.
>
> CM: little resource development for the community is done and resource development of the community is needed e.g. in addressing and chairing of meetings, etc.; I am referring here to the development of the partner.. more especially the community since I am representing the community.. I think I have already indicated that I feel that we need to be trained on many fields in the partnership as CM.. as I have said my fear is that.. I am not -saying that staff members should not be trained or any thing like that... but my fear we might loose staff members along the way.. they may get some greener pastures somewhere and leave [P'ship] and with all the information and all the resources.. the fear is that they might be around, well I agree with you that.. but the CHWs are only trained on what they are doing.. only on basic things.. that is what I was trying to say.. and for instance we do have some educated people in [location], though I am aware that they are having some other jobs to do.. but people of Newlands would never leave us, I am saying that people from the community will be more loyal than people coming from other places who-to are only interested in getting money and that is all, yes.. I am not saying lets get anyone from the community and just put him there because he is from the community and would be loyal.. we can try to look and see who at least we think is somebody who is loyal even within the community; we have got this summer and winter schools at UWC and so on that you will find that especially people from the partners can be trained.

CM: especially the community members.. we have got one thing in the community.. it is that they are very willing and able to do anything, but they are not skilled to do any specific task, like people will attend meetings.. they do not know meeting procedure.. they do not know what assumption of the various things are.. they do not know when they make a statement or when they talk.. when they address a meeting.. how to address a meeting or on what base the discussion is community.. they are not so used to these courses.. the academics they fully understand, the service people fully understand.. now the community is lacking far behind with regards their level of the understanding of what is happening within that curriculum.. so something needs to be done to open up to the community.. like some courses they do say community participation, but when you attend these course you will find that the community do not really understand what is happening and also they feel they do not want to make a nuisance of themselves by keep on asking the teacher or lecturer what do you mean by this and that.. because they feel they keeping the class back.. so they go through emotions and when they had to feedback they do not know how to feedback.. because they did not understand what was happening there in the first place, the drawback is that the meetings are long drawn out.. and also nothing has been done efficiently or effectively because for the simple reason is that many times because a lot of people do not understand.. then they get these long meetings and also the meeting has to be adjourned to another time because people did not understand the first..

Qte [6.3]

These areas that were suggested for the training of the CM could also be broadened a little to include this survey's findings where the groups pointed out that CM abilities were low in some domains. Specific training of CM on the techniques or means that could benefit them in the process of effecting HPE policy and bringing about change in the institutions. Other needed expertise were skills that might lead to the better management of the budgets or the designing and implementation of educational activities in general.

For the CS, their levels of skills appeared to be able to benefit from upgrading on the appropriate balance of short term fulfilment of basic needs vs. long term empowerment and development of communities, co-ordination:

AI: CS do not have enough skills to transfer; there is need for task & process objectives, also self help, combined vision needed; we have a problem in terms of transferring skills to the other members of the P'ship, with the current staffing, there is not enough skills to transfer, they themselves need upgrading; I don't think enough has been provided to give strength to the people who need co-ordinate the P'ship; I think that the P'ship has done very well for the CS, but for the partners it is still very poor

CS: CS resource development in the core office is good, but targeted at senior more than junior levels, and not at normal community rather than board members, this leads to frustrations

Qte [6.4]

But as the CS were included are part of the definition of the professional staff in the CPs, so they too could have benefited from the domain areas that were suggested by the survey to be required by the professionals.

As the type and area of training required by the stakeholders is different, accordingly the *appropriateness* of workshops, seminars and conferences in relation to their costs or the appropriateness of their content in relation to the trainees' needs and its relevancy to the South African context may need attention:

> HS: finances are wasted on fancy workshops & overseas trips, better to hold workshops in the community, have it in one of the wards of community & perhaps utilise CM to help prepare & cater for workshops, this will boost community; a beach- front hotel for 20 people costs money, when people come back you cannot make up what they really did, sometimes I feel that people go there for the food not for the things
>
> CM: we have spent a lot of money.. sending people abroad to various parts of the country, yet we have done, as far as I am concerned, very little in the community out there.. we spend more money flying people around and Putting them in nice places and we have not really begun to realise the major goals in that community.. and I think it should be the other way round.
>
> HS: if trips overseas are needed, better to places where communities or situation is similar to South Africa, going to places like Canada, a first world country, what can they teach us.
>
> CM: and I think we have got to be able to just open up, a broader approach than what we have got at the moment.. the broader it is the more exciting it will be.. for instance some of us find it very boring to be going to meetings to discuss one and the same thing.. agendas hardly differ because we are talking about the same issues.. if the issues were to be looked at and considered at different levels form different points of views.. then we would be having a very healthy organisation, invite people from outside, filling us in some scenarios.. which are compatible with others.. what are they doing in Brazil.. what are they doing in China.. in the states.. all sorts of things, we need to visit the universities.. we need to visit tertiary institutions.. and see what is available there.. so that we can steal some of the ideas.. we can implement some of the ideas.. securing the knowledge that there are some guidelines and when we are saying when we sailing to achieve our goals
>
> HS: sometimes not choosing courses appropriate to nurses needs, also problem of replacing them while they are away; needs are not asked for; we work around PHC & to develop us as service providers, there is other training that we want to go for, there is lots of other things; P'ship wants us to go to summer or winter school [at the local university], but not all courses are always relevant; we expect to get some in service education or workshops or anything, but P'ship's director must get our need first, problem that they plan their programmes without knowing our needs, if they want to develop us they have got to know our needs first
>
> **Qte [6.5]**

The *effectiveness* of the training needed attention. For example, the survey findings indicated that as regards the training of CHWs, significantly less proportions of the CM and HS than the CS and AI groups viewed it as either effective or extremely effective. Furthermore, the responses of the groups to that statement was in the beginning 'depression' or 'plateau' area of the curve [Figure (56)] as compared with the effectiveness of other CPs operations i.e. in the connecting area of moderate effectiveness between the domains of operations that were viewed by high proportions of respondents as effective and those domains which were viewed by low proportions as effective.

The accountability of *dissemination* upon return including feedback, follow up and transfer of skills after the training seemed to be a further issue of concern to all the stakeholders:

> AI: people when they come back, they do not utilise the skills we presume they have learnt, there is no evaluation of the implementation of the skills, but when I look to the CS, you can asses from their mode of operation, you can see the implementation of skills learnt.

AI: when they [CM]come back, the are changed, having new vision & insight into how things should work, we need that they come back & disseminate this information to the community

HS: those going on tours must come back & put something back into P'ship, there is no feedback, HS representative was top management physician, gave no feedback upon return; somebody has a trip but does nothing when they come home, they are not putting anything back into the P'ship, I do not know if there was an agreement to put anything back

CM: no feedback to constituencies; feedback is low; more accountability needed; there is no accountability as such, if there is there is a little to certain limit, people not coming back to tell us what is that we are supposed to do, you be told that somebody has been overseas to represent the community in international conference for development etc., but those people do not come back to give us report on what has happened, & what can benefit us from that conferences, we even begin to question ourselves who elected those people to go to represent the so-called community to those particular platforms, A special meeting [to decide urgent things] never was vocabulary of this organisation; When people elected to a certain position & you accept that position, you must accept responsibility that goes with it, that is where accountability comes in, you are accountable to the people that elected them, same like government, you are accountable to people that put you in office.

CS: like we've been to a conflict resolution workshop, I don't know for how long & there were changes that were supposed to be implemented but we are supposed to meet sometime in March for that and then how long does it really give us if we gonna say we want to change those things. And it is actually things that we had been saying... these are the problems, these are the problems that make us and the project not to be productive. But we still carrying them it on and on and on.

CS: [workshops] no follow up after attendance, those returning do not report back to the constituencies or put some of the skills learnt back into the P'ship

Qte [6.6]

The *selection* of the members from the stakeholders needed to be fair and balanced between the partner groups. It needed have criteria or policy, not depend entirely on the educational level, and people needed be informed timeously:

CS: there is no clear policy, reactive not proactive; criteria for selection to attend conferences is not clear

CM: community would like to democratise this thing in sense that when ever there is a CM on behalf of the P'ship with other people who are going out, that person should be actually chosen by community, so that he is committed to community to come back & report about what he saw outside, , community would like be given task to choose their people who they would like to represent when they go out, so that those come back , report and implement whatever they learned

CM: we would like is whenever a trip is to be undertaken, would actually like that maximum of people going should be from community, the community is the host, other people from other partners can add up on that, when those people are chosen, it should be left with community to decide who would be going, that is recommendation from the community.

CM: there has got to be some kind of quota.. e.g. number of CM or representative has got to be larger than that of both partners put together & it make a lot of sense that you have a majority from those people who are represented by larger numbers than the rest.

AI: there is an equal distribution of taking people from various AI to workshops; unequal distribution of benefits within one college effects which faculty of that college participates; only few selected people, am concerned with huge pool of people in the P'ship.

CM: I am not happy, my concern is that in most cases it is recommended that mainly CS should be ones to go seminars and things like that,; sometimes they get one person being involved, sometimes you there is not a single CM, what makes me unhappy is that you may not be sure for how long these CS will be part & parcel of P'ship, as community, we will always be at our places, will never leave [location] because there we live, CS

can resign, can give short notice and get better job now with all the skills I have got from P'ship, then that staff member is gone.

CM: CM are not always chosen, are informed within short time limits before function abroad, reasons quoted by director is that names must be submitted to function committee by certain date & things were done in a rush, this create problems later with sustainability as CM are not developed.

HS: it is a good exposure and friction to workshops etc., but what about the broader community; I thought CM would be recruited, trained & let back in the community to spread the gospel, do not know what is happening but have not seen anything of that yet.

AI: many CM had a chance to go to conferences or travelling seminars.

CM: what has been happening is certain members are just chosen especially those from the professional side of the P'ship, they are just chosen.

HS: overseas trips mostly attended by doctors & CS, no nurses attend; do not know of any other nurse who went on any of these trips, do not also think community was there, think it is the AI or CS there.

HS: [Bias] towards certain area of beneficiary locality, scholarships not well advertised & people only know about them when participants are leaving for workshops.

CS: conferences are mostly attended by the director, some academics or health services person, only time the administrator attended a conference was when she was called in by the donors.

CM: we debate before people go & unfortunately it is director who dominates these meetings, she often says or cites number of characteristics or qualities that so and so has & that particular conference or workshop requires specifically certain people who have a particular specific background, so in a sense you get a situation where you are not sure whether to push your point of view, I brought it up at a meeting, people did respond & shared my view, I think a decision was taken but I must assure you there has not been marked change for the better.

CM: another irritating issue is when trips are to be undertaken, it will necessarily be people from those institutions by virtue of that they are more enlightened than the CM, e.g. last time people went to manila, there was only one CM, the chairperson, you had nurses, who are new on the P'ship, going.. when in fact there has been people there all the years, all the years we have been there but have never gone anywhere, no one has to say so & so is not educated so he cannot or does not qualify to go, as long as they are CM they must go because somewhere down the line there is something they will pick from that gathering or conference even they may not have ability to participate because of language barrier, but a situation where people participate is bound to have certain benefits for whoever, no matter what education level.

Qte [6.7]

The *consequences* of lack of training of CM could be serious:

CM: first there will be no continuity when Kellogg moves away because people [CM] will not have acquired any information or knowledge, secondly people are bitter because this is an elitist practice, people are segregated against on basis that they do not have professions or are not enlightened or cannot speak English properly, it is very important for people be exposed to various situations.

Qte [6.8]

Innovative training needed to include networking:

CM: I suggest that there has got to be some kind of innovative ideas.. you have been doing this kind of job.. by now you should be very much proficient at what you have been doing all this number of years.. now I would like to transfer you to a certain organisation or perhaps get you some kind of situation where you can update your knowledge or your skills.. so that when you come back you can perform better.. this does not mean physically take the person out of East London.. out of Kellogg because that would have some financial implications.. but he would go into a network structure and get that person in touch with various organisations in the country which would I suppose impart something on that particular person on an advanced level, I think we are not ambitious sufficiently,. we are not ambitious.. we do not have self confidence.. we often think that if someone comes with such crazy ideas they will not work, we fear to experiment.

Qte [6.9]

Leadership Skills

Related to the expertise, abilities and training of the CPs participant groups were the skills of the leadership in the collaborative process. In this study, leadership was defined as the engine that drove the CPs, the group of members, trustees and leaders who usually decided on the course the CPs would take every time it met a crossroad. This group included the directors or CPs convenors, the board of trustees and the management or governance committees. Leadership issues were also intertwined with the domains of communication, role clarity, decision making

In discussing leadership, attention is focused on two main bodies which appeared to be critical in the CPs, namely the director or CPs convenor and the Board of trustees. Before discussing the skills of the leadership, two points could prove relevant. The first was the *visibility* of the leadership, a point that was also referred to in the cluster on clarity (clarity through visibility), and the second was the *composition* and *legitimacy* of the leadership. For the first point, in general, more visibility of the leadership seem to be advocated.

> HS: it is not clear who leadership is, they do not attend meetings, there is lack of communication & commitment; not clear who leader is in the P'ship, need a more dynamic person to interact more with HS at grass roots level, even in our area here, sometimes I did not even know who the leader is, with leadership I think about the chairperson, the person in the P'ship's office, perhaps I know who the leaderships are because I attend meetings, but I do not even know if my staff here at grass levels know who leaderships is; chairperson or director does not come to the clinic, even at P'ship's meetings, chairperson does not attend regularly, in important meetings, the person is not there; this is causing confusion between P'ship & people at grass roots, if they are not here, not attending their meetings, how can they expect us to take P'ship seriously, that is a problem with the other partners also, because they are not taking the P'ship seriously
>
> CM: leadership should be open to people, I mean management or staff must be open to everyone, so that they [community] may see her/ him as a good person who can do things for them, do not think leadership is open because people do not know whether this person is director or co-ordinator, do not know his portfolio, e.g. you have got a director at [P'ship], but many people do not know that director, they should call community meeting to inform & tell people, introduce the leadership to them, but as I told you that there is no representation at all, so few people will know then but majority of them do not know.

Qte [6.10]

As regards the *composition* and *legitimacy* of the leadership:

> HS: need more leadership from the community, not always academics.
>
> HS: do not know how it came that the people leading the P'ship be there, do not know how it happened, director who is leading the P'ship is very person who was the pioneer in initiation of the P'ship, whether they have imposed themselves into that position or not I do not know, if money is raised because of community, then when one comes back one must expose these funds to the community, they must know what type of structure they want & must participate, community must decide who must lead the structure, might not be same person, community will decide, the P'ship's pioneer, I feel maybe they were not quite right for leadership (director) position, somebody else might have been quite right, am questioning the mechanism used to bring him to leadership position, am not clear what mechanism was used, but still feel there are other people who could have managed the P'ship.
>
> HS: how legitimate is P'ship's board of trustees?

Qte [6.11]

When it came to the skills of the leadership, the survey inquired about three related domains of skills that could be useful for the CPs leaderships: the first domain was related to the *communicative* skills of providing information and reporting achievements, the second was connected with the *consultative* skills of giving recognition, seeking and welcoming views and listening to opinions within or without the CPs, and the third set of skills was associated with *providing opportunities*, whether educational or offering social gatherings or group activities or tours to CPs members. Figure (53) showed that within each of the three domains, the groups agreed on some points while disagreeing on others. The findings are reviewed below, interlaced with their qualitative counterparts which add more context to the specific finding.

First, the impression was that the role of director or CPs convenor had expanded to become a central, critical as well as a pivotal role in this cluster of SA CPs. The qualitative data suggested that the *management* procedures needed clarity, consultation (one CPs director insisted on calling himself management), support, devolution of financial and other responsibilities.:

> HS: P'ship management & procedures are unclear, dictatimg & there is a lack of consultation or marginalising & side lining of individuals, also use of influential pressure groups (e.g. the local women's league in applying pressure & accomplishing the agenda.)
>
> CM: no consultation, decisions taken alone e.g. renovating structures of the clinic or purchasing a machine; communication & consultation are not moving right way; director many times takes decisions alone without consulting board members, some of decisions impact now on participation of community, consultation did not happen, whenever decision is to impact on P'ship as a whole, director needs to go to B. members & put forward to them first before a decision is taken
>
> CS: management mostly by the director, what suits the director; director sometimes takes the more popular route rather than better route, does not stand by & protect CS from other partners; should not employ more CS before securing a physical working space for them
>
> CS: but I also think that the director does not get very good support from the board, she is basically all day on her own & tries to do I suppose what is best, do not think that the board is able to give her good direction & therefore she has to do a lot of things on her own, it is also her style, you get a position that if she does not do a thing then nothing will get done,
>
> CS: she[director] files all the claims, basically she is like a glorified administrator in the project, now when it comes to community development, I am responsible for the community development budget, why then can't I sign the claims for community development
>
> HS: director has no deputy, often needed to go on while director is away or unavailable, who is directly responsible when director is not present, disturbing to flow of work, now they are utilising a person responsible for a programme in the P'ship as a deputy, he is occupied all the time, cannot do his duties, in the report he gave in 1995 almost everything was not done & reason was that he was in charge, when he is in the role of director.
>
> CS: because I think she [director] wants to control the money, ultimately she is responsible for it, right, but she also needs to be able to trust the people that she works with because otherwise she have to do everything & take responsibility for everything, last week there was a cheque I have requested, she did not sign the claim, I got upset, people need the money but director did not sign the claims, I said couldn't you go to her and say this is an important claim, please could you sign it..[admin] is not assertive enough to actually ask her that., the relationship is such that he cannot take initiative because then she is on his back
>
> **Qte [6.12]**

The second issue was the characteristics, styles and attitudes of the central figure, the director. As regards the consultative skills of the leadership, the interview data, however, raised some particulars of the *style* and *attitude* of the CPs convenor or director :

> HS: unapproachable & inferior attitude; dictating terms to participants, if you attend meetings you would have realised that [top management] director come with their decisions & try to impose & push their points to the community
>
> HS: P'ship seniors need to change their attitude so everybody be able to approach them; attitude of the director is not friendly, most people are very much afraid to approach him, he becomes very short tempered & always dominant in the meetings, undermines other people, he looks at you, how educated are you & how much you know about politics, if you are not assertive enough in meetings then they cannot listen to you
>
> CM: director will be revealing correct points in ridiculous manner as if you, members of the board. more especially we [community B. members], you don't enjoy the stay with them, you [b. member] are stupid, reaction of the director, he is not so humble, to show need for staff, as if we are going to be controlled, to be shaped like a shrub, to give shape, just a tree for decoration, you can take pair of scissors & cut it the way you want, we are the people to govern, but, we are not told up to which level should we say something, our governing rules are trimmed by the director, his responses are harsh, he seems to be having more knowledge [information] than us, not only he is having more knowledge, he also wants us to know that he has more knowledge about the P'ship, I do not like it, feel I should say it, & the way he reacts, he is putting limits that this is not for you, I would like him to show us exactly up to which limit should we want to know, and up to which limit we should not cross, we should break being put in the corner, that this is not your field or your field is this one, I must raise concern about this
>
> CM: derogatory remarks, looking down on CS, manipulative, rude, wild, does not listen to others' complaints; intimidating; uses 'divide and rule' principle, lot of complaints rotate around her, the kind of picture that one gets.
>
> CM: director used principle divide and rule, she has favourites within CS, director capable of twisting information, creates problems,. she is rude, uses foul language in meetings, has no respect, tell people they can pack their things & leave, they do not like that, central person in [P'ship] having pressure on most CS, slight improvement, yes, 10 or 20 %, not 50%, but there is improvement.
>
> CM: attitudes for instance.. those people [director] who see themselves by virtue of qualifications higher above other people, they do make sometimes derogatory references to some people, e.g. saying 'this seminar is for relevant people.. the community will not fit in here', there are learned people in the communities, there are also those people who are not so learned. but are intelligent.
>
> CS: lack of openness, fear or avoidance kind of situation, authoritarian style, no discussion of staff problems; causes conflict of messages, unnecessary tensions, run down the core staff in an unprofessional manner, destructive, goes through phases of favouritism & flavour of the month, gives no or not enough give credit to work done; leads to division of staff, development of informal gossip network.
>
> **Qte [6.13]**

When it came to the communicative skills of the leadership, examples included communication, self development, occasional racist concerns as well as the abuse of funds, power or other benefits:

> CS: director does not share information within P'ships or from south African P'ships network; does not visit beneficiary sites often or give appropriate support to peripherals, meetings get cancelled etc.; director needs be good communicator & be able to listen; communication problems; director needs to have a deputy especially in this transition phase.
>
> CS: half the period [director] was away at a foreign University. project was then running in harmony
>
> CS: sometimes, e.g. who controls the evaluation information of the P'ship? researcher is Caucasian, director is from the previous 'coloured' ethnic group, sometimes has a racist tone

CS: power abuse & autocratic leadership style of leader not conducive of teamwork, problem with the last month's wages for staff member who resigned from the P'ship, needed an attorney to sort it, no grievance policy in place except till late. General abuse: CS & especially director have the capacity to control money, this invites corruption, need to deal gently with community, can she mange project, need some element of control; space for abuse of other funds or benefits open

HS: situation where director has got some benefits, which other CS members not entitled to, should director enjoy these benefits, other CS members want to be in same position, e.g. using company car, why can't they use it, she [director] is using the telephone, why should I be limited to phoning only [same city], as result of the womanly fight, director is a woman & rest are women, there is lack of recognising her as leader & boss of the organisation, recommendation be that people be more disciplined in work situation, one is employed & be liable to dismissal, people should understand work situation & are liable to be disciplined, also director should be empowered to take firm decisions that if x does y, then something should be done, so far no disciplinary measures that are taken

Qte [6.14]

The *consequences* of the lack of appropriate leadership skills were fear and feeling not free together with the lack of involvement or even challenge:

CM: it is mainly because of a fear of consequences from director that they (CM) do not want to put their complaints in writing

CM: instances where I think director must not be there when we are discussing issues because often people are uncomfortable because they do not have a director who is very humble or is sometimes considerate, often she is very rude, you are likely to offend her if you go on in particular vein of argument, perhaps very good idea to excuse her & say.. all right we will carry on without you.. because the people are not free to discuss, within the committee she has certain people she is very friendly to, those people even though they are aware of problems will not be free to articulate them, certain people are very much intimidated to speak up against the director.

HS: problem is some people refuse to be involved, after the meeting or days after the person would say I observed this, question is why did you not challenge it, no I did not want to be involved, you try to put out feelers, to indicate to people that the robots here are a bit yellow, but when people do not catch that one, then you just resign yourself & say fine, if they do not want to participate or if they do not want to say, how am I going to say it, there is a problem, you are going to be involved in arguments and it is going to be difficult to direct the meeting, the chairing, there was a question of some members of central CS who attend our meetings & take minutes, issue came up where a CM said she was afraid to talk because of tendency here to twist information after each meeting, then they would go out there & find something they said in the meeting twisted, but then they said somebody or some people from the meeting go out there & change the context, so there was a suggestion that because at meetings sometimes we talk about staff, it was unwise of us to have staff taking minutes, although the person really who took minutes is our administrative manger, we thought she was relevant & it was proper for her to be there to take minutes, because she is involved in the administration of the organisation

Qte [6.15]

The Board of Trustees

The process of establishing the CPs trusts was an evolutionary and purposeful process. The CPs documentary data and reports denoted that the process was characterised by wide consultation. The trusts were based on a fundamental operating philosophy that all activities involved should be based upon shared decision making. In facing the challenges of the past, the trusts usually had guiding principles of non-racialism, non-sexism, a sound developmental approach, an improvement of the beneficiary

communities, equity, and at least 50 % representation of the beneficiary community on all committees. However, the issue of the number of members in the board, i.e. its size was either left open or as in some instances, 'grew with time'.

Qualitative findings on the board of trustees related to the size, composition, meetings and interaction, and communication and implementation:

> CM: Bloated committee, big number of people; number increases to a point that it looks we are overloaded here, we are like a ship that is going to sink anytime because basically it cannot take the weight, we are so many here, I always refer to what I called a bloated committee, it is too large to be effective in its own operation & decision making
>
> CS: board meetings like a circus, big number of people, barking about a lot of petty issues
>
> CM: number & composition of that committee is changing, is biasing a little towards the professional side rather than community side, decisions which are taken are taken in favour of interests of those people who come from HS & AI as a matter of fact
>
> CS: board large, unwieldy, so many small subcommittees but uncommitted people, no follow through; organisational structure of the board of trustees is too large 27 members, most members do not attend meetings or give feed back to constituencies at the periphery; Right now organisational structure is a very large in number, makes it very difficult for this body to actually meet, over past few years even when there is an agenda, the board, who's the governing structure is not able to get through the items on the agenda and which also makes decision making very difficult. the organisational structure although it is board of governance & even director does not feed any information to CS the facilitators who carry out activities and this has also left many staff feeling abused, staff also question where leadership come from if governance structure don't doesn't give leadership how are we to carry out mission & goals of P'ship, that raises issue whether organisational .structure of 27 is ideal, whether effective communication & decision making can happen, for me its just a main vehicle that has no real clout, I'm not happy the way it currently operates
>
> CS: would like to see number of members [from the AI]on governance structure being reduced, we need to look at how AI can be best represented, problem is we struggle with 2 AI in [the local university]., we struggle with 3 faculties, much of the decision around that was that in terms of transforming this in the university that there would be one faculty representing all health sciences, last 5 years no headway has been made, think that's urgent issue that needs be addressed if we in anyway have a constituency that is going to be well-informed, we tried using mainstream structures within the university but even that has become problematic, e.g. joint academic planning committee, committees representative of all three faculties where all heads of Depts, including CPP, they actually sit once a month at that meeting, that's an ideal structure to facilitate communication, however we must note that last year, those heads of Depts attending those meetings where they get direct feedback from P'ship co-ordinator, they themselves are not communicating to their own faculties so even the mainstream structures are not facilitating P'ship work
>
> CS: CM get bullied by the director
>
> CM: I go to meetings in other areas or communities I get to listen but we don't know anything, why is this or why is that we don't get any feedback from the board members, we don't elect the board members at the P'ship office, community partners they elect their own members, it is up to board member to report back and forth, this is a feeling of our constituency & this is the feeling of the board, that is not happening, there is lack of communication
>
> CM: board is governance body, & management who runs day to day functions, whatever has been decided at board level is suppose to be implemented at management level, that seldom happens, I think that it is reason why in beginning stages the P'ship was not so effective & efficient, board is governance mechanism & the management are supposed to implement whatever is slowly coming through, the CS, they don't perform & conform to the requirements level, due to inexperience
>
> **Qte [6.16]**

Further themes about the Board included issues of attitude of the director, consultation regarding the filling of posts and the erection of buildings, power tactics and self interest:

> CM: You are not free because you do not know exactly you [B. member] field or sphere where you should interfere or not, you want to investigate something, you are told not to investigate because it is not your sphere, if we want to know about sudden (CS) appointment, they [P'ship management] say: 'I think that is management problem, not a board problem", we were stopped about queering employment of some junior positions, to be shaped by the person I am to govern, am no more a real governor, am rubber stamping, Wherever we meet, he is always there, you cannot go on living with a person like that, I should highlight this to B. members that we do not feel good & we are not free when we participate, it is embarrassing, maybe then I put a view which will show that I am a governor, 1 must say: why this & why not that, then somebody says: this is not your field, it cuts you short, you feel embarrassed, I must be open enough, we should have means & ways of being transparent, because if I am told, it mean that I am getting crushing, then I will be unfair because I have been told up to this limit and not that, I am afraid (to ask) because when you ask something it might be, I do not feel free when I am at a meeting
>
> HS: when appointing a director, that was their own agenda & top management had already decided who to appoint, community is completely against that, they impose decisions upon community, also in appointment of CS the director decides who to appoint, even if they conduct an interview, it is just for camouflage, they know who to appoint;
>
> HS: also worrying about leadership is the buildings that have been erected, the P'ship's site, it seems that leadership decided alone, without proper consultation of the structures, according to me, building is very small, not the size we expected, taking in account money donated for that structure
>
> HS: director also seems to use certain types of groups, in order to achieve their objectives, they are using influential groups if they want to achieve something or to bargain their needs (e.g. their political party's women's league), it will appear that top management are there in order to enrich themselves out of those influential groups
>
> CS: beware of community board members
>
> **Qte [6.17]**

4.2.3.7. Cluster VII: Institutionalisation; Sustainability, Dependency & Donors

The interview findings revealed the need for early attention to, the unconducive factors that counteracted and the strategies that were helpful in establishing sustainability. These appeared to be related to issues of dependency and other donor related factors.

Sustainability

To start with, the term '*sustainability*' needed be defined and agreed upon:

> CS: while we knew from the onset that the partnership was going to be funded for a period of 5 years we never really thought about sustainability and for me sustainability is not only economic or financial sustain but also political sustainability and social sustainability, I think that what the P'ship has not done is even to agree on what sustainability means, I think that for me in the next year, I would like the P'ship to address that issue, to arrive at a definition of what they understand by sustainability & then to develop activities that's going to lead.
>
> CS: for me sustainability is whether you have a job or when [P'ship] ends but sustainability for me is also if we have publicised, if we have included the partners from the onset in the development of this project, if they had been part of articulating kinds of education transformation that they wish to have then surely those activities could have been sustain.

Qte [7.1]

Early attention to a *shared vision* from the initiation coupled by investing resources in the CPs:

> AI: partners do not share vision, being a partner is because you have put resources in the P'ship.
>
> HS: unlikely, questionable, difficult, no volunteers, community involvement somewhat spoiled, need to sort out committed people now; other funding source needed, P'ship will be unable to sustain without external funding which is inevitable.

Qte [7.2]

As regards the sustainability of the CPs' *programmes*:

> AI: projects need be financially self-maintaining, aimed at entrepreneurship/ small business; money generated fast & ploughed back to make projects sustainable, running it like a business decreases dependency on outside sponsors, will not be pressed for forcing people into structures they are not ready for; benefits need be at collective community level not only to those involved.
>
> HS: do not see any sustainability, as soon as they move out it will just collapse to what it has been.

Qte [7.3]

Sustainability of the *Core Staff*:

> AI: concentrate on manpower component instead of paying large salaries, train and utilise volunteers, get participation from the university, students, more departments, involve other role players, secondments.
>
> CS: I think that most fundamental mistake that we've made in terms of the P'ship is to go and hire CS who actually are now doing the work of the partners and that is why the partners can now sit back and say that they [CS] get paid so now they must do the work. There is no need for me [partners] to be involved .

CM: if you look at P'ship you see that most people working there are not coming from [beneficiary location], you will find that only one person is there, in terms of capacity building for the community which is hosting the P'ship, there is a lack there.

CS: CS does not get no extra benefits, great uncertainty about the future, no promises have been made by the partners to absorb them

Qte [7.4]

Unconducive factors of sustainability included the recruitment of large numbers of CS which could lead to dependency of the partners and the CM on them, lack of commitment, capitalising on already existing structures, an unskilled CM workforce, not planning early for sustainability, and a 'legacy of dependency' due to lack of guidance from local CPs models:

AI: CS is inducing lethargy to partners, funding coming to an end & inexperience of CM who have not been empowered might force P'ship to collapse.

CS: in a way academics have also come to realise that having CS is more convenient because in a lot of ways CS takes the responsibility of what should have been the academics responsibility.

CM: going to have a problem with the people who do not have necessary skills to sustain P'ship, certain members who are not CM are those empowered when these trips are undertaken.

CS: fieldworker arranges a training programme for people in the income generating project, which is a good thing.. he then collects them in the morning, takes them to the training programme, buys them lunch, collects them in the afternoon & takes them back home, what I would say is that you are giving the training programme for free, what is the contribution of the trainee, contribution is that you must show commitment by being there, that is getting there on your own as the training was in [same location], & if they do not have money for a taxi we must look for an alternative way of raising that money, be it even if we need to write a proposal to get money from someone, people must understand that money does not just fall out of the sky and that we have all the money and we can just give it to them whenever we feel like it.

CS: and also the commitment of the partners.. it was lacking a lot.. people were not really committed to the project.. I mean the core staff was driving the project.. not the three partners.. that was also destructive.

HS: something sustainable must be on what is already existing, CM need understand that this is something that they must sustain, need more depth, more planning, after 3.5 years very little difference or change.

CS: I wonder how these structures will be sustainable after Kellogg, because if we are left with two years, this year is to set management structures, we are not working towards their sustainability because you can never do it in this year because you cannot plan this year for this year, you are supposed to have planned last year, how do I take you through sustainability? for 1997

CM: we have inherited Kellogg model slavishly, very little of our ownselves reflected in this structure, we were making very little use of resources out there in community, we go give hand outs, we are expecting them to accept word for word what we are giving them, we are not inviting back some fresh new inputs from them, we are creating and perpetuating the legacy of dependency, they are going to depend on us, I think it is time we said, do not depend on us, depend on yourselves, what we have to offer are skills, teach people skills like public speaking, leadership in true essence of the word, not just with symbols, we are stale jacketed, very much concerned with what Kellogg will say & will do for us.

Qte [7.5]

On the other hand, the conducive *strategies* that could have contributed to sustainability included skills training of the CM, secondments of posts from the government, absorption of CS by the corresponding partners, seeking alternative donors, sustainability in the finances and accountancy administration,

networking and the settling down of the innovation (P'ship) in the host institutions or strategic placement of itself in the national health departments and policy frameworks:

> CM: if there be people who are getting administration skills through P'ship, if Kellogg leave, these people [who were trained] could be of use in the community for sustainability of P'ship.
>
> CM: secondments of posts to the P'ships; continuity chances seem to be minimal; anticipate to see [P'ship] going on, so far government is busy seconding posts, people should come, work & conduct programmes while they are government paid, it is busy happening wherever we see need for a person in certain programme, but this person is [has got to be] within the government, it is not long until new government has said we have got secondment of posts already
>
> CM: CS absorption by various partners; we will try our best that all people within P'ship are absorbed by corresponding governments [governmental departments]
>
> CM: seeking funds from other donors; to request other funders, actually to conduct fund raising, I mean not to relax & depend on Kellogg alone; we have been saying this, fund raising beyond Kellogg help, it has been tough to, but it is a concern that has been raised, it is there but at the moment it has not kicked off,
>
> CM: finances also administered by & through the university partner channels, but partners also decided that, this puts a good financial control system in place which is important for later sustainability.
>
> CS: do believe that not all the activities are sustainable but I believe there's a lot can be done that doesn't have money, when I talk about sustainability I have to believe that there's a SA network who has co-ordinator & also made up of, they have management committee made up of directors & chairpersons of board of trustees, don't think in essence that committee has really taken it's job seriously of networking & advocating, it's left up to the individual communities to link with the RDP or with Dept of health & services & I don't really see that we ourselves have the capacity to organise, we need leadership & that leadership needs to come from board of governors.
>
> **Qte [7.6]**

Dependency

If it is reasonable to assume that sustainability after the donor support ends could be inversely proportional to the extent of dependency created during the 'seed funding' stage of the demonstration and implementation of innovation, then as regards *dependency*: generally, dependency appeared to be related to incomplete development of the people or environment, recruitment of CS, the policy on student bursaries, the issue of income generation projects, and the dependency of CS on the CPs director

> CM: the fear of this is that one day we will be leaving people hanging somewhere, we develop people & then at a point in time we just leave them.
>
> AI: P'ship's CS sort of do the work for the community rather than having the community work for itself, CS role needs be clear.
>
> CM: [relating to bursaries] a dependency syndrome is being created, like politicians before election, we promised them heaven but forget that we depended & still depend on funding, we do not have constant flow of funds, a lot is promised, people think father Christmas is there, planting a rural student suddenly in the centre of a glittering town with full bursary has negative effects, not only lots of students are failing in their examinations, but now they are even demanding better conditions & burning the mattresses.
>
> CM: [income generation projects] e.g. sewing project, the P'ship's facilitator came to us, asked quotations for material, we gave her (facilitator) quotations, is over a year now, they do not say a thing about that, I asked her,

seems as if I am starting now some quarrels within the project, we were already having our own project [sewing], but P'ship sees that we should have the project as the community, they promised to give us hand on what we are doing, we have long been waiting for them that they are going to assist us.

Qte [7.7]

Policy of the donor agency

Both sustainability and dependency needed to be viewed in the wider context that effects them. It was thus important to relate them to the *policy of the donor* agency, including the donor cycles, funding strategies, pressure by the donors, appreciation that there were no robust models or blue prints for the SA CPs and the amounts of funds donated:

AI: donor cycles too short for long process of HPE & community development; the need to satisfy sponsors & show progress as opposed to pace of the community, result is we do things for the community but people do not develop.

AI: new funding approved to three different projects linked to one main university is hoped to have a collective effect in bringing the three projects together to impact on main university.

AI: need be pressured by funders, state or government, like the previously Afrikaner universities were pushed to be involved in the community; peripheral units not funded from the university are those who wrote the proposals.

CS: need to acknowledge that there is no blue print for P'ships, much of the work is 'spade' work, the concept is very new and needs more time for something tangible to be produced.

CS: the core office have the capacity to control the money, the second thing, the issue of corruption, when it comes to money & there is lots of money, this P'ship is actually extremely well funded, in fact it is far too well funded as far as I am concerned, it is over funded, we do not have the capacity to spend the money, so opportunity to misuse money is great.

Qte [7.8]

Table (49). Interviews: Emerging themes with Examples - Whole Sample

Theme	Examples
Clarity	**Generally, clarity of roles, procedures and responsibilities need attention**
Roles	**HS**: the group that is least clear about their roles **AI**: some feel a lack of clarity and view their role as restricted to the deployment of students in the community **CM**: people participating in community meetings & programs are actually not clear where program is going to, only few people have knowledge of what is happening; lack of knowledge **CS**: not exactly clear about who they are attempting to service in their P'ships. Their primary focus seems to shift; co-ordinators of the various P'ships' programmes appear to be in the middle of many subgroups; would appreciate more clarity on their roles and a sense of belonging, lines of accountability seem not very distinct
Visibility	**Visibility needs attention**
Strategies	Strategies for increasing the visibility of and clarity about the P'ship include: more advertising, marketing, popularisation and communication, literacy, and advertising through various promotional media channels, otherwise nepotism could develop
Transparency: Lacking	**Clarity requires transparency to what each is doing & access to each others agendas; mixture of various levels of satisfaction**
Causes	The 'personality' and vested interests of the partners, the unwillingness to share, fear, suspicion, illiteracy, blocking by the P'ship's director or simply the lack of constitution and policy, of time, information or interest
Consequences	'Gossip networks', jealousy and the formation of sub-alliances within the individual P'ship
Areas	Filling of P'ships' vacant posts; salary levels of the CS; financial & budgetary issues; HRD in terms of educational trips nationally or internationally
Related factors	Levels of transparency seem to be related to the participant's administrative tier in the P'ships, whether it is board members, P'ships' programmes and the university-linked peripheral units involved in the P'ship Transparency needs to be a multi-directional process between all the stakeholders involved in the P'ship

Table (49). *contin'd* **Interviews: Emerging themes with Examples - Whole Sample**

Theme	Examples
Representation: Lacking	**Generally, there is under-representation of the youth**
	CM: more community representatives from the lower social strata, CBOs, religious and other civic structures are needed:
	HS: more HS representation especially from the central health department is advocated for:
	AI: more representation of various AI departments is reported to be needed
Reasons behind under-representation	Tribal, geographical, political or educational considerations or combinations thereof
Related factors	A fair amount of expertise and authority to make decision of the representatives is advocated for; the balance between the skills, representativeness and the administrative level of the representative seems difficult but desirable; composition & legitimacy of the leadership
Communication: Lacking	**Generally, time needs to be made for communication, as it contributes to visibility and seems to need improvement**
Timing of communication	Communication needs to be unconditioned to particular problems; be before the event and not after it i.e. more proactive rather than reactive; e.g. CM were not timely informed or consulted about appointments of CS or CHWs, salary changes or educational trips and tours abroad
Inadequate communication	Information being deficient; filtered; twisted or inconsistently flowing leading to "gossip" networks; or a bias could result from geographic; person; language or educational considerations. Related issues are that communication of the stakeholders with the beneficiary location and communities needs to happen early and that information is power:
Adequate communication	Communication needs be meaningful, relevant, information sharing and be as a part of an attitude:
Related factors	Communication seems to improve with presence of a HS co-ordinator; communication needs be dynamic, as the P'ship moves from initiation to implementation; phases and levels of communication, direct and multi-directional communication includes 'in house' communication or communication between the pairs of stakeholders; vertical and horizontal communication processes; organisational structure and its effect on communication; meetings as a means of communication; follow up and feedback

Table (49). *contin'd* **Interviews: Emerging themes with Examples - Whole Sample**

Theme	Examples
Ownership & Commitment	**Sense of ownership could use strengthening as regards the CM**
	Ownership needs to be spread out and be a collective ownership rather than individual one, a stronger but limiting sense of ownership was felt about the "old" members of the P'ships who also had and unequal distribution as regards the P'ships' resources
	Generally, more commitment of the AI and HS could be a promising strategy
Involvement: Lacking	**HS**: lack of time, need clearance from administrative authority and hierarchical considerations, times of meetings, transport problems & lack of support
Causes	**AI**: un-readiness to take part; lack of publicity; advertising & information; resistance to change; not taking risks; do not want to show their ignorance; overloaded faculty; position of the P'ship which sits out on the periphery; lack of advocating & lobbying of academics; lack of joint planning within the AI; and lack of transparency and clarity; those who are involved have benefited
	CM: unstable attendance; many political affiliations; personalisation or politicisation of P'ship, excluding many from participating; participation quality is low, community rubberstampers on decisions already made by others; community still dis-empowered; lack of continuity; representation issues
Power Issues / Consultation	**Generally, suspicion between the partners could be a hampering factor to the advancement of the P'ship; power struggles in the form of hidden agendas, win-loose situations, caucus meetings, mistrusts and conspiracy could be signs of an underlying feeling of suspicion**
Reasons for suspicion	This seemed to be ascribed to a variety of factors. These embrace issues related to the different paces of the stakeholders, the individual partner's 'personality', competition for resources, inadequate interpersonal relationships or simply the history of the place and the accompanying political ideologies
Existent power relations	Seemed to be a function of the size & structure of the P'ship, centralisation of authority, politics and political agendas, information power, and personality
Power-retaining strategies	Included a 'divide & rule' system, bribery in the form of opportunities, struggle fights and faction groups, the underlying 'know how' of the AI, and the retention of information
AI are in control	Their apparent control seem to be due to their superior knowledge and education, P'ships' constitutions that give them power to the P'ships' financial administration, and sometimes the physical site of the P'ship being on the university campus
Self interest	The core staff, the community, and community board members

Table (49). *contin'd* **Interviews: Emerging themes with Examples - Whole Sample**

Theme	Examples
Decision making	**Generally, consultation in decision making and co-operation seem to be lacking with unilateral decision making taking place**
Causes of lack of consultation	Domination of the decision making process can sometimes happen by the P'ship's director or the AI May include the P'ship's culture, a perception that CM have a lack of knowledge, or simple organisational dysfunction leading to lack of teamwork
Consequences of lack of consultation	missed opportunities and duplication of structures
Examples of the lack of consultation	numerous and in various domains; CS appointments at the P'ships, salary increments of CS, selection of students for bursaries or CHWs for training or CM for educational trips abroad, and programme funding
Human Resource Development	**Generally, training and development seem to be a main thrust of the P'ships mission**
Type & area of training	**AI**: need to learn more about the educational process of community based education and problem based learning; could benefit from more training on community-related issues **CM**: need training that would increase the level of their understanding and skills in the field of P'ships, income generation, meeting procedures, making statements, addressing meetings; also illiteracy training CS: their levels of skills could benefit from upgrading on the appropriate balance of short term fulfilment of basic needs vs. long term empowerment and development of communities, co-ordination
Appropriateness of training	As the type and area of training required by the stakeholders is different, accordingly the appropriateness of workshops, seminars and conferences in relation to their costs or the appropriateness of their content in relation to the trainees' needs and its relevancy to the south African context may need attention
Dissemination of training	Dissemination upon return including feedback, follow up and transfer of skills after the training seems to be a further issue of concern to all the stakeholders
Selection of trainees	Needed to be fair and balanced between the partner groups. It need have criteria or policy, not depend entirely on the educational level, and people need be informed timeously

Table (49). *contin'd* **Interviews: Emerging themes with Examples - Whole Sample**

Theme	Examples
Leadership Skills	
Visibility of the leadership	In general, more visibility of the leadership seems to be advocated for
	Management procedures need clarity, consultation (one P'ships director insisted on calling himself management), support, devolution of financial and other responsibilities
Attitudes	The characteristics, styles and attitudes of the central figure, the director; the consultative skills of the leadership; some particulars of the style and attitude of the P'ship convenor or director that suggest that the above picture could have some exceptions
Examples	Examples in other domains include communication, self development, occasional racist concerns and the abuse of funds, power or other benefits
Consequences	The consequences of the lack of appropriate leadership skills are fear; feeling not free; lack of Involvement or even challenge
The Board of Trustees	Qualitative findings on the board of trustees relate to the size, composition, meetings and interaction, and communication and implementation; Further themes about the Board included issues of attitude of the director, consultation regarding the filling of posts and the erection of buildings, power tactics and self interest
Sustainability	**To start with, the term 'sustainability' needs be defined and agreed upon**
Shared vision	Early attention to a shared vision from the initiation coupled by investing resources in the P'ship:
P'ships' programmes	Needed to become financially self-maintaining, aimed at entrepreneurship
Core Staff	Train/utilise volunteers; participation from the university, students; more departments; involve other role players, secondments
Unconducive factors	Included the recruitment of large numbers of CS which could lead to dependency of the partners and the CM on them, lack of commitment, capitalising on already existing structures, an unskilled CM workforce, not planning early for sustainability, and a 'legacy of dependency' due to lack of guidance from local P'ship models:
Conducive strategies	Included skills training of the CM, secondments of posts from the government, absorption of CS by the corresponding partners, seeking alternative donors, sustainability in the finances and accountancy administration, networking and the settling down of the innovation (P'ship) in the host institutions or strategic placement of itself in the national health departments and policy frameworks

V . Chapter Five

Discussion

In Chapter one, a wide and general background literature review was undertaken. Chapter two focused on the analyses of the partnership/ coalition concept in detail highlighting the domains that needed attention in the process of joint working and alliance building. Chapter three described the methods that were used in the study, while Chapter four depicted the quantitative and qualitative findings of the investigation.

Taken together the first four chapters addressed the study objectives that this research set out to investigate: to determine how coalitions operate and to identify the factors which contribute to coalition competency; to describe the level and type of coalition activities and assess outcomes over the previous years; to compare the stakeholders views' as regards the structural characteristics and operational parameters of the CPs; and, to identify the correlates of accomplishment and impact for each stakeholder group.

Chapter five moves on to discuss the study's findings in the context of the literature that was reviewed in chapters one and two, drawing upon both the similarities and contrasts with other relevant research and similar investigations. First, an in-depth analysis and discussion of both the quantitative and qualitative findings weaved together under common themes to furnish complementing pieces of evidence in the greater partnership puzzle. The general themes of the discussion overlap with and add to the themes emerging from the qualitative interviews. These included: clarity; communication; member skills and training; representation; involvement and contributions; member relationships, quantity and quality of participation; institutionalization and sustainability; and, organisational and personnel barriers to participation. Second, a discussion of the methodology and reliability issues as well as some of the study limitations and efforts for dissemination is undertaken.

5.1. The Purpose

In general, this research builds on two published studies: Rogers *et al.* (1993) who compared staff and members of tobacco coalitions in the USA and Gottlieb *et al.* (1993) who investigated the correlates of effectiveness of coalitions for smoking cessation also in the USA. The implication is that while engaging in the discussion, special reference is being made to these two groups of authors who were also from different institutions. This is due to the overlap of the investigated parameters in the three studies. This research however, goes beyond both studies as regards the following: the number of variables under study, the number of facets of CPs functioning under investigation, the number of intermediary measures utilized to reach accomplishment and impact, the number of comparison stakeholder groups in the analyses, and double the sample size of Rogers and colleagues and about ten times that of Gottlieb and

coworkers. This study also documents the use of questionnaires developed and validated in the USA in the context of a developing country setting, where the questionnaires were completed and internal consistency as well as the test-retest reliability were reported. To push the frontier still further afield, this study employed two extra methods as tools that were not reported in the previous studies. First, more emphasis on the issue of reliability of the survey through the re-admission of a short version of the questionnaire. Furthermore, the reliability indices reported were beyond those reported by Rogers *et al.* who only reported internal consistency indices and Gottlieb and colleagues who did not report any reliability indices. Second, the simultaneous collection of ample context-rich qualitative data from the interviews to gain further insights into the unique situations of these SA CPs, that would contribute to the better understanding of the findings from the survey. To the best of the researcher's knowledge, both the previous studies relied solely on quantitative methods.

It need be noted that the questionnaire employed in this investigation was developed from the two studies quoted above. To these, further items were added from other questionnaires used by the donor agency to evaluate their CPs in the USA. The understanding was that none of these questionnaires has been used outside the USA before. Given that the CPs concept itself is a relatively new concept, albeit in Africa, this study is the first large-scale work on CPs in the African continent that utilised mixed methodology in the investigation of the organisational intricacies of CPs. This obviously has implications on reliability issues. Therefore, while interpreting the study findings, the reader is invited to reflect upon the internal reliability and test-retest reliability indices of the various sections of the questionnaire [Tables (1 - 3) and Figures (1 - 6)]. Accordingly, the reader is cautioned that when a certain section had exhibited low reliability, care and discretion should be exercised when generalizing that section's results.

In the discussion, to help the reader navigate, the salient quantitative findings whether descriptive, comparative or predictive were reviewed and matched or contrasted with the literature in the field. Tables and Figures are often referred to help give a visual input to the existing relations between the stakeholders. To add more landscape to the survey findings, qualitative findings were used in their appropriate slots and were referred to by the Quote number indicating their places in the section on qualitative findings (section 4.2). The Quote number consists of three digits arranged in a cluster-section-quote configuration: the first digit represents the cluster number in the section on qualitative findings; the second digit represents the section number (quote block); and, the third is the specific number given to each individual quote in that particular section (e.g. Qte 1.3.2.).

The themes that are discussed relate to the diverse facets of collaborative working arrangements that were reviewed in chapters one and two. They embrace: clarity; communication; member skills & training representation; costs and benefits, satisfaction; involvement and contributions; member relationships; quantity and quality of participation; empowerment; institutionalization and sustainability; dependency; and, barriers to participation. For each of these general and overarching themes there existed further ramifications.

In weaving the discussion, focus is also given to the quantitative component of the investigation. Given the number of variables operationalised in this study in order to capture the essence of partnership working, to get a feel and gain insight into the more important variables as per their contributions to explaining the accomplishment and impact, a ranking system was established for the different questionnaire sections that significantly contributed to explaining the intermediary measures. This was accomplished by computing the number of times that each section contributed to significantly explaining any of the intermediary measures for any of the stakeholder groups, regardless of the significance level or relative contribution of the factor [Annex (15)]. The six factors which ranked highest were related to expertise of the professional staff (8 times) followed by the community members expertise and sense of ownership (6 times each) and finally community representation, interaction, and organisational barriers (5 times each). Accordingly, in discussing the study's findings, due attention is given to those critical variables.

5.2. Clarity: Clarity of Concepts, Formalisation & Role Clarity

Clarity of Concepts

Bracht (1990) recommended that there must be an accurate understanding of a community's needs, resources, social structure, and values, and early citizen involvement, in order to build collaborative partnerships and facilitate broad community participation. This study's findings provided additional empirical confirmation to Bracht (1990). Some of the issues raised in the interviews related to the early 'vision' stage of the CPs' initiation. Shared vision from the initiation seemed to contribute to long term sustainability later down the road. The sub-themes that emerged related to the need for understanding and an agreed upon interpretation of the CP concept as well as for a balance between the short term and long term objectives. They also related to the broader definition of health within the context of development and the operationalisation or practicalisation of the concept [Qte (1.1)]. Along a similar vein, Zakus and Lysack (1998) termed this stage 'preparing the ground'. The empowerment of the communities is a

learning process that required clarity [Qte (1.2)], development is a lengthy process and HPE is not a community priority. Peoples' needs were to guide the CPs programmes [Qte (1.3)]. Goals and expectations with respect to participation must be mutually identified and accepted by all involved, because organizational structures, in themselves, cannot ensure community participation (Foster, 1987; Robinson and Larsen, 1990; Lysack, 1996).

Clarity was also needed with respect to the approach the CPs were taking. There is literature to suggest that targeting project objectives as specifically as possible would lead to greater community cohesion around an issue, which, in turn, increased the likelihood of success (Levitt, 1986). This study reported a different view: that the substance of the CP warranted both early attention and thought. Alliances addressing narrowly and solely health issues are likely to face only short-term success, as for the hard-pressed communities, health on its own is frequently not their top priority. Therefore, CPs and alliances may sometimes be required to embrace a more encompassing approach to health: the community development approach, where a wide range of community concerns are addressed and met. From the participant observations, however, this approach, seemed to have two drawbacks: it rendered the energies of the partner groups more dispersed and consequently, their accomplishments less visible. Community development is a protracted process whereby communities are empowered to be able to take responsibility for their own health. Many of the 'potential' stakeholders might not see CPs as defined in the initiative as a priority. People or departments may therefore not be too anxious to spend their precious time and resources in partnership development (Anon., circa 1995).

Indeed, the five CPs that were examined had adopted community development approaches, and were engineered on broad-based community consultations. This resulted in a colorful spectrum of development activities [Annex (4)]: health sciences students training programme and bridging programmes in science and mathematics coupled with bursary assistance for students; community development programmes such as community gardens, water and water accessing projects, carpentry, brick making and sanitation projects. From formal & non-formal education programmes as well as vocational training programmes to youth activities, leadership courses, youth health desks, youth skills training, development and entrepreneurial skills. The message was clear: addressing a wide range of perceived needs.

The survey findings [Tables (43 - 47)] indicated that role clarity contributed statistically significant explanatory power to the intermediary measure of commitment. This was true for both the professional staff and for the whole sample. Related to role clarity was the issue of formalised rules and procedures. It

similarly contributed significant explanatory power to the intermediary measures of outcome efficacy and educational activities for some of the stakeholders under study. This is in accordance with Rogers *et al.* (1993) who also reported formalised rules and procedures to be significant predictor of both commitment and satisfaction for staff and members respectively. Conceptually, role clarity links to the clarity of understanding of the CP concept communication, involvement and formalised rules and procedures.

Formalisation

Regarding formalisation, observation at meetings and examination of the SA CPs documents indicated that the CPs were at various stages in the formalisation process. However, the CPs' leadership had understanding for both the necessity and the broadness of the issue of formalisation. The range of formalisation activities in this group of SA CPs spanned through different stages: from formalising agreements between the stakeholders to drafting and later signing a constitution (one CP had its constitution signed during the study, about 3.5 years down the road in a five year funding cycle). All the CPs had official Board of trustees, steering committees and a variety of other implementation committees/task forces. This seemed appropriate given that the higher the degree of formalisation the greater the investment of resources and exchanges among agencies (Marrett, 1971), the greater satisfaction with the effort itself (Schermerhorn, 1981), and the more responsible and committed agencies become (Andrews, 1990). The study findings also supported Andrews' (1990) views, as formalized rules and procedures were amongst the factors that contributed in explaining commitment and outcome efficacy of the CPs [Table (47)]. Further, this study indicated that the CS knew significantly more about these rules and procedures as opposed to the three "true" stakeholder partners [Figure (33)].

Formalisation often results in the routinisation or persistent implementation of the CPs operations. The more routinised operations became, the more likely they would be sustained (Goodman and Steckler, 1989). Chavis *et al.* (1987) found that block organizations that survived for 15 months and longer were more structured and task oriented than those that died out. Surviving block organizations had more officers and committees, were more likely to have written by-laws and were more likely to use written agendas and minutes to conduct regular and orderly meetings than inactive organizations

The most important element in coalition formation appeared to be in the articulation of a clear mission or guiding purpose for the coalition, what Gray (1985) termed 'direction setting'. Gottlieb *et al.* (1993) measured the formality of coalition structure using criteria such as whether there was a written

agreement, written mission statement, written objectives or yearly goals. In this study, the observation was that all the CPs had some provisional written policy documents outlining their vision, policy and some implementation issues. This was in agreement with Andrews (1990) who reported that written memoranda of understanding, by-laws, policy and procedures manuals were all signs of formalisation. Feighery and Rogers (1990) similarly reported clearly defined roles, mission statements, goals and objectives as examples of formalisation.

However, formalisation of objectives, mission statements and operating policies needed to be regularly reviewed for adjustments, particularly in such young CPs with no local models to draw upon. The study's quantitative data supported that this review process might need strengthening: more respondents seem to know about the mission statements and other written objectives but less of them reported the review of objectives periodically [Figure (33)]. Lindsay and Edwards (1988) reported that coalitions would find it helpful to review their mission statement frequently in coalition meetings. Similarly, Gottlieb *et al.* (1993) also suggested that the presence of written agreements and stronger staff orientation within their home organisation might aid the incorporation of new members into the coalition as there would be clear direction regarding agencies roles and responsibilities.

Role clarity

To formalize a relationship between diverse stakeholders demanded that they be clear about both the issues involved in the relationship and their relative roles in it. The degree of member input into coalition decisions might range from advice to control (Wandersman, 1981). Rogers *et al.* (1993) in a study in the USA reported lack of clarity among members and staff on coalition roles. This study, employing a sample size double that of which Rogers and colleagues based their analysis upon, reported a relatively good level of perceived clarity of roles. A range of about 70 to 95% of respondents from the stakeholders reported that they knew what their roles in their CPs were. However, Table (27) suggested that in this group of CPs, the overall level of clarity on roles in the CP was generally higher for the CS than the other partners. Table (27) and Figure (47) also indicated that there were discrepancies between the relative roles of the stakeholders whether it be in setting the CPs' budgets or selecting contractors or designing CP programmes. These findings were in agreement with Rogers *et al.* (1993) who also reported significant discrepancies between members and staff regarding the consensus on coalition role in budget setting and developing a comprehensive plan.

However, as Figures (48 - 51) indicated, this study further suggested that as regards to clarity of roles, the discrepancy also extended to the CPs' functional areas of designing goals and objectives and selecting local sub-contractors for the CPs' activities, a point that Rogers *et al.* (1993) reported as "striking, but non significant differences" between staff and members. It could have been that the discrepancy between staff and members views in their sample was about to reach significance and this study's sample size helped pick it up. Regardless of the cause, these discrepancies between the stakeholders in the clarity of roles seemed not to be in line with what Feighery and Rogers (1990) suggested: that staff roles should be clarified as soon as a partnership is formed. What was evident, however, in the SA CPs was that the CS had most roles in the four major aspects of CP functioning under investigation: budget setting, programme design, selection of subcontractors for the CP activities and developing comprehensive plans [Figures (48 - 51)]. This could have a later implication on the sustainability of the CPs. The spin off possibility of the issue of perpetuation of dependency by presence of abundant CS in the CPs shall be brought to attention in the discussion to follow (section 5.10.).

Although not all coalitions have the resources to employ staff, staff can reduce the burdens placed on a coalition membership. Butterfoss *et al.* (1993) suggested that when a coalition employed staff, it was likely to be more harmonious if staff and members were clear about their respective roles. Clarity needed also be on the operational understanding of how the CPs operated. This study's data [Figures (33) & (47)] suggested that the CS had more operational understanding as regards their roles and their knowledge of the CPs staff, committees and activities.

In parallel, the interview findings suggested that generally, clarity of roles, procedures and responsibilities could benefit from more attention [Qte 1.4]. The need for clarity appeared to effect all the stakeholders albeit to various extents. For instance, the CS were not totally clear about who they are attempting to service in their CPs [Qte 1.5]. Their primary focus seemed to shift more to servicing the community in view that it was the "disadvantaged partner", although a balance needed to be struck between the concentration on the various stakeholders as opposed to a specific partner. These findings add empirical leverage to what has been observed by Butterfoss *et al.* (1993) who supported Gwaltney (1992) in asking the question which remained to be addressed: when a coalition has a staff, who do they work for? Conflicts about lead agency role might put staff in the position of not knowing whether to take direction from the coalition or from the grantee/ lead agency who paid their salary and benefits. This obviously would have repercussions and implications on lines of accountability, another issue that needed to be clarified early if later grievances were to be avoided.

A further subdivision of the CS, namely the coordinators of the various CPs' programmes appeared to be in the middle of many subgroups. Their perceptions were that they would appreciate more clarity on their roles and a sense of belonging, as lines of accountability seemed not very apparent [Qte 1.6]. Lindsay and Edwards (1988) have advised on the issue of sustainability, pointing out that since participation in CPs was usually voluntary, lines of accountability could be loose as a result.

The lack of clarity was sometimes in relation to a specific aspect of the CPs. For instance, as regards the CM group, there seemed to be space for clarity as to the direction where CPs programmes were going, or if the CPs were "a research programme of the university" [Qte 1.7]. In relation to the AI, the impression was that some of them felt a lack of clarity and viewed their roles as restricted to the deployment of students in the community [Qte 1.8]. As for the HS, the finding that they were the group that was least clear about their roles seemed to be reinforced [Qte 1.9]. The CPs' Boards too could benefit from more clarity [Qte 1.11]. Miscellaneous examples indicated the lack of clarity on the policies relating to decision making, conferences and budget issues [Qte 1.12]. This clarity of purpose (Lindsay and Edwards, 1988) and of roles (Lazarus *et al.*, 1998; Gelmon *et al.*, 1998) is an essential foundation for successful coalitions.

In order that missed opportunities be minimized, the suggestions for possible roles of the HS included their involvement in the tutoring process of the HP students at seminars and workshops, in the actual running of the CPs and getting more involved in the community, in the clinic upgrading, in the training of health workers or lay people, or in the supervision of the health-related aspects of the programmes the CPs are running e.g. after care groups, crèches, day centers for the young or STD awareness clinics for the youth etc. [Qte 1.10]. This was in line with Gelmon *et al.* (1998) who reported the stakeholders of community-campus partnerships saw themselves in teaching roles, and were most satisfied when the institutions acknowledged and rewarded that role. Partners felt a responsibility for preparing future professionals who understood community problems and were prepared to use their skills to help unmet needs. In the context of the SA CPs, Lazarus *et al.* (1998) similarly pointed out that communities had the additional benefits in becoming active teachers of their future health care providers, while Langley *et al.*, (1998) pointed out that to ensure maintenance of productive partnerships, appropriate rewards and incentives have to be identified for those who actively participate in the programmes such as documentation to support promotion and salary increases.

Formality need not be narrowly viewed, and is not limited only to formalisation of rules and procedures. It also included formalisation of links, connections and agreements. Lindsay and Edwards (1988) recommended the importance of increasing the visibility and public recognition of the coalition's agencies. This study's qualitative findings suggested that the issue of visibility of the CPs contributed to clarity. As regards clarity through formality and visibility, the impression was that the formality of links or agreements between the stakeholders could benefit from improvement [Qte 1.13]. The qualitative data further supported that visibility needed attention and suggested various strategies for increasing the visibility of and clarity about the CPs. These strategies included more advertising, marketing, popularisation and communication, literacy, and advertising through various promotional media channels, otherwise nepotism could develop [Qte 1.14]. A message of 'spreading the news' of the CPs activities was being advocated for: if one has a dog, why not let it bark.

Clarity also demanded transparency. This study's qualitative findings lend themselves to the fact that clarity between the partners required transparency as to what each was doing and access to each others agendas. Generally, in the SA CPs that were investigated, transparency was a complex domain and a mixture of various levels of satisfaction seemed to exist [Qte 1.15]. The causes that contributed to the lack of transparency included the 'personality' and vested interests of the partners, the unwillingness to share, fear, suspicion, illiteracy, blocking by the CP's director or simply the lack of constitution and policy, of time, information or interest [Qte 1.16]. The consequences of the lack of transparency that emerged were 'gossip networks', jealousy and the formation of sub-alliances within the individual CP [Qte 1.17]. The areas of lack of transparency encompassed the filling of the CPs' vacant posts and salary levels of the CS. Special emphasis was placed on the financial and budgetary issues and human resource development in terms of educational trips nationally or internationally [Qte 1.18]. Levels of transparency seem to be related to the participant's administrative tier in the CPs, whether it was board members, CPs' programmes or the university-linked peripheral units involved in the CPs [Qte 1.19]. The final message was clear: transparency needed to be a multi-directional process between all the stakeholders involved in the CPs [Qte 1.20]. Open and transparent relations between the partners as well as action to confront mutual suspicions have been advocated as conditions for effective partnerships (Davies, 1998), while the lack of trust has hindered global partnerships between the public sector, international organisations, and government agencies (Malaspina, 1998).

Mizrahi and Rosenthal (1992) identified four "dynamic tensions" that account for conflict in coalitions: the mixed loyalties of members to their own organization and to the coalition; the autonomy a coalition requires and the accountability it has to its member organizations; the lack of clarity about the coalition's purpose as either a means for specific change, or a model for sustained inter-organizational cooperation; and the diversity of interests of its members. How a coalition manages these dynamics affects its cohesiveness and effectiveness.

5.3. Communication

In this study, the survey sections on communication contributed significant explanatory power to the intermediary measures of satisfaction, outcome efficacy, activity level and educational activities of the various stakeholder groups. [Tables (43 - 47)]. Rogers *et al.* (1993) also reported communication to be significant predictor of member and staff satisfaction, and member outcome efficacy and commitment in coalitions in the USA.

Durable coalitions often had frequent meetings which members are encouraged to attend (Hord, 1986; Benard, 1989) and a well developed system of internal communication to keep staff and members informed (Croan and Lees, 1979; Andrews, 1990; Cohen *et al.*, 1990). The quality of communication has been positively related to coordination and negatively related to conflict (Hall *et al.*, 1977). Open communication helped the group focus on a common purpose, increased trust and sharing of resources, provided information about one another's programmes, and allowed members to express and resolve misgivings about planned activities (Feighery and Rogers, 1990; Andrews, 1990). The study's findings indicated that the stakeholders agreed that the communication between the professionals and community members were of above average quality However, the HS in the SA CPs viewed that the communication between community members could benefit from improvement [Figure (22)].

Chavis *et al.* (1987) reported that active block associations used more methods to communicate with members than did inactive associations. Along those lines, this study's sample provided evidence that more than seven various mechanisms of communication were being employed to various extents in the CPs [Table (31) and Figure (53)]. Besides written and verbal reports at or outside meetings, other means of communication reported by the sample included meeting at conferences, seminars or awareness workshops, annual reports, memos and irregular publications, presentations, informal socials and reporting back, telephone, faxes and telephone conferences, as well as visits to other CPs nationally or

abroad. Broadcasting over air (radio) was used in one CP with remote dispersed communities and the joint purchase of mobile telephones for a high proportion of the partners was adapted in another CP. From the participant observation, the researcher further documented that several of the CPs had a semi-regular newsletter, while at another CP, they purchased a motorcycle so that messages and invitation letters could be communicated promptly to members living in rugged remote areas with no other means of communication. Several other authors have pointed that durable coalitions often had well developed system of internal communication to keep staff and members informed (Croan and Lees, 1979; Andrews, 1990; Cohen *et al.*, 1990; El Ansari and Phillips, 1997; Gelmon *et al.*, 1998). Similarly, Langley *et al.* (1998) pointed out that to assure the alignment of expectations of all members of a partnership, periodic reviews, adjustments and recommitment needed be undertaken through regular communication.

However, this study's findings suggested that it was the CS who reported the highest use of these communication mechanisms [Figures (53) and (57)]. The data also reflected the differences between the stakeholder groups in the use of the communication mechanisms. The finding that more CS utilised the various communication mechanisms was supported by the fact that it was also the CS who scored highest when reporting that the information they received was timely and gave them clear understanding of their CPs [Table (7) and Figure (22)]. It seemed that, for the SA CPs, the most frequently used way of communication was via verbal reports at their CPs' meetings [Figure (53)]. Outside the meetings, verbal or written reports from their or other CPs was less likely and as Figure (53) indicated, the gap widens between the staff's and community's options of communication mechanisms. Taken together, this related group of findings suggested that, at a general level in these CPs, formal or informal communication was mainly verbal at meetings and more focused on internal affairs with relatively less information being circulated about the other six sister CPs in SA. In their case studies from six Asian countries, Clark *et al.* (1993) reported formal and informal channels of communication as cooperative communication strategies ensuring there was a continous flow of information.

Lindsay and Edwards (1988) however cautioned against the lack of communication with similar initiatives and recommended communicating with similar coalitions in different geographic areas to learn about successes and failures in other communities. This cross-fertilization generated new and better coalition activities. Success stories of similar groups help maintain commitment to the cause. Along a parallel vein, King *et al.* (1996) advocated that increasing population benefits of health promotion efforts required the widespread dissemination and implementation of effective practice. This study's observations were such that most of the SA CPs had sent some of their CP members whether professional

staff and community members on educational tours nationally and internationally albeit at a restricted level. However, especially with the overseas trips, there have been wide-spread concerns about the lack of clarity of the selection process with a call that selection need to be fair and balanced, have criteria or policy, not depend entirely on the educational level, and that more community representatives need to participate in such tours abroad [Qte (6.7)].

A second observation in direct relation to networking and communication was the role of the South African Network (SAN) of Community CPs. The South African Network consisted of a group of workers funded by the same donor agency in order to network between the seven SA CPs. Together with personnel contributions from the CPs, the SAN had, to some degree, composed task forces/ groups related to various aspects of CP functioning, for instance, a task force on curriculum development and educational transformation, another on resource development and community empowerment, a third on identifying suitable and measurable indicators that could be employed in monitoring and so forth. One of the objectives of the SAN was to develop and facilitate the implementation of a "joint monitoring and evaluation programme" for the seven SA CPs. This was seen to be important to facilitate the development of the SA CPs, with the aim of generating information which could inform national, regional and local health policy and planning initiatives, and which could assist in the process of negotiating the future sustainability of the SA CPs.

The general impression was that the mission of the SAN was a boundary-spanning one: to span suggestions for evaluations, to record related experiences across the CPs, to cross fertilise ideas, to disseminate examples of good practice and so forth. However, the participant observations and impression from the stakeholders was that the role of the SAN has, since the inception, been a rather limited one. It consisted narrowly of ad hoc meetings and forums, with a lot of the work being implemented over long distance. The SAN coordinator was living about a 1000 kilometers away from the SAN office, of which he was in charge of. Some of the CPs reported that they had not been visited by the SAN coordinator since their inception (a period of approximately three years). Other CPs reported that the SAN coordinator had visited them once or twice briefly for a day or so. During an interrupted six month stay at one of the CPs, the researcher's personal observation was that the SAN visited them once for a few hours. Obviously, there could be space for an extended role for the SAN for more coordination and cross fertilisation between the CPs with the focus of local lessons to be learnt and the transference of skills and empowerment of the partners to better manage and experiment with their CPs as opposed to the more expensive trips abroad. To the extent that most of the survey respondents' knowledge was restricted

and were ill informed about the SAN, one of the survey questions relating to the effectiveness of the SAN had to be dropped from the questionnaire as it was yielding uninformed responses from the respondents. Upon inspection of the job description of the SAN coordinator, key responsibility areas seemed to consist of arranging seminars and workshops, networking with similar initiatives internationally, planning study trips and international meetings, coordination of visits by consultants, fund-raising, building advocacy for community-based education and so forth. Although these reflected a valid set of responsibilities, it need be noted that the participants' impressions at the CPs was that role of the coordinator was an 'externally oriented' one, connecting the SA CPs to others internationally. However, there seemed to be more need for the already restricted role in transfer of local lessons across the CPs, holding talks and workshops at community and health services level at the individual sites, ensuring regular flow of information about successful practices in the sister CPs. The low frequency as well as outputs of these activities, together with the coordinator's very low visibility, gave the impression that the coordinator was just flying around arranging fancy and expensive workshops.

Another aspect of communication was dissemination of new information and skills. Schindler-Rainman (1981) also suggested that feedback competencies were needed for successful collaboration, while Green (1987) described the engagement of practitioners at all stages through structures that facilitate communication, collaboration and mutual exchange (Public Health Association of Australia, 1993) as "rule of thumb". This study's findings suggested the accountability of dissemination of information upon return from workshops, training sessions or educational trips seemed to be deficient. The related issues of feedback, follow up and transfer of skills after the training were issues of concern to all the stakeholders [Qte (6.6)]. For instance, in one CP, feedback from HS representative on the CPs' board was not regular, so HS CP members would discover important decisions were already made without intially consulting them [Qte (2.3.2)]. Furthermore, when the HS representative in the CP was changed from a top management doctor who was not in touch with the nurses on the ground, to a nurse representative who worked in the area, feedback improved. For the HS, top level physician representatives could sometimes lead to unawareness of what was actually happening in the community and might not always be the best option for regular comprehensive feedback to the constituency [Qte (2.7)]. In the context of coalitions with a relatively young age, Francisco *et al.* (1993) reported that more frequent feedback might be particularly helpful when groups were just beginning, providing an opportunity to detect and celebrate early success. Coalition leaders and representatives need communicate evidence of progress and accomplishments to their constituencies.

5.4. Member skills & training: leadership skills

The organization charged with implementing community participation activities must be sensitive, open and knowledgeable about collaboration and coordination with other individuals and programmes (Rifkin 1981 & 1984; Nichter, 1986; Bracht, 1990), skills which, if not present initially, could fortunately be taught and learned (Pateman, 1970). Although the actual skills necessary were particular to each specific project, competency was generally required in five major domains: community organizing; problem solving and priority setting; health information collection and analysis; health intervention planning and delivery; and finally, programme evaluation (PAHO, 1984). Similarly, El Ansari (1994) reported that programme evaluation skills were lacking in a case study of a CP in Johannesburg, while Whyte (1983) recommended that the individuals whom participated also required on-going education and support.

In line with PAHO (1984), in this study, the sections on expertise embraced three major components namely the expertise of the professional staff and the community members, together with the skills of the CPs' leadership. On its own, each component contributed statistically significant explanatory power, to varying extents, to the intermediary measures of satisfaction, commitment, outcome efficacy, effectiveness, activity level and educational activities of the various stakeholder groups [Tables (43 - 47)]. This was in agreement with Rogers *et al.* (1993) who reported member expertise to be a significant predictor of member's sense of outcome efficacy, only in this study the skills and expertise of members and staff had explanatory power to a range of five other intermediary measures.

Gottlieb *et al.* (1993) also reported expertise of staff and volunteers to be a significant correlate of coalition performance. However, in their analysis it seemed that they did not include expertise singly as such, but rather as one of several items such as availability, turnover and interest all together grouped under one heading: personnel barriers. The limitation of this type of analysis is that it has the implication that the explanatory power of personnel barriers could not be attributed solely to the expertise of staff and members. On the contrary, in this survey, the questionnaire had different and separate sections on expertise and on personnel barriers, so in reporting the explanatory power of expertise, the researcher reported it undiluted or contaminated by other factors. Similarly, Gray, (1985) indicated that the effective implementation and maintenance of a coalition not only required motivated and involved members, but also required that members have the skills or 'capacity to participate' in order to operate an effective partnership and to be perceived as legitimate.

In the context of community-campus partnerships in the USA, Seifer *et al.* (1998) pointed out that sufficient human resources was seen as essential to their institution's successful involvement in the community. Along similar lines, Hall *et al.* (1977) reported that the competence and the performance of members were positively related to coordination among participating organizations and negatively related to conflict. This study reported relatively similar findings that staff and community expertise was positively and significantly related to the intermediary measures of satisfaction, commitment, outcome efficacy, activity level and educational activities for both each individual stakeholder separately and the whole sample. [Table (47)].

Similarly, Zackus and Lysack (1998) suggested that "a citizenry in possession of sufficient awareness of, and knowledge and skills in social organization and health related issues" was a predisposing condition for community participation in health. In this study, the abilities and skills under investigation included three groups of expertise areas: one related to community activities e.g. working with and organising community groups and reaching target populations; the second group of skills related to HPE policy and the process of bringing about change in the various institutions and stakeholders; and the third was strategic and mangement skills useful in CPs' work e.g. planning, budget management, maintenance of the CPs and implementing educational activities.

Several researchers have brought attention to the importance of the domains of stakeholder expertise and abilities, one of this study's six highest ranking variables contributing to the explanation of accomplishment and impact of the Cps [Annex (15)]. For instance, Butterfoss *et al.* (1993) pointed out the significance of coalitions partners' expertise, skills, training and 'capacity to participate' (Gray, 1985). This pooling of member assets seems especially significant when participation was voluntary and the coalition have few material resources of its own (Prestby and Wandersman, 1985). Similarly, Balcazar *et al.* (1990) found that a skills training program conducted with coalition members and chairpersons resulted in increased reporting of issues and overall improved effectiveness, Eng *et al.* (1992) stressed the importance of learning new skills, Bloxham (1997) reported how the external staff were seen to bring a specific range of skills and knowledge to collaborative efforts, while Maurana *et al.* (1998) reported that understanding of the community's assets and skills was one of the principles of good partnership.

A bird's eye view on the radar graph [Figure (32)] suggested that, in general, the CS and CM groups were the two groups that regard both the professional staff and the CM groups' expertise and abilities highest. Furthermore, Figure (27) indicated that the stakeholders agreed about the above average skills of

the professional staff. However when it came to the expertise of community members [Figure (28)], there was across the board disagreement of the stakeholders as regards the community's expertise. The professionals seemed to underscore the community's skills in about 60 % of the different domains of CPs functioning that were investigated. This finding suggested that the professionals might still view the lay person as unskilled, with limited resources and not having much to contribute to the CPs. Rogers *et al.* (1993) reported similar results in the USA where they reported a discrepancy between views of members and staff regarding their own and their counterpart's ability to deal effectively with tobacco control issues. The same trend as in this study was reported: members and staff rated equally staff expertise in tobacco control, but staff significantly down rated member expertise. This issue of professional under-appreciation of the community expertise has also been debated in a separate earlier qualitative study of another South African CP in Johannesburg (El Ansari, 1994). Similarly, Maurana *et al.* (1998) in their 'draft principles of good partnerships' brought attention that CPs need build on identified strengths and assets, while Seifer *et al.* (1998) cautioned against viewing communities as a set of needs and deficiencies while overlooking the community's strengths, gifts and capacities.

Leadership skills

Related to the expertise and abilities of the CPs' participant population groups was the skills of the leadership in this collaborative process. Strong central leadership was an important ingredient in the implementation (O'Sullivan, 1977, Feighery and Rogers, 1990) and the maintenance of coalition activities (Bailey, 1986; Sink and Stowers, 1989; Zapka *et al.*, 1992). In this study, leadership was defined as the engine that drove the CPs, the group of members, trustees and leaders who usually decided on the course the CP will take every time it met crossroads. This group included the directors or CPs' convenors, the board of trustees and the management or governance committees.

This study's findings suggested that leadership skills contributed significant explanatory power, although in a restricted manner, to the intermediary measures of satisfaction, effectiveness and educational activities of the various stakeholder groups [Tables (43 - 47)]. In Rogers *et al.* (1993), leadership skills were not reported to have been significant in predicting any of the intermediary measures. It could be that the increase in the power gained by doubling the sample size of Rogers and coworkers study (from 361 to 668 repondents), enabled this study to identify the rather restricted explanatory power of leadership skills that was not reported by Rogers and colleagues.

The qualities of leadership cited in the literature included: personal resources such as self efficacy, membership in other community organisations; level of education; a high degree of political knowledge, commitment and competence (Rich, 1980; Prestby and Wandersman, 1985); proven administrative skills in order to set agendas, run efficient meetings, garner resources and delegate responsibilities (Feighery and Rogers, 1990); skills in communication and interpersonal relations (Andrews, 1990); the ability to promote equal status and encourage overall collaboration in the member organizations (Hord, 1986; Lindsay and Edwards, 1988); and, flexibility (Cohen, 1989). In this study, the group of leadership skills under investigation included the domains of providing information, giving recognition, seeking and welcoming views and listening to opinions, providing opportunities, offering social gatherings or group activities, and reporting achievements. The bird's eye view on the radar graph [Figure (57)] suggested that, in general, the highest proportion of respondents who reported positively on the skills of the CPs' leaderships was the CS group followed by the AI and CM and lastly the HS. Given that the group of skills under investigation were related to recognition, views and opportunities, this finding could be a pointer to that the HS perceived themselves not to be fully incorporated in these group of SA CPs.

The WHO (1994) reported that the scarcity of knowledgeable, skilled and experienced leadership for CPs has hampered the necessary changes at all levels. It has left room for distortion of interventions and teaching programmes planned and managed from the top. A process aimed at collective action to improve the situation of the poor may even be considered subversive and could prove dangerous. The fear of negative impact at the personal level leads to a tendency to accept the status quo, and a failure to work towards genuine changes in favour of the vulnerable.

This study's qualitative findings shed much light on the issue of leadership skills and characteristics. These are reviewed under section (5.4.1). The stakeholders indicated concerns relating to the visibility as well as the composition and legitimacy of the leadership [Qte 6.11]. Management procedures needed more clarity, consultation, support and devolution of financial and other responsibilities [Qte 6.12]. As regards the characteristics, styles and attitudes of the CPs central figure, the director or coordinator, the leadership's consultative skills raised some particulars of the style and attitude that suggested that the communicative skills of the leadership could be improved [Qte 6.13].

Examples of inappropriate attitudes of the leadership included the issues of communication, self development, occasional racist concerns and the abuse of funds, power or other benefits [Qte 6.14]. The consequences of the lack of appropriate leadership skills were perceived as fear, feeling not free and lack

of involvement or even challenge [Qte 6.15]. Further themes about the Board included issues of attitude of the director, consultation regarding the filling of posts and the erection of buildings, power tactics and self interest [Qte 6.17]. Taken together, these findings were not in line with Brown's (1984) recommendations that when the leaders were attentive to and supportive of individual member concerns, and were competent in negotiation, garnering resources, problem solving and conflict resolution, the coalition tended to be more cohesive in reaching peripheral members and in maintaining coalition operations. Similarly, Washnis (1976) asserted that the strengths and personal characteristics of the coalition leaders were more important than any other factor in maintaining effective teams. The research literature also contained modest support for this hypothesis. For instance, Prestby and Wandersman (1985) included leadership as an important maintenance aspect of organizational control structures of coalitions. Leader's personal characteristics, such as leadership style (Mayer and Blake, 1981), decision making style (Knoke and Wood, 1981), networking and visibility (Schoenberg and Rosenbaum, 1980) and political efficacy (Yates, 1973) have all been found to be related to the maintenance of coalitions. Similarly, Seifer and Maurana (1998) pointed out that supportive leadership at all levels of the institutions was seen as essential to their institutions' successful involvement in the community, while Zakus and Lysack (1998) reported that a predisposing condition for community participation in health was a health care delivery system in which institutions and professionals have experience with and are committed to community orientation.

5.5. Representation

The thorny issue of community representation and inclusiveness has also been widely debated (El Ansari, 1994; Bracht and Tsouros, 1990; Yeo, 1993). For instance, Knott (1995) reported that the composition of the partnership's board was a factor affecting project sustainability, while Rogers *et al.*(1993) and El Ansari and Phillips (1998) found certain constituencies to be under-represented in the coalitions that they investigated in the USA and South Africa respectively. Even with good representation, Popay and Williams (1998) have indicated that there was no unitary "public opinion", but rather a multitude of voices waiting to be heard.

Haynes (1970) argued that although the term "community representation" has become quite popular, no one seemed to know a really satisfactory way of identifying community representatives. He questioned if one was to deal with the official leaders or the natural leaders, with staff of community organizations or with grass-roots support. He also inquired about who they were and how they were selected. Hochbaum (1969) also queried if they should be the more educated and knowledgeable or those who are likely to

bring the best understanding of the issues involved to the planning? Similarly, Zakus and Lysack (1998) reported that the people with sufficient health expertise who were also willing to donate the requisite time and energy to community-based heath projects were not always easy to find.

Generally speaking, community representation offered some explanatory power to each of the intermediary measures of commitment, outcome efficacy and educational activities for various stakeholder groups [Table (47)]. To the best of the researcher's knowledge, Rogers *et al.* (1993) did not report community representation to be a significant predictor of any of their intermediary measures, in-spite of including it in their questionnaire.

There were innumerable difficulties that relate to the matter of community representation. Determining who was the legitimate representative of the community was far from straightforward (Zakus and Lysack, 1998). Bracht and Tsouros (1990) and Yeo (1993) have suggested that CPs should ensure that the powerless were not marginalised further in CP building efforts. They recommended that planning needed to be as inclusive and representative as possible, and needed to be supported politically and administratively to function effectively. This survey indicated that the stakeholder groups agreed as regards the above average representativeness of their CPs of the various beneficiary communities in their geographical areas and locations [Table (5)]. This was in accordance with Rogers *et al.* (1993) who found that members and staff agreed that the coalition tended to be fairly representative of the people in their local health jurisdiction. However, Figure (21) indicated that the stakeholders also agreed as regards the under-representation of many stakeholder groups: about 10 - 30 % of each of the stakeholders viewed that specific workgroups (blue collars), rural population, CBOs, worksites/ businesses, the medical community, elderly, media, and schools (teachers, students) that could all benefit from better representation. Again, there was an overlap between this study's findings and those of Rogers *et al.* (1993) who, in a survey of 61 state mandated coalitions 18 months after formation, also found that important sectors were not represented. They reported that both members and staff felt that certain constituencies were not well represented, namely: various ethnic and underserved groups; medical and dental professionals; business and work groups; youth; media experts; and smokers.

Figure (21) showed that more representation of the youth on the CPs was a high priority for all the groups. This was supported by that average age of the survey respondents was about 41 years (std deviation: 11.5 years, range 18 - 78 years). Figures (10-12) depicited the age distribution of the survey respondents by CP and by stakeholder group. In Figure (10), the upper tail of the age distribution was

slightly longer than the lower tail, a slight positive skew to the right suggesting more people from the older age groups. The figure also indicated that the age bracket 18 to 23 years (midpoint 20 years) included only about 3 % of all the survey respondents. This proportion rises to about 13 % when the next age bracket is included.

Figure (12) showed that, although there were no significant differences in age between the partner groups, the CS seemed to be the relatively younger group. But the CS were not a 'true' stakeholder group, they were the CPs' champions and facilitators, the full time paid employees. The respondents from the three *bona fide* stakeholder groups, namely the AI, HS and CM seemed to be partly responsible for shifting the mean age up. Figure (11) also indicated that there were no significant differences between the ages of respondents of the various CPs, and although CP No. 1 seemed to have more younger respondents, the main bulk of the survey participants were between just under thirty years to just above fifty years of age. As regards the interviewees, the mean age of the informants was about 40 years (range 24 to 55 years). Again there was no interviewee under 23 years of age and those under 28 years were about 8 % of the informants [Figure (61)].

In agreement with the above quantitative results [Table (5) and Figure (21)], this study's qualitative findings suggested that in these SA CPs, more representation was needed from all the stakeholders involved: generally the youth needed to be more represented; from the CM side, there was need for more community representatives from the lower socio-economic strata, CBOs, religious and other civic structures; from the HS side, more HS representation especially from the central health department was advocated for; and, from the AI side, more representation of the various AI departments was reported to be needed [Qte (2.1 - 2.4)]. While some health experts believed that the representativeness of the health worker held the key to community participation success (Paap, 1978), others have argued that the ideal participation would only be achieved if health workers proved themselves capable of meeting the health needs of those they served (Jonas, 1978). To be effective, community participation must ensure that especially disadvantaged target groups were included in the process (Bracht, 1990; WHO, 1991; Lysack and Krefting, 1993).

In relation to representation, a common problems that arose related to the nature of community. Who had the right to speak for 'the community'? Zakus and Lysack (1998) pointed out that representation became an issue when the community health workers needed to be selected and when community leaders needed to be identified. In both instances, individual prejudices, stereotypes, and social and political ideologies

could create problems that seriously impaired the ability to organize in pursuit of better health (Rifkin, 1983; Collins and Green, 1994). In this study, the qualitative findings supported these views. Reasons behind under-representation and consequently participation included tribal, geographical, political or educational considerations and combinations thereof [Qte 2.5]. There were also some concerns relating to the size, and determinants of composition of the board of trustees [Qte 6.16], as well as some lack of clarity on guidelines on representation e.g. the number of individuals that constituted a committee or the criteria for inviting new members [Qte 1.4]. Unsatisfied with the current representation in their CPs, some CP members went as far as to question the composition and legitimacy of the leadership [Qte 6.11]. This was line with other authors who reported that difficulties arose when minority segments of the population did not share the same values and priorities as the dominant (or decision-making) segments, or, for reasons of culture (Woelk, 1992; Stone, 1992), gender (Rifkin, 1984; Mosse, 1994), or socio-economic status (Robinson, 1990; Green, 1991; Woelk, 1992), they found it difficult to become involved. Similarly, Green (1991) suggested that the methods used to select organization members and the degree to which they represented local issues were crucial in determining the perceived legitimacy of the representatives in the eyes of the population served.

Representation needed to be seen as a natural emergent of earlier good quality communication with the beneficiary constituencies involved. Bias in communication was likely to lead to bias in representation of those who were not communicated. This study's findings indicated that the members of the SA CPs members aired several concerns relating to communication bias. Geographic, person, language or educational considerations in communication might determine which constituency, locations or tribes are communicated [Qte 3.5]. Similar findings have been reported by other authors. For instance, "many communities are geographic only and have serious conflicts along class or other lines (religious, racial, etc.)" (M. Roemer, personal communication, 1985, cited in WHO, 1978). Similarly, Herman *et al.* (1993) have warned that member recruitment that was based largely on pre-existing networks might result in the exclusion of important constituencies and might define the level to which member organizations become involved in a coalition. In relation to CP-HPE projects in the USA that were funded by the same donor agency as those in SA, Knott (1995) similarly reported that the composition of the partnership's board was a factor affecting project sustainability. In some projects, most of the community representatives were health providers. Some community representatives should represent neighborhood associations and "grass roots" organized interests that have string advocacy skills and political connections with state and local government officials. However, representation by only local advocacy groups ignored the more mainstream

stakeholders in the community, including business, payers, hospitals, and government. A fuller representation of stakeholders in the community on the board would better assure the sustainability of the CPs.

Representation might be limited because some people felt they had nothing to gain or contribute given their situation, needs, and history. Often it was a minority, the better off, who were more involved. If the poorer and therefor sicker members of the community were not represented in the CPs, then it was unlikely that their perspective would be presented, thus perpetuating inequity. Therefore, participation should not be limited to those who already have some power. CPs should ensure that the powerless were not marginalized further in partnership building efforts (Bracht and Tsouros, 1990; Yeo, 1993). Knott (1995) also reported that some of the partnership boards had community representation only from health providers in the community who share the same values as university faculty. This study's participant observations indicated that in the SA CPs, the composition of the Boards were 25 % AI, 25 % HS and 50 % CM. This fact was also publicized in most of the CPs' brochures. However, in related work, researchers in the UK had further shown that even the most committed community health activists will eventually be criticized by their own consistency for appearing to be too closely allied with the health service managers (Van den Heuvel, 1980; Levitt, 1986).

Planning needed to be as inclusive and representative as possible, and needed to be supported politically and administratively in order to function effectively. As regards to empowering the powerless, the study's findings suggested that representation needed also to be linked to representation in the educational benefits of the CPs. For instance, the selection of members from the stakeholders to go on CPs tours or educational trips nationally or abroad needed to be fair and balanced between the stakeholders. Several concerns that were voiced related to the need to have criteria or a policy for the distribution of the educational benefits of the CPs, not to depend entirely on the educational level of the stakeholders, and people needed to be informed timeously [Qte 6.7]. Bias in the opportunities to gain skills could have an implication on the sustainability later on in the life span of the CPs.

Related to representation was the authority, responsibility and duties of the representative. Douglass (1973) cited Murphy's (1954) definition of the formal representative: that who has "..........approval by formal vote of his organization............". The other two types were the informal and type representatives. The informal representative that who did not have approval by vote from the various executive bodies or the administrative authorities of his agency. He did not speak for his agency but acted as liaison between it and the deliberating body. A type representative was one who was associated with an agency or group

only in so far as he personally was a member of that agency or group. He neither spoke for the agency nor acted as liaison. As regards the authority of representatives to make decisions, the study's findings supported the need of skills and power of the delegated representative. A fair amount of expertise and authority to make decision was advocated for [Qte 2.6]. In parallel, Table (25) and Figure (44) suggested that the highest percentage of respondents who reported that they were not in any position to make decision on behalf of their organisation was from the CM. On the other hand, the proportions of those who had delegated power to make reasonable decisions on behalf of their organisations were nearly equal in the stakeholder groups. For all the stakeholders except the community, the great majority of respondents could make decisions only after consultation either with other staff of their organisations or their respective boards. The emerging trend seemed to be one of negotiation where most of the stakeholders had to consult with their relative constituencies. In the case of the CM, they were the least who had to consult with their boards or other staff, perhaps as community organisations were frequently small to medium-sized congregations, were more flexibly driven and did not suffer from the extreme bureaucratic tradition that was generally well entrenched in the academic training institutions and the health service providers. Douglass (1973) concluded that providers who were formal representatives were most likely to yield an orientation in decision making that could be predicted by their organizational affiliation, as opposed to providers who were informal or type representatives tended to act in terms of their own self perceptions and attitudes. Representatives of consumer organizations, on the other hand, were consistently consumer oriented in their perceived roles and attitudes regardless the nature of their representation.

Related to the authority of the representative was the duty of follow up, liaison and transmission of information to the respective constituency. This point was also discussed in section (5.3) with communication. However, the qualitative findings also pointed to that the follow up and feedback of both the representatives to their constituencies, and the CPs to the attendees after the meetings might have been inadequate [Qte 3.19]. The need for good quality feedback has been recommended by Salem (1978) who argued that the term "representation" suggested that there was a relationship of some kind between the representatives and their constituents. Many representatives found this relationship non-existent or at best weak. She reported that one half of the respondents in her study made no attempt to report back to their constituents. Another one third described a haphazard and informal reporting system which consisted mainly of talking to immediate neighbours and others who might be contacted within the context of other activities. The few representatives who felt that they were communicating with their constituencies were those few who represented areas organized into block clubs. A related matter was the

issue of turnover of representatives. Analysis of the interviewees reveals that the turnover of members and representatives attending was high resulting in repetition and low continuity [Qte 3.18]. The qualitative data also suggested that the follow up and feedback after the meetings might be inadequate[Qte 3.19].

5.6. Costs, benefits, benefits: difficulties ratio & satisfaction

Wandersman *et al.* (1987) asked a major question in regards to participation in voluntary organizations: "if participation is such a good thing, why don't more people participate?". To aid the understanding of participation and lack of participation, theories of incentive management and political economy could prove to be useful. While incentive management related to more personally beneficial reasons, political economy subscribed to the notion of 'collective action and good'. It is worth noting that rewards for community participants were largely philosophical, emotional and symbolic as compared to health professionals and managers for whom participation often has tangible professional and career advantages (Jonas, 1978; Paap, 1978; Robinson and Larson, 1990).

The study's findings indicated that the sections on benefits, costs, and ratio of difficulties to benefit each contributed significant explanatory power, to varying extents, to the intermediary measures of satisfaction, commitment, outcome efficacy, effectiveness, activity level and educational activities of the various stakeholder groups. [Tables (43 - 47)]. Again, as this study operationalised more intermediary measures than those employed by Rogers *et al.* (1993), it was able to pick up the contributions of costs and benefits as a significant explanatory variable to more of those intermediary measures. To be specific, Rogers *et al.* (1993) reported participation costs and coalition benefits to be significant predictors of satisfaction and outcome efficacy only.

In relation to the benefits and costs of being involved in the CPs, the radar graph [Figure (32)] suggested that, in general, all the stakeholders felt that they gained some benefits from their participation in their CPs. However, the CS and CM were the two groups that valued the benefits of being involved in their CPs' most, while the HS and AI seemed to value the same benefits less. Figure (32) also suggested another related finding: the inverse relationship between the stakeholders' views on benefits and costs. Those who perceived their benefits to be highest also viewed their costs as lowest. The CS who valued the benefits of their CPs most, also viewed their costs as the least of all the stakeholders. For the AI and HS who valued the benefits less than the CS, they also viewed their costs as higher than the CS. An

exception to this inverse trend was the CM group who where the second highest in viewing the benefits of being involved, but when it came to costs, their costs were the highest.

The potential benefits of collaboration have been widely rehearsed: increased networking, information sharing and access to resources (Kaplan, 1985; Hord, 1986); attaining the desired outcomes for the coalition's efforts (Rich, 1980; Zapka *et al.*, 1992); enjoyment of the coalition's work (Benard, 1989); receiving personal recognition (Bailey, 1986; Benard, 1989; Wandersman and Alderman, 1993); and enhancing one's skills (Rich, 1980; Roberts-DeGennaro 1986b; Wandersman and Alderman, 1993). In contrast to payoffs that facilitated participation, members might decline involvement if it was perceived as costly. Costs that were often cited included: devoting time to the coalition that was taken from other obligations (Rich, 1980; Bailey, 1986); overcoming an unfavorable image held by other partners (Schermerhorn, 1975); lacking direction from the leadership or staff of the coalition, perceiving a lack of appreciation or recognition, becoming burnt out, lacking the necessary skills and feeling pressured for additional commitment (Wandersman and Alderman, 1993). This study's findings indicated that the reported agreement between the stakeholders on the costs ranged from feeling that the CPs activities could have done better to reach the constituencies and communities and that the stakeholders' skills could have been more fully utilised and harnessed for the benefit of the CPs [Figure (25)]. However, all the stakeholders and especially the AI did not view CP activities as problematic or keeping them from doing their work. There are important costs involved in participatory activities and unless these costs were taken into account, only the most privileged segments of society participated, thereby excluding and possibly worsening conditions for lower income citizens (Zakus and Lysack, 1998). Unless participation was carefully developed to take these considerations into account, few might be willing to be actively involved or involved for very long. Another challenge to the evaluation of gains of CPs was that the benefits were spread among different constituencies: students, faculty, the community and the institutions (Gelmon *et al.*, 1998). Lazarus *et al.* (1998) reported that bringing students to interdisciplinary settings to observe and work with the professional role models facilitates their understanding of the benefits of the collaborative approach. Benefits of collaboration were different for groups working jointly. For instance, in partnering for health, Hancock (1998) has cautioned that the motivation of the private sector was profit, while on the other hand, the health promotion sector seeked to improve health. Although this is true, it need not be forgotten that in a sense, all industries benefit from improved health as it leads to higher productivity.

Some research has also been performed on the ratio of benefits to costs. Norton *et al.* (1993) reported that there seemed to be few studies that make these types of comparisons. For instance, Freidmann *et al.* (1988) reported that leaders (who tended to be the most active participants) might actually accept a ratio of benefits that was equal to costs, while members (who were less active) might want a higher benefit to cost. In relation to this domain, the study findings [Figure (46)] were such that those participants who perceived themselves to be very involved in their CPs showed the highest percentage who viewed their CPs' benefits to be favourable i.e. more or much more benefits than the difficulties. On the other hand, those who reported to be not very involved exhibited less proportion who perceived the benefits to be of a favourable ratio.

On face value, it might be tempting to jump to the conclusion that this study's findings were in the opposite direction as those of Freidmann and colleagues (1988). Two points were against this conclusion: First, in this study the differences between the stakeholders' views on B:C did not reach statistical significance [Table (22) and Figure (45)]. Secondly, the researcher's view was that it would be difficult to directly compare this study's finding with Freidmann *et al.* (1988), as one could not ascertain the temporal relation between involvement and the perception of benefits to costs. It could have been that some individuals were not very involved and so did not perceive a favourable B:C ratio, or it could have been the opposite: individuals did not perceive this CPs' work as having a favourable B:C ratio , and as a result they did not get very involved. Norton *et al.* (1993) have eluded to a similar point: that this type of cost versus benefit analysis could occur prior to participation in an organisation (anticipated incentives and barriers) or can be ongoing evaluative process for members of voluntary organisations (perceived costs and benefits). Whichever way the directionality was, that is whether involvement leads to a favorable perception of B:C or vice versa, Shermerhorn (1975) suggested that before potential members began to collaborate, they must believe that collaboration would produce positive outcomes. Positive expectations might create a climate of optimism that sustained member commitment (Florin *et al.*, 1989). Well-structured studies of member benefits and costs suggested that participants would invest their energy in an organisation only if the expected benefits outweigh the costs that were entailed (Rich, 1980; Prestby *et al.*, 1990, Norton *et al.*, 1993).

However, this study's findings were in parallel with both Wandersman *et al.* (1987) and Prestby *et al.* (1990). Both authors reported differences among members and non-members in perceptions costs versus benefits, where members perceived greater benefits than costs. This study's findings further documented the difference on a three level gradient [Figure (46). Both Wandersman *et al.* (1987) and Prestby *et al.* (1990)

reported on two comparison groups namely member and non-members. This investigation reported on three comparison groups: those not very involved; those moderately involved and those very involved in the CPs. As regards the percentages of participants who viewed favourable benefits to difficulties ratio, there was a gradient that increased as one moved from the less involved to the very involved participants. [Figure (46)]. i.e. as involvement increases, a better B:C ratio was perceived. This gradient provided a 'dose-response' support for the relation between involvement and perception of favourable B:C ratio. However, the reader is cautioned that although there seemed to be an emerging trend, the differences were not statistically significant.

As regards the stakeholders, this study indicated that it was mostly the academics who viewed this ratio to be a favourable one i.e. the benefits were at least equal to, a little more or much more than the difficulties [Figure (45)]. To the researcher's surprise, this survey also suggested that the CS viewed CPs work to carry more difficulty than benefits. One might have expected to find that it was the CS who really viewed and realistically perceived the benefits of the CPs. This finding could be due to the combination of simultaneous amplification and dilution effects: amplification of their perceptions of difficulties and costs as the CS were intricately involved in the primary tasks of running the CPs and the day-to-day endless issues that needed continuous organizing and on going resolution and, dilution of their perceptions of benefits as they were working with multiple agencies and communities, where benefits were dispersed and required a long time interval to accrue, crystallize and appear in a tangible, measurable form.

In general, the motivating conditions influencing interorganisational cooperation derived from the benefits potentially associated with such activities. Schermerhorn (1975) cited several motivating conditions conducive to cooperation in the literature: resource scarcity (Aiken and Hage, 1975), where there was perceived organizational shortages of funds and manpower, scarcities of facilities, services and information; in response to crisis or environmental pressures; or at a more general level to have a potential favourable impact on organizational image or identity. Organizations might be favourably predisposed towards interorganisational cooperation where there was need to gain access to otherwise unavailable resources, free internal resources for alternative use, and/or more efficiently employ existing resources.

To the best of the researcher's knowledge, Rogers *at al.* (1993) reported no discrepancies between member and staff views on the benefits and costs of participation in coalitions in the USA. The

assumption is that they found no differences in their study. In the SA CPs, however, the findings were different: the stakeholders showed disagreement in their views on all of the benefits of the CPs that were investigated. Figure (25) illustrated these differences in opinions. It also illustrated that the AI and HS viewed significantly less benefits than both the other comparison groups, even though Figure (45) indicated that the same two groups (AI & HS) had the same (i.e. not statistically significant) proportions as the CM and CS who perceived their CPs as having favourable B:C ratios (i.e. more benefits than difficulties).

5.7. Involvement & Contributions

In most instances of collective action, only a fraction of people or organisations with shared grievances or interests became involved in the effort (Olson, 1965; Mcarthy and Zald, 1977). Moreover, most of those who did get involved did so at a relatively minor level, such as simply belonging to an organisation and paying dues (Rothenberg, 1992). Analysts of collective action have pointed to a number of reasons for this, including the costs of involvement (such as time and effort required), lack of knowledge about the effort, lack of prior organization of affected groups, and the fact that the results of collective action often accrued equally to those groups or individuals who worked for them and those who did not (Snow *et al.* 1980; McAdam, 1986).

The findings suggested that, on its own, the section on involvement contributed statistically significant explanatory power to the intermediary measure of educational activities [Table (47)]. On the other hand, the radar graph [Figure (57)] further suggested that the extent of involvement of CS and CM groups seemed to be more than the other two groups. It was possible that involvement could have been influenced by the type of stakeholder group. On average, more proportions of the CS and CM viewed themselves as either moderately or very involved in their CPs [Table (24) and Figure (34)]. Herman *et al.*, (1993) also reported that agency type did seem to influence the level of involvement. In looking at involvement details, this study similarly reported differences between the stakeholder groups as regards the percentage of CPs meetings attended or the numbers of hour per week spent on CP related activities [Figures (35 - 36)]. What was again apparent is that the CS reported more involvement in recruiting new members, serving as spokespersons, implementing activities, and representing the CPs to other groups more than the three other stakeholders activities [Figures (37 - 40)]. Excluding the CS, it seemed that the CM were more involved in recruiting new members and acting as spokespersons to spread around the CPs by word of mouth, while the AI and HS involvement was more when it came to implementing

educational or cultural activities or events sponsored by the CPs. This finding of a high level of the CS and lower levels of involvement for the three "true" stakeholders supported Herman *et al.* (1993) findings that in coalitions with no permanent staff, heavy reliance rested on the members to coordinate and perform all coalition activities.

As regards involvement the survey finding indicated that 70 % of respondents rated themselves as either not very involved or moderately involved in their CPs. The study's qualitative findings reflected similar views. For instance, the HS "seem not to be very involved; not satisfactory; not visible; not much participation; not pushing the CPs; need more time with the community instead of just sit in the CP's meetings" [Qte (4.4.)]. Several causes seemed to have contributed to the lack of involvement. Apart from the lack of clarity discussed earlier (section 5.2.), the causes included the lack of time, administrative authority and hierarchical considerations, times of meetings, transport problems as well as lack of support [Qte (4.5.)].

Participation of the CM also seemed to be problematic, with unstable attendance and many political affiliations, participation of community grass roots levels in CPs` projects was needed, as the participation quality was low, and the community could have been rubber-stampers on decisions already made elsewhere in the system [Qte (4.11.)]. A set of problems arose when the minority group itself preferred not to engage actively in the participatory process. It was precisely the poor and disadvantaged who may discount participatory processes, instead preferring professional handlimg of community matters (Stone, 1992). When disadvantaged minority groups are accustomed to being bypassed, or at most condescendingly solicited and then ignored, then it would hardly be a surprise that they would have little interest in being involved (Christensen, 1990).

Generally, academics were seen to be busy people with a high turnover at meetings [Qte (4.6.)]. The administrative level and commitment of individual players such as the heads of departments of various faculties seemed to be important [Qte (4.7.)]. The reasons attributed to lack of involvement fell broadly under un-readiness, communication problems, lack of clarity, resistance, lack of lobbying and joint planning, and the 'minor' importance of the CPs. They embraced the un-readiness yet of the AI to take part, lack of publicity, advertising and information, and resistance to change or taking risks. Other reasons quoted were that the AI did not want to show their ignorance, overloaded faculty, position of the CPs which sort of sit out on the periphery, lack of advocation and lobbying of academics, lack of joint

planning between the AI, as well as lack of transparency and clarity [Qte (4.9.)]. An important consequence was the dispersion of energies of the AI partner [Qte (4.10.)].

Involvement seemed related to issues of ownership. As regards sense of ownership, Lindsay and Edwards (1988) reported that without the sense of shared ownership, coalition members would always feel they were working for someone else's agency. Figure (26) indicated that the stakeholders all reported above average to high sense of ownership, with the CS and CM groups scoring highest. A coalition must be genuine and co-owned by its member agencies in order to be effective. Likewise, Gray (1989) reported on the importance of joint ownership of decisions in collaborative efforts, while Goodman and Steckler (1988) pointed out that a lack of transference of ownership to the community and other social agencies might result in little grassroots support in the community to lobby for project continuance later on. In a like manner, Eng *et al.* (1992) articulated that the concept of primary health care strived to ensure a continuum of preventive and caring service that reflected active involvement and ownership of the community in which it was practiced, while Bracht *et al.* (1994) brought attention to the relation community ownership and program continuation.

Contributions

The study's findings on contributions also conformed with the finding that the HS ranked lowest and the CS highest in their degree of involvement. Figure (23) indicated that the responses of the groups when asked about the various kinds of contributions they made was compatible with their extent of involvement. Here again, the ranking of the stakeholders' responses was similar to their ranking in the extent of involvement [Figure (43)]. The CS contributions of time, money, in-kind resources or the facilitation of access to special populations was the highest while the HS responses were the lowest. An exception was on the contribution of in-kind resources such as printing, equipment facilities etc., where the CM contributions fell even lower than the HS, although this difference was a statistically non-significant one and needed be viewed in the light that these communities were remote, rural, undeserved and underprivileged communities who did not posses much goods to offer to the CPs as in-kind contributions when needed, as opposed to the CS or the AI. In general, the highest contributions of all the groups in their CPs was that of time and the least was money. This was in line with, Herman *et al.* (1993) who also reported availability of time and scheduling conflicts to be a major barrier to coalition involvement.

In attempting to understand the reasons behind the HS low extent of involvement, the survey findings related to costs of participation and specifically the question 'if being involved in the CPs was a problem' might contribute some insight. Here the stakeholders again expressed different opinions. The HS ranked first as regards viewing that their participation in the CPs was problematic, followed by the other stakeholders who viewed less problems in their involvement [Figure (25)]. This finding was compatible with the one above on the extent of involvement where the HS reported the least proportions who were 'very involved' [(Figure (34)] in the same way that they viewed their involvement as most problematic and vice versa. This revealed yet another inverse relationship (besides the first one on benefits and their inverse relationship to costs): the more the perceived problems in the CPs [(Figure (25)], the less the involvement [(Figures (34 and 57)]. This seemed to hold true for most of the stakeholder groups.

The study's finding that the CS viewed their involvement as the least problematic might be clarified in the light of that they were full time paid employees, with no other responsibility except the driving and advancement of the CPs. This might have contributed to their tolerance to and perceptions of problems, which to them was part and parcel of their day to day activities. In contrast, the "true" stakeholder groups all were voluntarily participating, all had their major responsibilities and overloaded agendas, so their views, perceptions, tolerance and thresholds of what might constitute a problem could have been different. Herman *et al.* (1993) also reported that the majority of representatives to the coalition were directors of clinics or departments with limited time available. It was not surprising that in their study, 77 % of the respondents reported time and scheduling conflicts to be their major barrier to coalition involvement.

However, it is appropriate to caution the reader that the above findings about the extent of involvement and its relation to the amount of problems perceived in this involvement could be a product of other factors. In examining alternative explanations that might contribute to more understanding of these issues two points emerged:

First, was the possibility of varying magnitudes or amounts of *opportunities* that were open to the individual stakeholder group to participate or get involved in the CPs. More opportunities for involvement could have contributed to understanding the reasons behind the observed differential involvement of the groups. However, Figure (30) suggested that this might not necessarily be the case, as the groups did not differ in their opinions in expressing an above average agreement that they felt that

they had many opportunities for participation in their CPs. This could operate against an assumption that a participation opportunity factor might be operating differentially towards the various stakeholders.

Second, was the possibility of varying degrees of availability of either community members as volunteers or professional staff for the CPs. Figure (47) indicated that as regards availability of professional staff, about 70 % of the HS respondents agreed that this presented either a major or minor problem in their CPs [Table (29)]. So lack of availability could have been a reason for lack of involvement. Furthermore, the proportions of AI and HS respondents who perceived the availability of professional staff as a problem were significantly more than from the CM or the CS groups.

5.8. Member relationships:Interaction & Decision making

The organizational climate is the group member's perceptions of several important organizational characteristics. Giamartino and Wandersman (1983) reported that the organizational climate of a coalition helped in assessing its 'personality'. In relation to partnerships and alliances, organisational climate might be characterised by relationships among members, member-staff relationships, communication patterns among members with staff, and a partnership's decision-making, problem-solving and conflict resolution processes (Butterfoss *et al.*, 1993).

Although the current literature is limited in addressing the effect that relationships among coalition members had on the climate of a coalition, it was reasonable to hypothise that positive relationships among members were likely to produce a productive melieu for the coalition (Butterfoss *et al.*, 1993). In this survey, the findings suggested that, on its own, the section on interaction contributed statistically significant explanatory power to the intermediary measures of satisfaction, commitment, outcome efficacy, activity level and educational activities of several of the stakeholder groups [Tables (43 - 47)]. To the best of the researcher's knowledge, neither Rogers *et al.* (1993) nor Gottlieb *et al.* (1993) reported on interaction.

Interaction

The study's questionnaire section on interaction queried the various aspects of the interaction processes, the differences, disagreements and conflict resolution on the one hand, and shared vision, togetherness and teamwork on the other. Overall for this section, the CM and AI groups expressed the highest

agreement with the statements, followed by the HS and CS who, in general, agreed less strongly [Figures (30 and 32)].

Within the section, in relation to the interaction between the stakeholders at CPs meetings and the atmosphere of the meetings, the survey findings suggested that the stakeholders fairly agreed (*M* ranged from 4.4 to 5.7) that the interest in the meetings was generally high, and that the CPs used the resources of all its members where everyone participated in the discussions and felt safe in speaking out. The groups also agreed that the meetings had free discussion in a friendly, co-operative atmosphere, and ran smoothly without interruptions, fighting for status or hidden agendas [Figure (30)]. Taken together, these findings suggested that there was a considerable friendly and democratic atmosphere where opinions were openly expressed. These findings were in agreement with Zakus and Lysack (1998), who advised that one of the predisposing conditions for community participation in health is a political and administrative system which promotes local authority for decision making, resource allocation and programmes. Along similar lines, Seifer and Maurana (1998) pointed out that developing a strategic approach involved asking questions and engaging in a dialogue around the answers to help create a vision. Similarly, in the context of the myriad of organisations that were usually involved in CP work, El Ansari (1994) supported the need for democratic processes that were also simultaneously flexible, as he cautioned that over-attention to democracy issues in CPs could sometimes be stifling: the time consumption was enormous and swift decisions and responses, when required, could not be promptly made as most issues required considerable debates.

In relation to the interactions between the stakeholder groups within partnerships and coalitions, Hord (1986) suggested that frequent interactions at all levels was a continuing requirement and one of ten salient features of the characterizes the complex collaborative process as opposed to the apparently more simple cooperative process. Similarly, Gray (1989) reported that the skillful management of early interactions was often crucial to continued collaboration, since these informal interactions lay the groundwork for subsequent formal interactions. Understanding how this process unfolds was critical to successfully managing multiorganizational relations. If collaboration was successful, new solutions emerged that no single party could have envisioned. Conversational interactions among collaborating parties were critical as they tried to define the problem, agreed on recommendations, or designed action steps. In this way they created a negotiated order. Along similar lines, El Ansari and Phillips (1997) found that there was a narrow but deep discrepancy between the views of the professionals and community members as regards the interactions in their CPs.

On the other hand, this study's qualitative findings were not in total agreement with the assumption of the "friendly and democratic" atmosphere. Generally, suspicion between the partners could be a hampering factor to the advancement of the CPs. Power struggles in the form of hidden agendas, win-loose situations, caucus meetings, mistrusts and conspiracy could be signs of an underlying feeling of suspicion [Qte (5.1)]. The reasons for suspicion seemed to be ascribed to a variety of factors. These embraced issues that were related to the different paces of the stakeholders, the individual partner's 'personality', competition for resources, inadequate interpersonal relationships or simply the history of the place and the accompanying political ideologies [Qte (5.2)]. The existent power relations seemed also to be a function of the size and structure of the CP, centralization of authority, politics and political agendas, information power, and personality [Qte (5.3)]. As a result of the power deferentials and struggles, the bargaining and power-retaining strategies employed included a 'divide & rule' system, bribery in the form of opportunities for tours and self-development, struggle fights and faction groups, the retention or use of information and technology as power, where the AI had the underlying 'know how'[Qte (5.4)]. Seifer and Maurana (1998) similarly pointed out that in many communities, the institutions were viewed with mistrust and skepticism, not as partners or assets. This suspicion might explain the importance of community groups and people's organisations of creating pressure on traditionally unresponsive official agencies (Tandon, 1992), while Clark *et al.* (1993) described pressure strategies in action, either to create public pressure or to create leverage power.

Given the power tensions described above, the general impression was that the AI were in control. Their apparent control seemed to be due to their superior knowledge and education, the CPs' constitutions that gave them power to the CPs' financial administration, and at times the physical site of the CP being stationed on the university campus [Qte (5.5)]. In general, self interest of the stakeholders may be a critical factor in interactions [Qte (5.6)].

Decision making

The findings suggested that, on its own, the section on decision making did not contribute significant explanatory power to any of the intermediary measures of the stakeholder groups [Tables (43 - 47)]. The radar graph [Figure (32)] also suggested that the groups' responses were somewhat clustered together in the above average range of agreement, with not as much differences in opinions between them as seen

with other sections of the survey. However, the higher responses to decision making were expressed by the CS and AI and the lower ones by the other two groups.

The survey indicated that the stakeholders agreed in opinions on about 50 % of the aspects connected with decision making processes in their CPs. The groups agreed least that decisions were made only by a small group of leaders. They indicated a higher agreement that it was easy to get their ideas across to the CPs' leadership if they had suggestions and that they felt they had many opportunities for participation in their CPs. The groups also favourably indicated that participation in decision making by CM was high. However, when it came to influencing of decision making by community representatives, the groups agreement was slightly lower [Figure (30)].

In this study, about 70 % of the sample reported that decision making was either effective or extremely effective. However, the survey findings also indicated that about 60 % of the participants viewed the process of decision making in their CP to be either a major or minor problem. The interviews furnished the landscape for understanding these findings [Qte (5.7 - 5.11)], where the impression was that generally, consultation in decision making and co-operation seemed to be deficient in the partnerships, with unilateral decision making sometimes taking place. Of special concern was the influence and leverage that the partnership's director or the academic partner can bring to the decision making process. For instance, some community participants were unclear if it was the partnership's collective board or the partnerships director that was the source of decisions. Some of the reasons behind the lack of consultation included the 'do your thing' culture that may unwittingly sometimes be nurtured in the partnerships in the face of big workloads and tight time frames or simple organisational dysfunction leading to lack of teamwork. Another reason was the professionals' cautious appreciation of the community's' indigenous abilities and skills and the perception that community members lack the necessary knowledge. To help the decision making process be representative, a fair amount of expertise and authority to make decisions of the delegated representatives was advocated for. This was further supported by the survey finding that less than 30 % of SA participants reported that they have full authority to make decisions on behalf of the organisations they represent, which was lower than Gottlieb *et al.* (1993) findings in the USA that 57 % of coalition members had unqualified authority to make decisions on behalf their organisations at coalition meetings. For the group of CPs partipcating in this study, decision making was further hampered by unequal interactions in the meetings, the language and technical jargon that was sometimes used between the members and stakeholder groups and may have an

inhibitory effect on attendance, the hidden agendas, as well as the turnover of members where new faces frequently needed socialisation and updating.

The climate in which a coalition operates might be enhanced when the leadership shared decision making with the general membership (Zuckerman and Kaluzny, 1990), and when no one individual or organization had more authority or controlled more of the coalition's resources than another (Andrews, 1990). Shared decision-making might lead to greater understanding and commitment to the issues confronting a coalition (Brown, 1984). Wandersman (1981) suggested that the degree of member input into coalition decisions may range from advice to control. This study employed a similar range of member inputs ranging from 'no role' to 'approval' when reporting quantitative findings regarding member input in the section on role clarity (section 4.1.4.2.). Regardless of the method used for decision making, encouraging member involvement by formalizing procedures might improve the coalition's ability to sustain itself.

Qualitatively, the study's findings revealed several concerns indicating that consultation and co-operation in decision making seemed to be lacking, with unilateral decision making taking place [Qte (5.7)]. The decision making process could sometimes be dominated by the CPs' director or the AI [Qte (5.8)]. Although a cause and effect relationship was difficult to verify, causes of the lack of consultation included the CPs' culture, a perception that CM had a lack of knowledge, or simple organisational dysfunction and its attending lack of teamwork [Qte (5.9)]. Consequences of the lack of consultation included missed opportunities and duplication of structures [Qte (5.10)]. Examples of the lack of consultation were numerous and in various domains: e.g. CS appointments at the CPs as well as their salary increments, selection of students for bursaries or CHWs for training or CM for educational trips abroad, and programme funding [Qte (5.11)].

Maintaining an open dialogue in the spirit of understanding with an aim to reach agreement on joint values, responsibilities and action plan is not a straight forward case (*Ad hoc* private sector group, 1998). Butterfoss *et al.* (1993) in a review of the literature reported that problem-solving and conflict resolution strategies were less commonly reported as important tools for enhancing the climate of a coalition than were decision-making strategies. Negotiations for reaching a compromise and resolving conflict might be formal or informal, and helped improve the climate when they facilitated future interaction among coalition members. Regardless of the problem-solving approach that was employed, a coalition's operational milieu might be enhanced when the process was defined clearly so that the resulting solutions

did not conflict with the responsibilities of individual participants (Andrews, 1990). Thus conflict resolution might aid coordination among members especially when member interactions were defined and frequent (Hall *et al.*, 1977). The researcher's participant observations of the SA CPs suggested that the CPs had no effective conflict resolution policies in place. Towards the fourth year of a five-year funding cycle, however, one of the CPs had started to feel the need for a more formalised conflict resolution policy and had intiated some steps to adopting one. In parallel, the interview data suggested that the same was also true for a grievances policy [Qte (6.14.4)]. An example of the consequence of lack of conflict resolution policies were some 'unfair' actions that were undertaken by the CPs director in response to a CS member that was resigning. These actions, which included unpaid wages that the CS claimed to have earned, were unaccepted by the CS who seeked the assistance of a lawyer with experience in labour affairs to settle it. As friction between stakeholders involved in joint working was a common occurrence in alliances, a formal conflict-resolution or grievances policy could have been of assistance in these particular instances. A related finding that surfaced from informal talks with participants from one CP revealed that about six CS employees had resigned within the preceding six months, a point that was confirmed when interviewing the same CP's secretary who had resigned a few months earlier.

Mizrahi and Rosenthal (1992) argued that conflict, an inherent characteristic of coalitions, may arise between the coalition and its targets, among coalitions members and staff, and among coalition partners concerning issues such as leadership, diverse goals, benefits, contributions and representation. The "dynamic tensions" that account for conflict are: the mixed loyalties of members to their own organization and to the coalition; and the diversity of interests of its members; the autonomy a coalition requires and the accountability it has to its member organizations; and, the lack of clarity about the coalition's purpose as a model for sustained inter-organizational cooperation. How a coalition manages these dynamics affects its cohesiveness as well as the effectiveness of its programmes. Similarly, Butterfoss *et al.* (1993) reported the need for conflict resolution strategies. Negotiations for reaching a compromise and resolving conflict can facilitate future interaction among coalition members. Conflict resolution may aid coordination among members especially when member interactions are defined and frequent (Hall *et al.*, 1977).

5.9. Quantity and quality of participation: Empowerment

Small, single issue coalitions may tend to adopt a decisions-by-consensus method, but larger, multi-issue coalitions may aim for a working consensus (e.g. two-thirds majority), especially when time was limited (Brown, 1984). Regardless of the method used for decision making, encouraging member involvement by formalising procedures may improve the coalition's ability to sustain itself. The participant observations indicated that in this group of SA CPs, the composition of the Boards are 25 % AI, 25 % HS and 50 % CM. This fact was also publicized in most of the CPs' brochures. However, this study was in agreement with other authors (Brownlea, 1987; Siefer and Maurana, 1998; The Coalition for Healthier Cities and Communities, circa 1998) that rather than the headcount, it was the quality of participation vis-à-vis the issues of professional domination and power struggles that really mattered. Research indicated that when ordinary individuals participated alongside health professionals and project managers, those with intimate knowledge of the system and the greatest professional prestige would have a greater impact on the process than their numbers might otherwise suggest (Van den Heuvel, 1980; Levitt, 1986; McComas and Carswell, 1994). For example, consumer board members have been shown to possess significantly less influence in decision-making than health care provider members, even though virtually no difference existed between the two groups' levels of participation (O'Neill, 1992).

As Brownlea (1987) pointed out, "participation may be seen as a way of broadening the range of inputs to a decision, but in fact may represent a kind of tokenism. The input was received, but very quickly discarded as of little or no consequence. The motions have been gone through. The democratic ideal has been observed, but there was little power behind the participants' input." The expected difference that participation was supposed to achieve might well vary between those drawn into the system to participate and those already in the system and who have ultimate decision-making power. Rather than influencing a decision, participation may provide a platform for the acceptance of a decision made elsewhere in the system. As such, participation may validate or legitimate the *status quo* rather than promote change. Even though they were participants, they might largely be observers; while being in the game they were more reserves rather than players with lack of real access to the decision arena. Participation was ultimately about moving away from a "them and us" mentality towards a partnership which can be of mutual benefit to all parties (Pietroni and Chase, 1993).

Lysack (1995 and 1996) also reported that an avoidance of the participatory process has been observed in the international disability context where rural villagers have refused to participate in community-based

rehabilitation projects. Villagers were suspicious of community participation because of fear that limited medical services would be replaced with something less. From the researcher's own experience in this study, the observation was that when the community was not in agreement with its health project or with the leadership of the project, participation quickly waned away. Shallow/narrow -participation should be explored and understood. The conflict between stakeholders would affect who participated and who did not. Non-participation was not necessarily passive, but an active choice reflecting this conflict. "Symbolic participation" might serve to legitimise low quality care for the poor (Ugalde, 1985). With conflict in the community, involving one organisation may put off others, identifying the project with one sector. From the fieldwork in this study, the researcher further reported empirical evidence that non-participation was not a passive but an active decision in some of the CPs. Over the 24 months of data collection, the researcher experienced two instances where non participation was an active choice. The first was due to discontent with their CP, one small community decided to boycott this investigation as regards providing information and contributing to the survey, even after multiple meetings with the researcher who repeatedly explained his independence of and non-affiliation with any of the CPs or the funding body. The second was related to another CP where a small number of academics from a nursing college decided not to participate in the study, as they had their differences with the director of the CP. The message was clear: an active decision not to participate.

In adopting a sceptical view, the qualitative findings revealed that the style and attitude of the CPs' leadership [Qte 6.13] was pivotal in limiting or conversely encouraging and enhancing the quality of participation of CM members which seemed to be problematic, with unstable attendance and many political affiliations [Qte (4.11.1.)]. There could be a fear of the community becoming "rubberstampers" [Qte (4.11.3.)]. This was in agreement with Madan (1987) who adopted a sceptical view towards community involvement in health. Community involvement could be debased easily and employed to describe euphemistically the manipulation of people by politicians, bureaucrats and technocrats for purposes which were believed to be for the people's good– and may be well so – but which were conceived by these others in a manner that objectified and infantalized people. Community involvement thus becames a part of a social rhetoric, even just a cliché. It was equally dangerous to romanticise the people – particularly the most needy – and have expectations of what they could do for and by themselves which, being unrealistic, only contributed to the shaping of a cynical attitude towards the contribution of people to their own welfare.

The academic institutions were seen to be in power, especially that the CPs' constitutions supported the university for the financial administration [Qte (5.5.1.)]. The participant observations and scrutiny of the

documents supported this view. All finances from the donor body to the CPs and out of the CPs were administered through the academic partner in these CPs. It also seemed that this was a mandate by the donor body [although at a brief conference discussion, the donor body's SA programme director expressed that was not a perquisite from the funding body, but rather it "was what the CPs wanted" (Hlalele M., pers communication, Kenya, 1996)]. On the one hand, if finances were channeled to the CPs via their university component they automatically became exempt of being taxed. That increased the final yield to the individual CP in terms of dollars received. Besides, in this manner a sophisticated accountancy log could be kept, as the university already had the administrative expertise to do it. The finances were then kept in a university's bank account. However, it was not readily apparent who and where the interests of such large amounts of finances (millions of South African Rands) accrued to. On the other hand, this process helped reinforce a view that seemed well entrenched within the community: again, the project was controlled by the academics. Some interviewees suggested that a joint bank account needed be held and be accessible to all parties, as opposed to all financial transactions getting university agreement first before being cashed. This process might have perpetuated a feeling of inequality on behalf the CM side: although they comprise 50 % of the Board, university clearance would always be needed. Was this a real CP? Thus, as O'Neill (1992) has reported, even quite unintentionally, community participation usually ends in consolidating the power of professionals, rather than achieving the ideal of broad-based local involvement.

Lindsay and Edwards (1988) reported that "real" coalitions were the mutual creations of co-equal agencies involved from the beginning in the ground floor formation. Along a somewhat similar line, Panet-Raymond (1992) also identified two models of collaboration on a continuum from real partnership (*partenariat*) to paternalism (*paternariat*). Real partnership, he maintained, was defined as a relationship, formal or informal, between equal but different partners. The other model of collaboration was paternalism which was usually planned and imposed (Panet-Raymond, 1992). In this model, the contributions of each party were obviously different though often considered as mutually essential. But there was a dominant party, which recognised the community and its groups only as they serve its own agenda and policies. This was not a relationship based on mutual interdependence, but a one way relationship in order to complement the public sector's programmes which it could not implement by itself. Budgetary and political motives were obscured by a patronising community that rationalised this form of so-called partnership. Here a key agency/ies might often keep the leadership by imposing their agenda and perspective. Their sensitivity to community dynamics and culture was not great and their acceptance of criticism was very limited. There may be distrust and disregard. There was no real dialogue and therefore, no real partnership.

Empowerment

Related to the quantity and quality of participation was the process of empowerment. Hawks (1991) undertook a concept analysis of power and defined it as 'the actual or potential ability or capacity to achieve objectives through an interpersonal process in which the goals and means to achieve the goals are mutually established and worked toward'. Power could be both negative and positive. The positive aspect has been defined as 'power to', and the ability to be able to help people, while the negative aspect has been defined as 'power over', and was associated with forcefulness. The oppressive use of professional power has been an area of debate and investigation. Wallerstein (1992) reported that in the public health field, empowerment has traditionally been defined, by its absence, as powerlessness. Adding empowerment strategies significantly equalized professional/ consumer relationships (Biegel, 1984) and increased people's participation in health activities (Pilsuk *et al.*, 1982).

As regards to 'power over', the qualitative findings furnish many examples. The findings reported and discussed earlier in the section [4.2.3.6.] on the leadership skills revealed some evidence that oppressive styles and non-sensitive attitudes of the CPs' coordinator or director could have derogatory effects. Naturally, this would work against empowerment of the people. The researcher's personal observations supported that for instance, in one CP, the coordinator exerted much political and tribal leverage when the post of the CPs' director became available. When the broader community expressed that it would be more appropriate to appoint a director who was not from that geographical location so as to avoid any bias, the coordinator, backed by an immediate constituency of women from the same national political party as the coordinator, arranged a form of 'demonstration or protest' against any candidate that was not from the CPs' geographical location. There were threats that they would make the new candidate's life "hell". In the context and history of aggressive violence in SA, this was sufficient for candidates to back out, thus perpetuating the abuse of power and subsequently, loss of hope on behalf of the broader community of both ownership and that change and empowerment were eminent. As the coordinator and his supporters were all from one political party, this was also an example of the politicisation of a CP, where the broader community perceived that this CP was intended for participants from a particular political party. Informal discussions with the respondents also uncovered some concerns relating to this issue.

It need be noted that empowerment need not lead to a zero-sum gain, with one group having to give up power. Empowerment could expand power as people mobilize to control their personal and community

lives (Swift and Levine, 1987). However, Braye and Preston-Shoot (1995) concluded that there was a powerful legacy of professional socialization that might foster barriers to empowerment. This might include, as well as initial relative powerlessness of users of services, professional fears of loss of status and power, fear of change, lack of organizational support and lack of trust on the part of both users and professionals. The existence of such legacy meant that changing practice would not be easy.

The section [4.2.3.6.] on human resources development also revealed the community's concerns of including more CM in the various training schemes that the CPs subscribed to. This gain of skills was one form of empowerment, for according to Gibson (1991), empowerment was seen as " a process of helping people to assert control over the factors which affect their lives. This process encompassed both the individual responsibility in health care and the broader institutional, organisational or societal responsibilities in enabling people to assume responsibility for their own health". Gibson stated that empowerment is a positive concept, addressing people's strengths, rights, abilities, rather than deficits and needs.

The professionals too needed to know how to empower people. This required a distinct sets of skills that these professionals did not posses by nature of their academic training, but fortunately could be taught. Gelmon *et al.* (1998) emphasized that new health professionals needed a different set of competencies for practice. For instance, the findings suggested that in these SA CPs, it was felt that power was with the academic institutions. As Barnes and Walker (1996) stated, authority deriving from professional knowledge was balanced by authority deriving from experiential knowledge of the user, thus rendering empowerment a collaborative process. As power was located in the expertise of the health care professionals, self understanding was a pre-requisite for empowering others. Health professionals therefore needed skills in teaching and counseling and in coordinating multi-disciplinary teams in order to facilitate empowerment of others. Similarly, Eng *et al.* (1992) brought attention that an important caveat, however, related to leadership in the process of community empowerment. For many health care professionals, there was an unstated belief that their education prepared them to assume leadership roles in a variety of settings. This assumption had great potential to be damaging in the process of creating community competence and empowerment. For PHC providers and managers to actually engage in the dynamics of the community empowerment, a great deal must change in the usual patterns of education and practice.

Rappaport (1981) reported that all partners must be committed to investing themselves and their resources in the effort and to strengthen existing capacity to cope with basic needs in order to grow and

develop in all dimensions as individuals, families and communities. Similarly, Hawe *et al.* (1997) reported that capacity building by health promotion workers, to enhance the capacity of the system to prolong and multiply health effects thus represented a 'value added' dimension to the health outcomes offered by any particular health promotion programme.

This study's findings also indicated that empowerment of the communities was a learning process that required clarity, time and pace [Qte (1.2)]. This was in agreement with Kieffer (1984) who maintained that empowerment was labor intensive, as the significant transformative transition could only grow from long-term engagement. In becoming empowered, he reported, individuals were not merely acquiring new practical skills; they were reconstructing and reorienting deeply engrained personal systems of social relations. As such, it would be frivolous to pretend that there could ever be developed a "short course" in individual empowerment. It was not simply the issue of time, but more importantly the question of practice. Empowerment was not a commodity to be acquired, but a transforming process constructed through action. Balcazar *et al.* (1990) reported that a skills training program conducted with members and chairpersons of an advocacy coalition resulted in increased reporting of issues by members, improvements in the chairperson's ability to conduct action-oriented meetings and overall improved effectiveness of the consumer organisation. Skills training should be based on a review of the relevant literature and external policies that might affect the coalition's operations (Andrews, 1990; Cohen, 1990).

As regards the amount of CM who were actually working in the CPs, the number varied across the examined sites. In one CP, there was only one community member who was a paid employee of the CP acting in a capacity of core staff. In yet another, the number of CM employed as community health workers was much higher. Wallerstein (1992) suggested that the concept of organizational empowerment comes from democratic management theory. In an "empowering" organisation, individuals assume genuine decision-making roles and hence become empowered through their work.

When inappropriate solutions and technologies are imposed on the people, they might lack skills or resources to bring about expected change. Furthermore, acceptance of this sense of powerlessness was assumed to be manifest in consistent trends of declining voter participation, particularly among lower income and economically displaced population. It was also seen as evidenced in the decline of society's "mediating structures" and the pervasive "erosion of social competence". The goal of empowerment therefore was to enable communities to analyze their situation and reality and to efficiently address root

causes of their situation to become less dependent on outside resources, personnel, services and regulations.

As regards outcomes of the CPs, Table (20) and Figure (31) suggested that it was the CS and the CM who perceived that the CPs' activities would increase community involvement in health. A related question was whether to analyze empowerment as a process or outcome. As Wallerstien (1992) has suggested, empowerment was an interaction between both concepts. Empowerment implied group affiliation, community bonding, and collective action, not just an individual measurement of self esteem. Empowerment therefore was not a fixed outcome of objectively changed conditions, but rather an ability to judge situations and determine whether the conditions are appropriate to demand change (Zimmerman, 1990).

The problem of measurement of empowerment has also been brought to attention. Wallerstein (1992) reported that the casual use of the terms "powerlessness" and "empowerment" has led to a lack of theoretical clarity and measurement problems. Measurement of community-level empowerment and its effects on health were still at an early stage. Bearing this difficulty in mind, in this study, the researcher measured the perceived effectiveness of the empowering process across the stakeholder groups. The study's findings [Table (34) and Figure (56)] suggested that 70 % or more of the AI and HS viewed that the CPs' activities were either effective or extremely effective in helping the community emerge as a political force on issues of health. The balance between the short term and long term objectives and how they related to the broader definition of health within the context of development might not be a straight forward one to strike.

5.10. Institutionalization, Sustainability & Dependency

Institutionalization is generally considered to be the final stage of a diffusion process, during which programme innovations "settle" into organizations (Beyer and Trice, 1978). It is increasingly recognized that many health promotion programmes will not become institutionalized, regardless of how theoretically sound, well implemented, and effective they may prove to be (Goodman and Steckler, 1987-88). The organizational innovation literature (Berman, 1978; Glaser, 1981; Miles, 1983), and that pertaining to community health development (Simmons, 1976), also illustrated that successful programme implementation does not necessarily assure long-term programme viability.

Knott (1995), however, was concerned with sustaining the Kellogg community-university partnerships once the Foundation's funding and programme support discontinues. He argued that past experiences suggested that many demonstration projects failed to continue once the sponsoring agency withdrew initial funding and other support, and proposed that building sustainable partnerships depended on much more than producing successful individual projects.

This study's findings suggested that to start with, the term 'sustainability' needs be defined and agreed upon [Qte (7.1)]. This was in direct support to Shediac Rizkallah and Bone (1998) who reported that several terms were used to describe the concept of continuity. While these terms tended to be used interchangeably, they were not synonymous. For instance, the definitions of sustainability advanced by leading development agencies emphasised health benefits as being at the heart of the sustainability process. If that was the case, then modifications in populations' health habits were only slowly achieved through education and social change, hence the need for an environment in which change was supported and reinforced (Resnicow and Botvin, 1993; Prasad and de L Costello, 1995). Educational messages and other intervention activities needed to remain in place for new generations of individuals to be exposed to them (Shediac Rizkallah and Bone, 1998).

In contrast, if the emphasis in 'institutionalisation' was the persistence of the programme itself rather than on the benefits it delivered (Steckler and Goodman, 1989; Yin 1979), then it may carry the connotation of inflexibility and adoption of a programme in toto (Shediac Rizkallah and Bone, 1998). To this the researcher's observations of the academic partner in the CPs verified that maximum expansion of the innovation has not been accomplished yet, as many departments and training institutions still needed to get on board the CPs for the betterment of HPE. A related issue was how far had the innovation or health promotion intervention been embedded into the participating agencies i.e. how much has it been institutionalised and routinised into their day-to-day activities?. Has, the innovation and the host agencies both sufficiently changed to accommodate each other? Has the innovation/ intervention reached its maximum expansion within its host organisations (Goodman and Steckler, 1989)? Knott (1995) (*vide infra*) has suggested several indicators to help assess how much the academic partner has changed to adopt the innovation. Green (1989), commenting upon a visit to a project ten years after its initiation, however, questioned if institutionalisation was the proper goal of grant-making, drawing attention to the need to sustain the benefits on the ground rather than maintaining the paperwork in the participating institution.

Finally, if sustainability referred to building the capacity of the recipient community, then the emphasis was on the process occurring at the level of the community as whole. In this case it is related to the social capital and the empowerment of the beneficiary communities. Here, Robertson and Minkler's (1994) definition provided insight: the 'nurturing of and building upon the strengths, resources and problem-solving abilities already present in individuals and communities'.

Planning for sustainability needed to start early, so early attention to a shared vision from the initiation coupled with investing resources in the CPs is critical [Qte (7.2)]. It was also related to the continuity of the CPs' programmes [Qte (7.3)] as well as of the Core Staff [Qte (7.4)]. Unconducive factors of sustainability included the recruitment of large numbers of CS which could lead to dependency of the partners and the CM on them, lack of commitment, lack of capitalising on already existing structures, an unskilled CM workforce, not planning early for sustainability, and a 'legacy of dependency' due to lack of guidance from local CPs models [Qte (7.5)]. On the other hand, the conducive strategies that could have contributed to sustainability included skills training of the CM, secondments of posts from the government, 'absorption' of CS by the corresponding partners, seeking alternative donors, sustainability in the finances and accountancy administration, networking and the settling down of the innovation (P'ship) in the host institutions or strategic placement of itself in the national health departments and policy frameworks [Qte (7.6)].

Taken together, the above findings reinforced the general impression that there seemed to be a few strategies that accommodated and addressed the issues of continuity. The full time employees that a CP usually hired to get jobs done were frequently the first to leave the alliance when the donor funding ended. This frequently resulted in a sharp "drop" in the CP's activities, sometimes to irretrievable levels. Early due thought as regards this group seemed to pay back later. At times they were 'absorbed' into the different partners agencies. On other occasions the appointments were kept as joint appointments between two or more participating agencies. Yet on other occasions a CP might, desperately, search for an alternative donor body who might have more interest in long term delivery of partnerships as opposed to the shorter-term demonstration projects. Shediac Rizkallah and Bone (1998) have also brought the same point to attention when they reported that specifically, programme staff, community coalition members and other representatives from surveyed community health promotion projects identified deficient funding, and the need for diversified and reliable long-term funding base as obstacles to achieving current goals and objectives.

However, as regards programme continuity, the stakeholders of the South African partnerships were examining several approaches and proposed some guidelines. They were engaging in several parallel and non-mutually exclusive conducive strategies that could together contribute to programme sustainability (El Ansari and Phillips, 1998). These included skills training of the community members and the professionals in the form of seminars and workshops locally and abroad as well as communication with sister partnerships through the South African community partnerships network or international collaboration with other same-donor funded partnerships in a preparation for complete community ownership when the funding ends (MUCPP, 1995). This capacity building and transfer of skills was critical, and as Goodman and colleagues (1993) have higlighted, if community health promotion projects are to be successfully planned and implemented, a transference of professional expertise to community members may be necessary through more extensive workshops, mentoring, and other training opportunities. Similarly, Bracht *et al.* (1994) proposed that participation by community leaders in programme development and implementation would lead to higher levels of perceived programme ownership and increased chances of programme continuation by communities after the period of external funding ended.

Other options that were aimed at enhancing continuity were the secondments of posts which were to be stationed at the partnership premises but financially supported from the central government, or the absorption and integration of the partnerships' core staff into the corresponding partners or participating agencies. Parallel avenues that were examined were the sustainability of the finances and accountancy administration of the partnerships by having all the books kept and maintained by the university partner, where they are incorporated into the finance and accounting systems of the academic partner. Other alternatives focused on seeking alternative national or international donors who might show interest in longer-term funding or opportunities for running the partnership programmes in a financially self-maintaining entrepreneurship fashion thus allowing resources to be recovered and ploughed back to make programmes sustainable. The proposition was that running the programmes like a business decreases dependency on outside sponsors, and would not press or force people into structures that they are not ready for. Furthermore, emphasis was attached to wide networking and the settling down of the innovation (partnership working) in the host institutions (stakeholder organisations) or its strategic placement in the national health departments and policy frameworks. Taken together, these aspirations and strategy options pursued by the South African partnerships address the notion of "built-in-ness" of the innovation into the participating agencies (Miles, 1983). They are in line with Goodman and Steckler (1989b) suggestions of the necessity of integration of the health promotion programme within the

subsystems of its host organizational environment, through developing an organizational niche for the programme, a mutual adaptation between the organization and the innovation. The observation was that, for this cluster of CPs, although the variety and multiplicity of the proposed solutions for continuity might appear to be piece-meal, with various shreds of partnership activities being internalized into different agencies, the overall strategy is nevertheless in line with Shea *et al.* (1996) indications that an entire programme may be continued under its original or an alternate organisational structure, parts of the programme may be institutionalized as individual components, or there may be a transfer of the whole or parts to community ownership. The critical issue was that when local health agencies accept funding for community health development programmes they need to consider the adverse impact that termination might have on communities and agencies alike. Yin (1979) asserted that programme failure was more costly after it was fully implemented since resources have been fully mobilized, career decisions have been made at the expense of other options, and community trust has been extended.

The issue of the presence of core staff in the CPs itself held lessons. For instance, in the context of the USA, Gelmon *et al.* (1998) pointed out that the sites that were actively led by faculty who took visible and direct hands-on responsibility for the projects were making the most progress toward programme goals. Sites that relied on administrative staff to do most of the project management were less successful. However, some of these 'administrative' individuals were extremely engaged in the community (often because of their own professional backgrounds), and had been integral in the accomplishment of their respective sites. From the participant observation across the five SA sites, the researcher supported Gelmon *et al.* (1998) views: the presence of a large number of full time paid employees to 'administratively' run the CPs might backfire and be partly responsible for the lower involvement rates of the true professional partners, the AI and HS. By definition, CPs do not imply the presence of third parties (CS) to aid in the running of the projects and programmes. Although CS brought with them expertise and experience, on the long term, they might sometimes be seen to induce inertia in the 'true' stakeholders, as there was someone available to get the job done. This might perpetuate dependency of the true stakeholders on the CS, with its attending potential disadvantage later in the life span of the CP when it came to sustainability. Figure (9) helped to clarify the point: about 10 % of the whole study sample were CS, but this percentage varied across the CPs, where at one CP it was less than 5 % and at another more than 15 %. Given the monetary costs that this group exhausts, an alternative line of action would have been channelling those monetary resources to administrative staff from the true partner groups. This would have added advantages: the routinisation and standardisation of the operational aspects of the CPs as they became embedded in the structures and the daily activities of the hosting

agencies and organisations, as well as the training and capacity building of those individuals who would have been involved in the CPs. Both of these measures could have in turn contributed to sustainability and the persistent smooth continuity of the programmes, as the Foundation's seed funding ended and the participating institutions slowly take over full responsibility and funding. In this manner, the transference of the intervention to the host agencies starts early and continues persistently in an incremental manner through all the stages of the implementation phase, so that by the end of the funding cycle, the innovation could have reached its maximum expansion within its host institutions.

Another observation was the frequently overlooked component of time frames - CPs were not created overnight but rather they evolved over time, so time frames and funding cycles needed to allow for a gradual and slow process. The need to do things *with* the community as opposed to doing things *for* the community, dictated that time frames and donor cycles needed be realistic. Partnership work is slow and time consuming, and had to proceed step-by-step at the pace of the participating agencies, many of who already had a heavy workload. Furthermore, empowerment of the communities is a learning process, and similarly, development is a lengthy cause and inclusion of the relevant parties is usually build on incrementalism and gradualism. The time pressure that might be exerted on a CP and the need for timely reports and evaluations by donor agencies may work against the best interest of an alliance trying to gradually and cautiously find its appropriate niche in the participating health agencies so that it gets institutionalised. In relation to dissemination in health promotion, King *et al.* (1996) have also eluded to parallel 'donor pressure' findings when they pointed out that premature dissemination could result from pressure by funding agencies to sell early "success stories" to justify the large expenditure of funds on demonstration projects.

Partnerships needed time to build trust and confidence between the diverse partners, and the interaction of all these effects is an evolutionary process, so stakeholders better be committed for the long haul. The CPs under study were on a five-year funding cycle. This duration of time might have been sufficient to start the initiative but obviously not to complete it. Besides, some of the CPs had an initial time-lag of about a year before they qualified for full funding. This 'latent' period, when present, excited an initial wave of participation which frequently and quickly withered away, adding more delay to the already slow-moving process of harnessing the participant agencies into one direction for synergism and impact. Elsewhere (El Ansari, 1994; El Ansari and Phillips, 1998), the researcher has cautioned against the effects of time lags and delays, as well as 'frozen' periods in the initial stages of funding on programme initiation and the maintenance of the initial drive of eager community members and organisations who needed something they

could 'get their teeth into'. In parallel, Janz *et al.* (1996) found that adequacy in duration of funding and the ability to locate additional funds were reported as factors that impeded intervention effectiveness by staff of almost half of 37 AIDS prevention and service projects nation-wide.

In relation to CPs HPE, Knott (1995) argued that to build sustainable projects in large-scale organizations required changing the organization's rules, incentives, rewards, and culture. It might also require new structures and personnel. Since the CPs still received Foundation funding, it was too early to tell how significantly the universities had changed. Critical indicators might include: required courses in the curriculum; number of regular faculty involved in the educational programme; merit incentives for the faculty to teach in the programme or to operate practice plans in the partnership sites; changed rules for practitioners in the health center to participate in university departments as community faculty; new hiring resources allocated to primary care community teaching areas; and, on-load teaching for community participation by regular faculty.

Demonstration project grants tend to emphasize the development of conceptually sound and well implemented programmes for replication elsewhere. This "multiplier effect" entailed first demonstrating implementation effectiveness at the original site, and then disseminating proven programmes to other communities. One irony of this approach, was that after grant termination, programmes worthy of replication could fail to thrive at their original demonstration sites. Thus a policy weighed toward a multiplier effect could cause institutionalization to become a latent concern for the implementing organization (Knott, 1995). That is, long-term survival was less important than effective programme implementation. Focus on deep implementation with no attempt to build a political constituency for a programme could hinder further institutionalization (Goodman and Steckler, 1987-88).

In general, the impression was that the HS seemed to be the group who viewed the long term viability of their CPs the least. This was supported by four separate pieces of evidence relating to multiple aspects of sustainability: sustainability as an outcome and the certainty about the CPs' future existence; sustainability in relation to the organisational barrier of the availability of funds; sustainability in relation to the effectiveness of the CPs' fund raising operations, and sustainability as a product of formalised rules and procedures and long range plans beyond the donor funding.

First, in relation to certainty about the CPs' outcomes, the survey responses indicated differences between the groups on two related issues, where the CS and CM perceived an above average certainty

that their CPs would exist beyond Kellogg funding and that their organisations or community were ready to implement permanent structural changes to sustain the CPs' goals [Table (20) and Figure (31)]. On the other hand, the AI and HS exhibited the lowest levels of the groups, which was of average certainty about both the issues.

Second, as regards the availability of funds as an organisational barrier, the proportions of the HS and CM (above 75 %) who viewed it as either a major or minor problem were significantly higher than the proportions of the CS and AI [Tables (32 - 33) and Figure (54)].

Third, and in relation to the effectiveness of the CPs' operations, when it came to fund raising, more than 50 % of the sample of each of the CS, CM and AI viewed their CPs to be either effective or extremely effective in fund-raising, while again less 50 % of the HS respondents subscribed to this view [Table (34) and Figure (56)].

Fourth, when inquiring about the rules and procedures, the proportion of respondents from the CS group was significantly higher when the groups were queried about if their CPs had a long range plan beyond Kellogg funding, where again the HS reported the lowest proportion [Table (22) and Figure (33)].

As reported in Table (32), the availability of funds was viewed by about 75 % of the sample to be a either a major or minor problem in their partnerships. This empirical finding provides support to Gottlieb *et al.* (1993) who indicated that the problem of availability of funds was reported as either a major or minor problem by at least 49 % of the 52 'Smoke Free' coalitions that they examined in the USA. In parallel, the findings suggested that other areas of concern were the availability and interest of community volunteers, as well as the professional staff turnover, where these were reported by about one third of participants as major problems. It was feared that lack of funds as well as availability and turnover of partnership participants may conspire against the long term viability of the alliances. With the end of the initial five-year funding cycle that the CPs were on coming closer, the continuity of the projects might be subject to some instability. Sustainability of the partnership projects need to be thought about early by the participating agencies, as maintaining a coalition is a dynamic process that develops through the linkages between the member organisations and the coalition in a process that supports the life of a coalition, in order to keep it from declining and to sustain it against any opposing forces (Roberts-DeGennaro, 1986b). It is the attainment of long-term viability and integration of innovations in organizations (Goodman and Steckler, 1989b). As Knott (1995) has pointed out, an important question to

ask was 'what are we trying to sustain?', while similarly, Shediac-Rizkallah and Bone (1998) brought attention to the notion that what was meant by sustainability yields different approaches due to the multiple perspectives and the conceptual ambiguity.

Goodman and Steckler (1987-88) suggested that where programme ownership was shared throughout the programme, institutionalization was more likely to occur. When networking was extensive in implementation, but when shared ownership with allied agencies and the community was low, or as a result of ideological constraints, passive instead of active support for programme institutionalization may result. Although a basic tenet of community health development was that community involvement was a necessary prerequisite for community-based programme advocacy and institutionalization, and community support for the programme's activities could be high, project ownership might not cross over from the professionals to the community or other agencies. Such a lack of transference of ownership to the community and other social agencies might result in little grassroots support in the community to lobby for project continuance later on (Goodman and Steckler, 1987-88). Innovative programmes were more likely to be maintained when they become an integral part of the host organisation (Rogers, 1983; Steckler and Eng, 1992).

Dependency

If it is reasonable to assume that sustainability after the donor support ends could be inversely proportional to the dependency created during the 'seed funding' stage of the demonstration and implementation of innovation, then generally, dependency appeared to be related to several aspects. These included incomplete development of the people or environment, recruitment of CS, the policy on student bursaries and the issue of income generation projects [Qte (7.7)]. Related to these issues were the policy of the donor agency, including the donor cycles, funding strategies, pressure by the donors, an appreciation that there were no blue prints for CPs and the amounts of funds donated [Qte (7.8)].

Although not all coalitions have the resources to employ staff, staff could reduce the burdens placed on a coalition membership. Butterfoss *et al.* (1993) suggested that when a coalition employed staff, it was likely to be more harmonious if staff and members were clear about their respective roles. Similarly, this study finding of a high level of the CS that could contribute to an 'inertia' of the *bone fide* partners, as well as lower levels of involvement for the three "true" stakeholders [Figure (34)] supported Herman *et*

al. (1993) findings that in coalitions with no permanent staff, heavy reliance rested on the members to coordinate and perform all coalition activities.

5.11. Barriers to participation

Four types of barriers must be addressed by every coalition: barriers of organisation, of attitude, of vision and of ignorance (Hagebak, 1982; Allensworth and Patton, 1990). Barriers of organisation included those imposed by agency structures and systems, legal and regulatory systems, existing reporting systems, limited funding, time constraint, lack of common vision and personnel turnover. In parallel, Eng *et al.* (1992) also reported that it was essential that health care professionals had investment in the success of the community, and needed to remove the barriers that come between them and members of the community, while El Ansari and Phillips (1997) found that the professional staff and community members expressed a narrow and shallow discrepancy in their views of the organizational barriers in their CPs.

This study's findings suggested that, on its own, the section on organisational barriers contributed significant explanatory power to the intermediary measures of satisfaction, outcome efficacy, activity level and educational activities for the various stakeholders and the whole sample [Tables (43 - 47)], a feature not reported by Gottlieb *et al.* (1993). On the other hand, personnel barriers contributed significant explanatory power to the intermediary measures of satisfaction, outcome efficacy for the professional staff and to activity level and perceived effectiveness for the community members [Tables (43 - 47)]. This was in direct agreement with Gottlieb *et al.* (1993) who also reported that personnel barriers to be positively related to both perceived coalition activity and effectiveness.

For instance, Figure (54) indicated that goal setting, marketing of individual partner's materials and leadership from national level were reported by at least 45 % of respondents not to be a problem. This was in partial agreement with Gottlieb *et al.* (1993) who reported that goal setting as well as materials marketing were rarely viewed as barriers. This study's three most commonly reported problems in CPs functioning were related to availability of funds, lack of participation and competing priorities among partners where about 30 - 50 % of the sample perceived them to be a major problem in their CPs [Table (32)]. This was also in agreement with Gottlieb *et al.* (1993) who found that availability of funds and competing priorities among organizations were amongst the most commonly reported organisational barriers. However, this study's findings differed with those of Gottlieb *et al.* (1993) in two aspects. First, issues that were not a problem in their study but were seen as problematic in this study: they reported that

decision making was rarely viewed as a barrier but this investigation reported it as ranking fourth in a set of 16 organisational barriers that were investigated, where about one quarter of the sample perceived it as a major problem. Second and conversely, issues that were a problem in their study, but did not emerge as a significant barrier in this investigation, were coordination of activities and differences in agency service areas, where at least 40 % of this study's sample viewed both not to present a barrier in the CPs.

As reported by others and seen in this study [Tables (28-29) and Figure (47)] professional staff priorities and turnover, together with volunteer availability and interest were common barriers for coalitions to address (Lindsay and Edwards, 1988). This investigation reported that the barriers of PS priorities and volunteer availability and interests were percieved to be a major problem by over 30 % of the whole sample across the five CPs under investigation. These findings were in agreement with Gottlieb *et al.* (1993) where key areas of concern were related to staff and volunteer functioning. Availability of staff and volunteers for the project as well as staff priorities ranked highest amongst the reported personnel barriers and were reported by at least half the respondents. However, as this study reported higher percentages for those three barriers [perceived as major or minor problems, Table (29)] than those of Gottlieb *et al.* (1993), this suggested that for the SA CPs, these personnel barriers were more of a problem than in their US coalition counterparts.

The barriers of staff availability, conflicting priorities and turnover reported by Gottlieb *et al.* (1993) and confirmed in this study have the potential to cause interpersonal tension among agency representatives, staff burnout, weaknesses in programme delivery and a lack of continuity in representation. With high staff and volunteer turnover, the coalition would be constantly socializing new members, making the sense of 'we' (Hord, 1986) difficult to achieve. Hagebak (1982) provided useful suggestions for documentation of agreements and provision of a 'history' of the coalition, that would help familiarize new staff and volunteers with past efforts.

In parrallel, some newly hired CS members or representatives from the AI or the HS providers who were assigned to work on the CPs might have not had a clear sense of two issues: where the CP was going, and their agency's position on various issues. Thus they might have been reluctant to commit their agencies to specific activities. It need be noted here that this was also related to their authority to make decisions on behalf the organisations they represented, a point that was discussed earlier in the section on representation [section 5.5.; Table (25), Figure (44)]. Gottlieb *et al.* (1993) reported that staff resource issues were viewed by respondents as more of a problem than volunteer resources. They also concluded

that this probably reflected the much stronger role staff played to carry out the primary task of coalition functioning, rather than a high level of continuity in volunteer participation. Although this study's findings agreed to a great extent with those of Gottlieb *et al.* (1993), the researcher was reluctant to suggest that this was also the case with the SA CPs. In these CPs, the impression was that both staff and volunteer resources were equally viewed as problems. For instance, Figure (47) suggested that the personnel barriers that were viewed to be major problems by this study's respondents exhibited an equal spread on issues related to staff and volunteer resources. The only exception was related to interest in the CPs' activities, where it was viewed by the least number of participants to be a major problem. However, in this study, as Table (47) suggested, it was the CM who least viewed the staff and volunteer resources to be personnel barriers to the CPs. Having said this, it need be noted that in spite of the CM being the least, their levels were around the 50 % level. Herman *et al.* (1993) also reported on the barriers to involvement in a family planning coalition, where the most frequently mentioned major barrier to coalition involvement was the limited time available. This report has discussed the issue of available time under costs of participation (section 5.6.), but in relation to interest in CP activities, this study's findings agreed with Herman *et al.* (1993) where both studies observed it to be the least of the barriers, although this study reported a slightly higher percentage than theirs (16 % vs. 10 %) of the sample who reported the lack of interest or no vested interest in the coalition as barriers to involvement.

Because of the barriers experienced in staff and volunteer availability and turnover, it is essential that coalitions attend to issues of group formation and identification (Gottlieb *et al.*, 1993). The acceptance of the need to address and perform group maintenance tasks of role negotiation, relationship building and developing group ownership of the issues and goals are important to the long term viability of any coalition. Specific suggestions for developing this aspect of the coalition include rewarding members, staff and volunteers; the creation of a network through which coalitions can share their successes and help others; and, the recognition and discussion of organisational constraints and differences (Schindler-Rainman, 1977 and 1981).

Taken together, the quantitative and qualitative findings that emerged from this study suggested some barriers to the partnerships' functioning that could benefit from further attention. According to Hagebak (1982) and Allensworth and Patton (1990), four types of barriers are addressed by every coalition: barriers of organization (e.g. those imposed by limited funding, personnel turnover and existing reporting systems), of attitude (e.g. political considerations, turf guarding and negative past experiences), of vision (e.g. absence of adequate models) and of ignorance (e.g. lack of awareness of problems and potential

solutions). Similalry, Habana-Hafner *et al.* (1989) suggested the critical areas of the degree of decentralisation of authority, the nature of leadership, decision making and communication. In line with Hagebak, Allensworth and Patton, and Habana-Hafner *et al.* frameworks, in this inquiry three broad areas that encompass the essence of the barriers under study emerged and were identified:

(1) Consultative decision making processes, interactions, and power relations as both the organisational barriers of decision making and competing priorities ranked high as obstacles, where at least 65 % of participants perceived them as either a major or minor problems obstacles, together with issues related to assumptions of leadership by a lead agency and partnership vs agency credit for activities, where 40 - 50 % of participants perceived them as either a major or minor problems [Figures (54 - 55)].

(2) Sustainability issues, as on the one hand the availability of funds and partnership vs. organisational fund-raising ranked high among the organizational barriers examined [Figures (54 - 55)], while simultaneously the issues of time, interest and availability of community volunteers as well as professional staff turnover ranked high among the personnel barriers [Figure (47)]. These were further supported by the finding that fund-raising was perceived by about 45 % of respondents to be either ineffective or extremely ineffective [Figure (56].

(3) Communication and communication systems: about 60 % of respondents perceived communication to be either a major or minor problem in their CPs [Figure (54)], while about one third percieved communication between the partners to be either ineffective or extremely ineffective [Figure (56)]. Consequently, about half the sample viewed the coordination of community volunteers to be either ineffective or extremely ineffective [Figure (56)]. Finally, in view of the importance of communication as a critical domain contributing to effective partnership functioning, as identified in the partnership literature (Butterfoss *et al.*, 1993; El Ansari and Phillips, 1997; Popay and Williams, 1998; Zakus and Lysack, 1998).

Although Zakus and Lysack (1998) highlighted that one of the factors leading to viable community participation in health was the recognition of the right and duty of people to participate in public and community affairs, the power differentials are at their greatest between professionals and lay people, and between formal organisations and community groups (Popay and Williams, 1998). Mackay and colleagues (1995) identified, barriers of perceived occupational status and of occupational knowledge and barriers of fear. Whether the domination was from the professionals' side or the fear was from the

community's side, these barriers do not encourage working and planning as part of a team. Public participation is perhaps the most challenging aspect of health partnerships, with no unitary 'public opinion' but a multitude of voices (Popay and Williams, 1998). Collins and Stein (1989) have highlighted that participation can mean anything from manipulation to user control, including non-participation, varying degrees of tokenism or degrees of power (Forbes and Sashidharan, 1997), while Bloxham (1996) pointed out that good interpersonal relationships, together with respect for different professional roles, are important elements in effective inter-agency collaboration. Power disparities and concerns about preserving an institutional power base also pose real obstacles to collaboration. Parties will be reluctant to collaborate if they are at a disadvantage to adequately represent their interest or if they believe their interest will be deemed secondary to more powerful ones (Gray 1989). In the South African context, the obstacle of historical barriers and past prevailing socio-economic and political conditions (Zabala, 1992; Callinicos, 1993) was undergoing a process of reconciliation, as relationships characterized by long-standing bitter adversarial interactions among the parties often create insurmountable obstacles to collaboration (Gray, 1989). Within this domain, Schindler-Rainman (1977 and 1981) brought attention that the organisational constraints and differences need be recognized and discussed, while Gottlieb *et al.* (1993) reported that organisational barriers significantly contributed to explaining the perceived effectiveness and activity level of coalitions. This study's findings furnished further evidence in support of Gottlieb and colleagues (1993).

Often the critics of collaboration assail it as idealistic and naive (Fiorino, 1988), and that making the sense of 'we' is difficult to achieve (Hord, 1986). Partnerships need to attend to issues of group formation and identification, relationship building and developing group ownership of the issues and goals for the long term viability of the collaborative effort. In many instances, however, the outcomes of collaboration have often far exceeded the expectations of any of the parties. On the one hand, Fiorino (1988) pointed out that the positive outcomes include: greater perceived influence over decision making and greater flexibility in inventing solutions; opportunities to educate other stakeholders; improved communication among parties and access to information; and, higher quality solutions than those expected from conventional processes. Conversely and on the other hand, Hagebak (1982) and Allensworth and Patton (1990) cited nearly the same domains as the four types of barriers are addressed by every coalition (e.g. limited funding, personnel turnover and existing reporting systems, political considerations, negative past experiences). In agreement with Allensworth and Patton (1990), Habana-Hafner *et al.* (1989) similarly cautioned about barriers like the degree of decentralisation of authority, the nature of leadership, decision making and communication.

The apparent controversy between the these two polars seems more imaginary than true. It is the researcher's interpretation that both groups of authors were referring to the same issues, but with a single difference: the point in time of the life of the collaborative effort when the issue was examined. It is feasible to cross the apparent controversy if the issues raised by the two groups were viewed in a chronological and time-series fashion, where today's barriers and obstacles, if challenged and crossed, are rendered tomorrow's positive outcomes. It is important to note that the outcomes that Fiorino (1988) refered to are not straight forward, guaranteed, immediate or readily available to a partnership, and as this study has shown, it was the very same positive outcomes that Fiorino (1988) described that could function, early in the life span of the partnerships, as barriers requiring prompt attention before they become outcomes. Only after their resolution as barriers could they be viewed as positive outcomes. The impression was that in the case of the cluster of CPs under investigation, these areas are still in the stage of being barriers that need to be crossed thus transforming them to outcomes. A further finding was that in several areas, the barriers reported were more perceived by the professionals than community members. The organizational and personnel barriers might pose threats to the smooth functioning as well as the accomplishment and impact of collaborative efforts. The findings suggested that the CPs face three broad areas which were barriers to fostering effective joint-working programmes in which the beneficiary community was a major stakeholder. These areas reflected decision making and power structures, sustainability and continuity, and communication and communication systems. Early in the life-span of health alliances, coalition practitioners and health administrators need to pay due and comprehensive attention to these domains if the partnership strategy is to be an effective tool for empowerment, investing in the social capital and promoting the health of the population. Coalition research needs to address effective and efficient on-going means and strategies that health alliances can adopt to internalize and then transform partnership barriers and challenges into positive outcomes and results.

5.12. Methodology, Reliability, Dissemination & Limitations

Globally there is growing recognition that research is needed to obtain information for decision makers in the public health sector and that the type of research needed includes both qualitative and quantitative components (Yach, 1992). Qualitative methods take a holistic perspective which preserves the complexities of human behaviour (Strong, 1992). In parallel, the whole system approach was advocated by Popay and Williams (1998) in the context of partnerships for health, while in relation to health promotion programmes, Gillies (1998) endorsed that quantitative data alone was insufficient and qualitative techniques are more appropriate for exploring community-based approaches.

The use of mixed methodology in evaluation has been publicized and the utilisation of qualitative and quantitative data for health education programme planning, implementation, and evaluation has been highlighted (de Vries *et al.*, 1992). For instance, Patton (1980) highlighted a "paradigm of choices" which recognises that "different methods are appropriate for different situations" and supported the use of multiple methods, both quantitative and qualitative. Similarly, Black (1994) reported that health services research was dominated by quantitative methods: research tended to be considered real and serious only when it uses these approaches, and advocated using quantitative methods in combination with qualitative methods while acknowledging that some situations are inevitably beyond the scope of quantitative methods but could be investigated more appropriately by qualitative ones. In parallel, Strong (1992) supported the need for qualitative as well as quantitative methods, and Kroeger (1983) suggested that communicative field research (as a qualitative, descriptive and analytic tool) and interview studies should be used together since they complement each other. He added that in reality this was often ignored. Recently, rapid appraisal methods have started to be used in developing countries in an attempt to integrate the qualitative and quantitative methods within time constraints (Anker, 1991; Medical Research Council, 1995). This study responded to such calls and provides additional empirical confirmation for the necessity of the simultaneous or sequential use of various research tools and instruments by the same or different researchers. As discussed above, the deliberate simultaneous use of the survey and interview and the blending of both their findings added more insights and aided in the understanding of the barriers that the South African CPs are encountering.

In this 'cluster evaluation' of a group of US-funded South African partnerships (Barley and Jenness, 1993; Worthen and Schmitz, 1997; W.K. Kellogg Foundation, 1993 and 1994), both research tools were used in conjunction with each other: the survey was employed to learn about the overall picture as regards the distribution of the concerns that were perceived by the stakeholder groups as barriers to effective partnership working, while simultaneously, qualitative findings from the interviews were used to capture and understand the richness of the process and give a detailed enough understanding of the meanings of activities and actions, and of the process of change.

This study described an approach to evaluating large-scale initiatives that span multiple project sites and respond to multiple evaluation needs at the project and programme levels. Six measures pertaining to evaluation needs were operationalised as precursors of accomplishment and impact, in this study, namely: satisfaction; commitment; outcome efficacy; effectiveness; activity; and, educational activities.

Worthen and Schmitz (1997) have reported that cluster evaluation is an example of a type of evaluation that has emerged in recent years in response to large scale initiatives funded both by private foundations and public agencies in the US and several European countries. The name 'cluster evaluation' originated in the W.K. Kellogg Foundation. The apparent increase in this evaluation approach can be seen from a rough count of the number of presentations made in two annual meetings of the American Evaluation Association (AEA) that employed or reported on some form of cluster evaluation (n = 10 in 1995, and n = 25 in 1996). Inspection of Kellogg documents indicated that a cluster is a group of projects (usually five or more) which are similar in their strategy or targeted population group. They may be at different stages in their funding cycle but whenever possible, should be within the first half of the grant term. This allows projects adequate time to adapt and modify their activities as appropriate as they participate in the cluster evaluation and networking with other projects. (Anon., circa 1994). This description, including the young age of the CPs fitted the five SA CPs that the investigation decided to examine.

Across the five CPs under investigation, while funding and programming may have been decentralized, the need to aggregate evaluation data centrally and learn about effective practices across sites for policy and programming purposes will probably not decline. Accordingly, in this study the researcher deliberately reported the findings in the aggregate form, keeping the relation between the researcher and the individual CPs a confidential one. This is in line with Barley and Jenness (1993), who reported that the relationship between the projects and the external evaluator conducting the cluster evaluation is confidential. Emphasizing this point in the design phase of the study was, as Barley and Jenness (1993) put it: "ensures an environment in which projects can be comfortable in sharing with cluster evaluators the realities of the work they have undertaken - problems and frustrations, as well as triumphs. This generally increases the usefulness of evaluation findings". In effect, data pertaining to each of the CPs shall be individually analyzed and those findings fed back to the individual CP for implementing further modifications or adjustments. This is also in line with the donor body's philosophy on cluster evaluation, which when stated simply, was that 'evaluation functions to "improve, not to prove" ' (W.K. Kellogg, 1994).

Furthermore, the actual process of collecting the data and simultaneously running 'provisional analyses' whilst in the field (321 questionnaires were analysed in the field and the provisional findings disseminated whilst collecting the rest of the sample), this cluster evaluation facilitated two points that Worthen and Schmitz (1997) have eluded to. First was the cross-site communication which was at the core of cluster evaluation. Sharing information was intended to begin early and continue throughout the

cluster evaluation. This was viewed as one of cluster evaluation's potentially greatest strengths. To this end the researcher has acted in two capacities: first, as a data-rich mobile vector for cross fertilization of ideas, lessons and successful practices across the CPs; and, through the process of taking the respondents through the process of completing questionnaire sections, raising valuable awareness around multiple interacting diverse facets of CPs functioning to which many respondents were unaware of especially from the community members side.

Second was the stakeholder-based participatory evaluation, where cluster evaluation assumes some amount of responsibility for strengthening the capacity of local projects in evaluation, and typically includes grantees as vested stakeholders in evaluation planning and implementation. This latter point was also thought of in the design stage of the study, as well as when implementing the evaluation, the attempt was to ensure that local workers from the CPs were trained on some forms of evaluation techniques by shadowing the researcher (in one CP the evaluation officer, in another two Master's in Psychology students undertaking research apprenticeships at the regional university, in a third CP it was a youth worker etc..).

Reliability

Taken together, the evidence [Tables (1 - 3) and Figures (1 - 6)] indicated that the reliability coefficients for the various questionnaire sections were of good magnitude. For most sections, Cronbach's Alpha reliability coefficient (Chronbach, 1951) was above 0.7 (75% of questionnaire sections), with few sections falling between the 0.65 and 0.7 level. Cronbach's Alpha is appropriate for assessing the stability of the subscales (Politi *et al.*, 1994; Eisen *et al.*, 1994; Pomerleau *et al.*, 1990 and 1994) and values > 0.7 were taken as reliable (Nunnally, 1978). Rogers *et al.*, (1993) reported a high degree of internal consistency within mulit-item measures using Cronbach's Alpha as a measure. The results of this investigation were in agreement. However, Rogers *et al.*, (1993) measured Cronbach's Alpha for their whole sample of both coalition staff and members. Instead of the general measure that Rogers and colleagues employed, and as regards the staff and member predicting variables are concerned, this study goes on further to report on the reliability scores for both groups separately, and of the whole sample. However, for the organizational predictors and intermediary measures, the report was for the whole sample. All the study's reliability tests were above the 0.65 range, with the majority of sections scoring between 0.7 - 0.9 indicating a high reliability index [Figure (1)].

As the survey instrument was developed and tested in the USA, the transfer of the instrument to a South Africa setting was one concern for reliability. This led to the design of a short version of the questionnaire (circa every 6th respondent). Tables (2 - 3) and Figures (4 - 6) displayed the results of the test-retest reliability (LV and SV of the questionnaire). This study's methods of comparison of the stakeholder groups as regards the first and second admission were in agreement with Hansen *et al.* (1997). They employed Cohen's Kappa index (Rogot and Goldberg, 1966) in the case of dichotomous data. Kappa values < 0.4 were considered as 'poor' agreement, values 0.4 - 0.75 as 'moderate to good' agreement, and values > 0.75 as 'excellent' agreement (Fleiss, 1981). In following the same cut off values we report that 80 % of the questions repeated in the SV of the questionnaire showed a Kappa value of > 0.4, whilst 20 % were 0.75 or above. However, for continuous variables they employed the intraclass correlation coefficient which was derived from two-way analysis of variance. We employed simply a comparison of means (repeated measures). T-tests for paired samples were computed. Again, as Figure (4) indicated, 75 % of the questions were not significantly different. This further demonstrates high reliability.

The implications of these findings was that this investigation provided further evidence to support that questionnaires developed in the industrialized world could, under certain circumstances and when the questionnaire was appropriate, be used in a developing country setting. Sandelowski's (1986) pointed out that there was a special need for qualitative researchers from developing countries to conduct their own research. If this was the case (and this study agreed with Sandelowski's recommendation), then survey instruments developed and validated in the West will inevitably be transferred and employed across a range of country, language, ethnic, and political settings. The study's findings suggested that this could prove to be both feasible and reliable. However, it need be noted that great effort was invested on behalf of the researcher. During the fieldwork at the SA CPs, most respondents were carefully followed up with support and clarifications of the questions as needed, including multiple visits and telephone calls. It could have been different if the questionnaires were mailed as in the case of Rogers *et al.* (1993) in the USA.

Dissemination

The fifth objective of the study was dissemination of findings and guidelines recommended to maximise the impact of the CPs. The goal here was to decrease the gap between research and practice in health promotion (Lancaster, 1992; Crosswaite and Curtice, 1994; Johnson *et al.*, 1996). The aspect of concern

was that the full potential of health promotion programmes was sometimes not fully achieved because of insufficient transfer of knowledge about effective programmes from research into practice. Despite this concern, the study and practice of dissemination remains somewhat neglected (Schwartz and Capwell, 1995). To counteract this observation, the researcher ensured that the CPs under investigation had input from the beginning of the design stage of the study. This is in line with the principles of participatory action research which indicate the significance of involving those who are implicated in the research process from the beginning, and ensuring a sharing of decision making power (Cornwall and Jewkes 1995; Green *et al.*, 1995). About one year before the commencement of the data collection phase of the study, a structure for continuous communication between the researcher and the five CPs provided the opportunity to overcome the dis-juncture experienced between research knowledge and their practical experience (Eakin *et al.*, 1996). In parallel, the movement of the researcher to and fro between the CPs facilitated a cross fertilization of ideas, procedures as well as awareness of similar pitfalls and obstacles. The researcher also facilitated the updating of the resource centres of the participating CPs with various published partnership literature thus perpetuating the dissemination process of other successful practices overseas. Furthermore, an full interim analyses was undertaken (whilst in the field) at approximately the middle of the study (321 respondents as opposed to the final 668) and the results were disseminated to the participating CPs as well as in several national and international forums. All publications and reports resulting from this investigation have been and shall be sent to the CPs and the final recommendations are also in the process of being sent. However, King *et al.*, (1998) indicated that the dissemination not only includes communicating information, but also persuading about the relevance of the new information, a decision by others to adopt the changes and sustaining the changed practices (Cameron *et al.*, 1996; King *et al.*, 1996).

Limitations

Notwithstanding, this research had some limitations. First, as with cross sectional studies, it represented a point in time which may not be representative of the partnerships' life span. Second, data was collected about 3.5 - 4 years after initiation and thus results could be generalisable only to CPs of similar age. Third, the scores were self reported responses and as such could be subject to respondent bias. Fourth, the lack of objective independent measures of effectiveness which could have added more insight to the results. However, to the best of the researcher's knowledge, and in contrast to previous studies (Marconi and Bennet, 1990; Rogers *et al.*, 1993; Gottlieb *et al.*, 1993; Choi *et al.*, 1990) this research appraised CPs from four distinct points of view: the professional staff from the academic institutions and health services

who participate in the partnerships, the community members who are voluntarily involved, and the full time core staff who are paid employees in the partnerships. Furthermore, the findings are being fed back to this group of young participating CPs to assist in their development and evolution and as a pioneer attempt in developing a local prototype model for the South African partnerships thus aiding in decreasing the "barriers of vision" due to lack of local models to draw upon.

VI . Chapter Six

Conclusions

"A citizen is one who participates in power." Aristotle

South Africa, although classified as a middle income country, has a health status worse than many countries of similar income. The majority of the population have inadequate access to basic services including health care, clean water and basic sanitation. Between 35 and 55 % of South Africans live in poverty (1994 figures). Seventy five percent of the poor live in rural areas compared to 53 % of the general population. About 16 % of newborns are low birth weight and malnutrition is common, present in 30 % of children. The HIV epidemic is well established in South Africa, with approximately 1.2 million people infected (Department of Health, 1995a;1995b;1996).

Against this background, the health strategy has been no longer seen as the job of solely the health department and the importance of the wider determinants of health has been recognized. Intersectoral collaboration and cross-agency working had been advocated and the emphasis has been placed on closer working links between local education and health service agencies. Government papers (Department of Health, 1995a;1995b) have stressed the importance of joint working relationships, while policies have highlighted the need for coalitions between the health care providers, educators and other stakeholders. The documents advocate mobilizing partners for health, where national policies and programmes need to involve those who are required to implement them. The emphasis has been on building networks, alliances and partnerships for health and empowering people to take action at the national, regional and local level.

However, a healthy community partnership is a dynamic state of renewal and improvement. It builds a culture that supports healthy life choices and a high quality of life. It aligns practices, policies and resource allocation to bear upon and sustain an engaged citizenry examining and experimenting with a variety of programmes that address the root causes of ill health: from education to support networks, from responsive governance to voluntarism, from safe neighbourhoods to innovative dynamic communities, and from cultural sensitivity to a sense of place and ownership. In short, a health partnership is built on a foundation of multiple assets: economic, social, environmental and human (Norris *et al.*, circa 1999).

These multiple assets dictate that CPs are multi-dimensional endeavours. In relation to the multiple facets that stakeholders bring to a partnership, data was collected via questionnaires from 668 respondents that

comprised the stakeholder groups in the cluster of SA CPs under investigation: the academic medical and nursing training institutions, the health service providers, the lay community members and the full time paid employees of the CPs: the core staff. Five CPs provided the data for this study. In parallel, systematic data were collected through 46 semi-structured interviews of representatives of member organizations and individuals of the stakeholder groups. Published reports and partnership documents were also scrutinized, and participant observation was facilitated by the researcher residing at each of the CPs for several months.

In this investigation, the first objective was to determine how coalitions operate and to identify the factors which contribute to coalition competency. To this end a wide review of the literature was undertaken where the critical variables in partnership functioning were identified and systematically categorized according to importance. The impression was that the variables involved in partnership fostering are numerous and interlacing rendering them difficult to isolate. A consequence of the multiplicity of facets is that the overwhelming literature on partnerships is dispersed between many academic disciplines making it difficult to locate for the busy practitioners and administrators.

The second objective was to describe the level and type of coalition activities and assess outcomes over the previous years. In fulfilling this objective a wide description and an in depth analyses of the activities and programmes of the SA CPs was undertaken, as well as an overview of their various outcomes and their effectiveness, whether they were related to sustainability, increasing health professions students practice and commitment to PHC and the underserved, or related to educational outcomes, and increasing community involvement in health care decisions. Within this context, the accomplishments of the CPs span four programme areas:

a. ***Partnership developments***

The initial stage was to establish appropriate and functional governance structures spanning the traditional social, political, economic, educational and organizational boundaries of community, academia and services (Lazarus *et al.*, 1998). Given the historical disparities between the community, academia and services within SA, establishing appropriate and functional governing structures was a long, difficult and painful process. The reasons for higher representation from the community (50 %) was to ensure that the voice of this historically dis-empowered partner was heard and taken seriously. The result has been community participation in and ownership of governance and programmatic activities. Unfortunately, however, this form of representation also resulted in a lack of participation and ownership

by the academic and/or service partners. As the community partner becomes more empowered to participate as an equal stakeholder, it might be time for the CPs to reconsider a more equal representation of partners on the supervisory boards.

b. *Community empowerment*

Given the historic social, political, economic and educational disadvantage of the community partner, empowering this partner was a priority for the CPs (Lazarus *et al.*, 1998). With pressing community needs at the outset of the initiative and the inertia of the academic and health service partners, few CPs made a distinction between 'empowering the community to participate as an active partner in the governance and programmatic activities of the CP' versus the endless scope of community development. Consequently, a wide range of community development projects emerged within the CPs.

c. *PHC sites and service development*

One of the central objectives of the SA CPs-HPE was to enhance the health status of the participating communities through the development of community-based academic/service PHC sites suitable for intersectoral collaboration, interdisciplinary HP education, research and comprehensive PHC services (Lazarus *et al.*, 1998). All the CPs have established community-based sites. The facilities and programmatic activities at these sites vary between the CPs. Generally these sites included a community-based PHC clinic and/or a range of community development projects. The clinics were frequently attached to a community centre, where many activities, workshops, meetings and seminars were being undertaken. Simultaneously the same space was sometimes used by the younger generations for dance practice, or by elderly women undertaking a sewing project.

d. *Educational development*

The key objectives of the SA CPs-HPE were to train health professionals who would be aware of, responsive and accountable to the needs of historically underserved communities. While the community development programmes empowered the community and the academic/service PHC sites provided the essential PHC services, the main concern of these programmes, in terms of the goal of the CPs initiative, was to create the context for appropriate health professions education. Essentially, health professions education is an attempt to influence where, what and how graduates would practice. The CPs intended to produce graduates who would be most likely to practice in historically underserved communities (where), choose PHC careers (what) and practice in an interdisciplinary manner (how). Perhaps the biggest impact

of the CPs on educational development has been the creation of alternative community-based teaching and learning environments for students through the development of academic/service PHC sites.

The third objective of the study was to compare the stakeholders views' of the structural characteristics and operational parameters of the CPs. Here, a broad comparison of the stakeholders' perception, views and opinions about their CPs was undertaken in connection with a variety of structural characteristics and operational parameters of partnership fostering and maintenance. The overall impression was that the highest scores were those of the CS followed by the CM and finally the two professional partners, the AI and HS. The findings suggested that in general, training and development seem to be a main thrust of the CPs' missions. The observation is that clarity of roles, procedures and responsibilities as well as good visibility of the CPs is imperative. Clarity requires transparency to demonstrate what each stakeholder is doing and provide access to each other's agendas. Generally, time needs to be made for communication, as it is important for information flows and contributes to visibility. Although there was an under-representation of the youth, there seemed to exist a mixture of various levels of satisfaction in the CPs, with the community members lacking a sense of ownership. The findings also highlight that consultation in decision making and co-operation seem to be lacking with unilateral decision making taking place. This might lead to suspicion between the partners and could hamper the advancement of the CPs. Power struggles in the form of hidden agendas, win-loose situations, caucus meetings, mistrusts and conspiracy may be signs of an underlying feeling of suspicion. In the long term, this will not to be conducive for sustainability, another issue that needs to be defined, agreed upon and given careful attention.

The fourth objective was to identify the correlates of accomplishment and impact for each stakeholder group. To this end the study's regression analyses indicated the diversity of factors (and their relative contributions) that explained accomplishment and impact (via satisfaction, commitment, effectiveness, outcomes, activity and educational activity as intermediary measures) for the different partners. Each stakeholder seemed to be a unique mix of aspirations, vision, culture and structure. The aim is to identify, understand and respect the various "baggage" that stakeholders bring to the partnerships in an ongoing effort to draw the academic institutions, the health services providers and the beneficiary communities in one collaborative and synergistic effort.

Finally, the fifth objective was to inform the development of support systems, thus disseminating guidelines recommended to maximise the impact of the CPs. As described above in the section on dissemination, this study has, from its inception, been a consultative and a step-by-step participatory

effort with the involved CPs. Community members on the board, as well as representatives from the other stakeholders acting on behalf their constituencies, gave their consent before the study commenced. All along the data collection phase training of local workers was undertaken. Cross fertilisation between the CPs was also an ongoing process. Finally, all published outputs have been sent to the CPs, and confidential reports are being prepared for each of the individual CPs after analyses of each individual dataset.

However, amidst a general atmosphere of the WHO's 50th anniversary, progress towards HFA has been hampered. Amongst the list of hampering factors for the progress towards HFA has been the difficulty in achieving intersectoral action for health. With "too many cooks" drawing up agreements and frameworks for closer working relationships and future co-operation, partnership building and health alliances working with a collaborative mode could benefit from a closer understanding. Attention needs to be paid to the components of the viability of CPs: initiation, maintaining momentum and sustaining progress. Awareness to principles of good practice for multi-agency working and conversely, of the destructive nature of some of the pitfalls that could hinder CPs fostering could prove to be a sound investment for stakeholders embarking on a partnership building endeavour.

Perhaps a question to ask early is : "what makes healthy people?" (Norris *et al.*, circa 1999). Health is more than the absence of disease. It is an optimum state of well being: mental, physical, emotional and spiritual. Health is wholeness. It includes a sense of belonging to community and experiencing control over one's circumstances and fate. Optimal health is a by-product of people realizing their potential and living in a community that works (Norris *et al.*, circa 1999). "Community" can be everything from a neighbourhood to a metropolitan region. It can be the workplace or a group of shared interests and faiths. In the end, one's "community" is where one is and with whom one is with. A healthy community is one that is continually creating and improving physical and social environments, and expanding those community resources which enable people to support each other in performing all the functions of life and in developing themselves to their maximum potential.

To facilitate and sustain the growing movement of partnerships nation-wide, each pertinent study finding is going to be individually reviewed, highlighting the implication that the finding has and followed by specific recommendations to strengthen the area that the study finding addresses:

1) *Finding*: One of the issues raised in the study related to the early vision stage of the CPs' initiation. There seemed space for agreement on what development, empowerment and the standing of health within the context of development really meant, as well as what collaboration entailed and the direction the partnership was attempting to embrace.

Implication: Early vision and understanding are imperative, given that partnerships are a relatively new concept and area for many. Although encouraging, the concept is complicated, often poorly understood or agreed upon, and the parties - professionals and lay community members alike - are not always strictly clear about how they are going to achieve their aims.

Recommendation: Articulating the concepts and making sure that all participants are on the same 'wave length'. This shall require numerous meetings, consultations and canvassing of good leaders in all sectors who would be involved in the collaborative effort. Dialogue weaved around the partners' concerns could function as a starting point. Vision needs to balance between the short term (e.g. brick laying or training projects) and long term attainable and measurable objectives (e.g. more health professionals to practice PHC in underprivileged areas or self-sustainability of the CP). Therefore, attention to the ways in which the stakeholders' concerns are intertwined and the reasons why they need each other to solve the problem may aid in bringing viewpoints to converge into a common vision. The point is that in the case of the SA CPs, this collaborative efforts are aimed at long term relationships, one that requires visions to be continuously re-visited and aligned.

2) *Finding*: Clarity and understanding of roles, responsibilities, rules, and procedures could benefit from attention.

Implication: Clarity of roles, rules, procedures and responsibilities need be high on the agenda. Not only clarity of the expectations of rewards, but also of goals and commitment (Hord, 1986; Langley *et al.*, 1998). Lack of clarity in the partnership may frequently lead to confusion and consequently non involvement. Clear objectives and expectations are important to get equity out of a partnership. Clear understanding that embraces the different origins and cultures of the stakeholder groups and recognises the mutual roles, responsibilities, resources and limits is fundamental. Clarity of procedures and duties when made explicit, binds all the partners in a mesh and contributes to accountability.

Recommendation: Over time, a written, agreed upon and signed constitution helps focus, refine and prioritise the community's needs and define the partnership's mission, by-laws and 'ways of doing business'. Clear definitions make it possible for the partners to identify what local resources are present and what type of programmes might be needed. Formal links and protocols help formalise rules and processes and make them explicit. For instance, the CS needed to be clear that they were servicing all the partners in their CPs with no over-focus on a particular one. The CPs' programmes co-ordinators were in the middle of many subgroups and consequently lines of accountability needed to be made distinct for them. The CM called for more overall clarity and transparency as well as popularisation of and communication with their partnerships, the academics required to both utilise and integrate themselves in the partnership more than the mere deployment of students but as resources, expertise and skills for local and regional development. Finally, the HS were enthusiastic to contribute more to the teaching and training processes in the community and at the university rather than functioning as a passive receptacle for receiving students. The message is: *Reach* common ground through clarity and integrate the workings of more both formal institutions and partnerships with leadership from neighborhoods and grassroots groups. *Help* leaders of all sectors see their roles in building healthy sustainable community partnerships.

3) *Finding*: Although a fair amount of representation was reported, some groups were under-represented.

Implication: Wide representation of all the stakeholders, whether professionals or lay community, as well as a strong membership base is critical as a means to increase the "critical mass" behind the partnership (Anon., circa 1995; Zakus and Lysack, 1998). Stakeholder groups are usually diverse and if the partnership is to flourish as many parties as deemed necessary need to be consulted as early in the process as possible.

Recommendation: Member recruitment that is based largely on pre-existing networks may result in the exclusion of important constituencies and may define the level to which member organisations become involved in the effort (Herman *et al.*, 1993). For instance, in this cluster, biases in communication and consequently representation were due to geographical, political, educational and, where appropriate, tribal considerations. Accordingly, partners need to be aware of these frequently unwitting tendencies and the manner in which they operate in order to avoid them. Inclusion of the relevant parties is usually not an easy task and is an evolutionary, time consuming process built on incrementalism and gradualism. As a consequence, collective and ongoing attention to the CM members concern for the need of more community representatives from the lower social strata, CBOs, religious and other civic structures should

be attended to. Similarly, more HS representation especially from the central health department and more holistic representation of the various AI departments seems a sound investment. For this cluster, other groups that needed more invitations included the youth, low income/unemployed groups, NGOs and voluntary organisations, and minority groups. The related domains of the expertise, turnover, follow up and feedback, as well as decision-making authority of the representatives were also crucial, where the findings suggested that these areas could also benefit from strengthening. The message is: *Expand* the base of constituencies and voices (youth, business, the community grassroots, leaders, etc.) in bringing their views, indigenous knowledge, gifts, skills and expertise to the CPs. *Be* a vocal and visible part of the nationwide community partnerships movement.

4) *Finding*: Leadership of the partnerships is critical. The skills, the visibility, the composition as well as the legitimacy of the partnership's leadership are all factors that could affect the quality of participation of the stakeholders. Lack of appropriate leadership skills could generate feelings of fear together with lack of involvement or even challenge.

Implication: The attitudes and styles of the partnership's leadership are both central and pivotal. Leadership skills are indispensable although frequently lacking (Eng *et al.*, 1992). The range of skills needed is broad and ranges from communicative, change agent and consultative expertise to organisational, strategic management and community organising abilities. The skills required as the partnership moves from initiation to implementation to maturation are not necessarily the same. From the entrepreneurial skills to the early-stage catalyst, facilitator, and champion skills to the later organisational, managerial, and implementation skills, and eventually, more routine and administrative leadership skills.

Recommendation: The characteristics, manner and spirit of the partnership's directors, convenors, board, and the management or governance committees are important. Leadership needed to be both more visible as well as transparent in some partnerships, while in others the need was for a more open, consultative, constructive, facilitative and communicative mode. Thus, some of the SA leadership could benefit from giving members the support and recognition required, seeking and welcoming views and listening to opinions in order to generate ideas. Leaders also needed to both provide and evenly distribute opportunities, as well as devolution of financial and other partnership responsibilities. Leadership will need to demonstrate the fair and appropriate use of partnership funds, partnership leverage and power or other partnership benefits through timely and broad consultations with the partners regarding issues such

as the filling of posts, use of project vehicles and the erection of new buildings or the selection of contractors. Leaders will also require thought to the number, size and composition of the board and other committees or task forces so that meetings are manageable and interactions and communication can be improved. The message is: *Focus* corporate and organisational investment towards greater community benefits – align communities' policies and resource allocation with what creates health.

5) *Finding*: Timely as well as adequate communication are crucial elements in partnership functioning.

Implication: A clear line of communication between the partners contributes to visibility and transparency and helps avoid any misunderstanding or difficulty that will lead to rampant conflict. Lack of release of information on execution timetables may circumvent effective monitoring by beneficiaries and hamper grievance mechanisms. A regular newsletter, written and verbal reports at meetings and outside of meetings helps update everyone. A good quality, frequent, non-selective information flow is often needed so that the partners do not become 'strange bedfellows' due to lack of communication. The SA CPs indicated that if information was deficient, filtered, twisted or inconsistent, then this might generate caucus meetings, pressure groups and "gossip" networks.

Recommendation: Communication and the free flow of information between the numerous diverse parties is a key point. Everybody needs to get the same information. The partnership convenor's role in promoting a culture of open communication is a considerable point in the collaborating process so a 'culture of silence' is not created. Avoidance of long meetings and technical jargon, choosing convenient meeting times and perhaps rotating the meeting place between the various partners to keep an even balance and consequently satisfaction could prove worthwhile. For this cluster, communication needed be meaningful, relevant, accurate and be as a part of a more general attitude of sharing information and power. Consequently both 'in house' communication or alternatively, communication between the pairs of stakeholders shall require to be facilitated more attentively through more both formal and informal means. For instance, more formal and stringent invitations and reporting back procedures, as well as memos, directives and notifications that keep all players updated, along with informal means which build on relationships and capitalise on personal connections, contacts and friendships, conduits and fellowships, and mutual esteem between the partners. The message is: *Sustain* an ongoing community discourse and civic exchange between the many groups and partnerships in the community. *Generate* local media attention.

6) *Finding*: Human resource development is imperative. It is critical that all the partners are empowered with the expertise skills needed for collaborative work.

Implication: Mere attendance at a meeting can wrongly be equated with participation, as even though the community are participants, they may largely be observers. Human resource development helps enhance the manpower quality as groups will be reluctant to collaborate if they are at a disadvantage to adequately represent their interest or if they believe their interest will be deemed secondary to more powerful ones who posses abundant skills. Capacity building is similarly important for the continuity/ sustainability dilemma.

Recommendation: Investing in building the capacity of the partner members of the alliance seems to be a sound investment. When the community is one of the stakeholders, then building the foundation of partnership through its social capital, whether by way of transfer of skills or empowerment becomes critical. For instance, the academics needed to learn more about the educational process of community-based education and problem-based learning, the CM required training that would increase the level of their understanding and skills in the field of CPs, and the CS could benefit from upgrading on the appropriate balance of short term fulfillment of basic needs versus long term empowerment and development of communities. Another factor is the appropriateness of workshops, seminars and conferences in relation to their costs or the pertinence of their content in relation to the trainees' needs and its relevancy to the south African context. Finally and equally important is that health professionals need to learn to fully appreciate rather than swiftly discount the wealth of indigenous knowledge that communities posses. These communities have accumulated information and expertise necessary to look after their own health. Health professionals need build on this knowledge. The message is: *Build* the capacity of the groups to act on its ideas.

7) *Finding*: The scope, development and substance of a partnership warrants continuous attention and thought.

Implication: Alliances addressing narrow and solely health issues are likely to face only short-term success, as for the hard-pressed communities, health on its own is frequently not their top priority. Therefore, partnerships and alliances may sometimes require to embrace a more encompassing approach to health: the community development approach, where a wide range of community concerns are addressed and met.

Recommendation: Although some authors have advocated for the limitation of coalition activities and objectives, and that a single solid success could boost the morale of a coalition more than a myriad of mediocre projects (Lindsay and Edwards, 1988), the SA CPs, nevertheless, adopted a wide array of social, educational, bridging as well as training and vocational programmes. Consequently, it need be clear that the community development approach has two drawbacks: it renders the energies of the partner groups more dispersed and consequently, their accomplishments less visible, as community development is a lengthy process whereby communities are empowered to be able to take responsibility for their own health. Given that benefits may well take time to accrue, as the partnership matures a two-pronged strategy of initiation of programmes while implementing and strengthening those that are already running and had proved effective may be needed. The message is: *Launch* new initiatives and strengthen impact of the existing community partnerships.

8) *Finding*: Consultation in decision making was sometimes lacking with unilateral decision making taking place.

Implication: Non-consultation could generate suspicion, division, anxiety and the perception that people's opinions are not drawn upon, as well as missed opportunities and duplication of structures.

Recommendation: Consultation is at the heart of partnership work. For instance, the procedures by which the CS appointments were undertaken, as well as their salary increments were not clear to the community who was not consulted. Similarly, the selection of students for educational bursaries, community health workers for training or CM for educational trips abroad were sometimes undertaken unilaterally. A third area was approval for funding to certain programmes that were put forward by the academics. When groups are not consulted, involvement and commitment gets fragmented and quickly wanes away. The message is: *Surface* common issues and the resources to address them – help identify barriers to positive change and uncover innovative ideas. *Break* through community "turf wars" and connect fragmented resources and services – build public consensus and commitment necessary to generate action for better outcomes.

9) *Finding*: A frequently underplayed area of CPs is evaluation.

Implication: This needs to be thought about from the initiation. Agreed targets and indicators (although not always straight forward) are important. Equally critical is the use of combinations of multiple research tools to investigate the various facets of the efforts (Black, 1994).

Recommendation: Here, the role of SA Network of CPs needs to expand greatly. The aim is to encourage as well as initiate evaluation efforts based on solid scientific bases and supported by the Foundation, implementation of the evaluations as well as wide dissemination of the results. At present the impression is that the SAN seems partially idle. In parallel, training and capacity building of partnership members on evaluation methodology, rapid appraisal methods and techniques and undertaking qualitative or simple surveys could prove effective. The point to note is that evaluation need to be thought about early. As soon as aims and objectives are set, an appropriate question to ask is: how is the attainment of goals going to be measured? The message is: *Stimulate* action and track progress for accountability.

10) *Finding*: A frequently overlooked component is time frames and funding cycles.

Implication: Partnerships are not created overnight but rather, they evolve over time so time frames and funding cycles need allow for a gradual and slow process (Janz *et al.*, 1996). Stakeholders have to proceed in a step-by-step fashion at the pace of the participating agencies. The time pressure that might be exerted on a partnership and the need for timely reports and evaluations by donor agencies may work against the best interest of an alliance trying to gradually and cautiously find its appropriate niche in the participating health agencies so that the programmes and activities get institutionalised

Recommendation: Time frames and funding cycles need be realistic to allow for the interaction of all the many facets of partnership functioning in a gradual evolutionary process. The need to do things with the community as opposed to doing things for the community, dictates that time frames and donor cycles need be long enough. Partnership work is time consuming, and many of the participating agencies already have a heavy workload. Empowerment of the communities is a learning process, development is a lengthy cause and inclusion of the relevant parties is usually build on incrementalism. In the case of the SA CPs, five year cycles may be required to start and implement the process but may not be sufficient to complete it. Building trust and confidence between the diverse partners is an evolutionary process, so stakeholders better be committed for the long haul. As routinisation of activities and programmes within the participating

agencies is a key factor in the continuity equation, consequently, the message is: *Place* the partnership strategically within local, regional and national development structures and planning.

In the South African context, consultative joint-working and decision making is a practice of local democracy and civic renewal. It is engaging citizens and organisations in dialogues leading to action and policy on what makes healthier communities. The dialogues need to establish ground rules for the groups in a flexible and relaxed atmosphere where everyone is a resource and no one is an expert. The questions encompass the characteristics of a healthy community and how the groups can work together to improve the health and quality of life of the community. What would excite the partners enough to become more involved and engaged in improving the conditions of the community? However, following the dialogue there needs to be a mechanism to ensure that the results of these conversations advance local actions (Norris *et al.*, circa 1999). The agendas need a set of common principles, priorities, and strategic opportunities thus providing a unifying and credible message pointing to both individual actions and to the institutional, community and policy change that may be required. Bringing in more stakeholder perspectives, talents and commitments to the partnerships needs to become a platform for action as well as a boost to the local momentum and political willpower.

Change is often met with resistance. A major challenge to sustaining the efforts of the SA CPs programmes would be to extend stakeholder participation beyond those who were the early adopters, and to prevent these individuals suffering burnout. Many faculty choose to engage in community-based initiatives in their courses because of their own belief structures and the values of the institution. A struggle to overcome the barriers would need more faculty involvement, commitment of academic leadership, and institutional commitment. The aim is that if the partnership activities and programmes at these institutions is to be sustained, it is likely to be sustained as compartmentalised efforts that do not expand to involve more partners. One important issue that needs to be remembered is that community needs are usually far greater than the capacity of the other two partners. The partners need recognize that each is getting unique benefits out of the partnership that would probably otherwise not be available or affordable to them. Therefore, mutuality of satisfaction in terms of respect, understanding and communications are needed. Partners need that effort be devoted so that communication is clear. Government and educational institutions frequently operate in bureaucratic ways that do not foster interdisciplinary collaboration, which is seen essential to addressing community needs. The institutions are often described as compartmentalised, political and fragmented.

In the new and democratic South Africa, there is a pressing need to meet the HPE reform. The CPs under study are examples of new and remarkable health coalitions that are being implemented in several previously under-served localities. The analyses of the predictors of accomplishment and impact for diverse stakeholders hold lessons for managers and researchers concerned with health alliances, coalitions and partnerships. Explanation of why stakeholders are satisfied or committed, or what explains their views on effectiveness and activity levels of their partnerships may inform efforts in other settings. With diverse stakeholders who traditionally and historically did not communicate with each other, it is important to be somewhat cautious in considering the stakeholder groups engaged in these collaborative efforts as homogenous entities.

Interdisciplinary work is extremely hard work, a slow process and may be difficult to sustain. It is also extremely rewarding (Lazarus *et al.*, 1998). Through the SA experience this study has learned that success grows progressively form the stakeholder experiences and relationships. While understanding each other's roles is considerably enhanced, it also brings with it greater respect and sharing of skills. It is the appreciation of knowing the depth and breadth of one's discipline and the complementary expertise to others. The resulting collaboration that is undertaken in partnership with the community, and pays due attention to their individual values, has the potential to enhance the quality of care for the community.

A beneficial investigation that would yield information across the life span would be a repetition of selected questions to the same SA CPs now, three years after the first investigation. This would generate directly comparable information that could provide insights into how the parameters under study fluctuate with the life span of the partnerships. At present, there are attempts to incorporate some of the questions into a questionnaire that a South African Ph.D. researcher is developing and intends to administer it to one of the partnerships that participated in this investigation. The importance of collecting data across the life span of the programmes is critical, as are stand alone cross sectional studies. However, future research into partnerships might need parallel and independent objective measures of outcomes, activities and effectiveness, as this would enhance the understanding of perceived versus observed measures of accomplishment in joint efforts as well as the effect of respondent bias in surveys. Research into the specific outcomes and benefits that collaborative endeavors bring to each stakeholder group e.g. students, faculty, service providers and community as regards a battery of indicators could give insights into the adjustments needed to programmes in order to accomplish their educational, service, and empowerment aims and vision. Finally, the use of complementary qualitative

and quantitative methodologies to investigate the intricacies of joint working is a daunting, but nevertheless a highly appropriate manner and is recommended.

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List Of Publications

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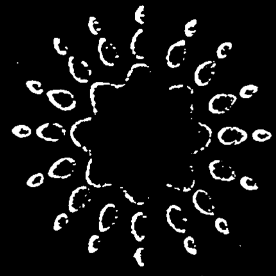

network news

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The theme of the next issue of network news will be Inequalities in Health.

If you have any articles, photos, graphics, letters or features to submit on this or any other topic, please send them to Elaine Mooney at the address below.

DEADLINE: 5 January 1999

•editorial

Sustaining Health for All principles

Health for All principles are sustainable. Eleven years on, Health for All is a global movement. Yet new policies come and go and we are currently at the sharp end of changing policy around the UK. The raft of new policies in local government and the health services appear to have HFA principles at their very heart. They must continue to keep them there if they are to achieve sustainable improvements in health.

An important issue was however raised at the recent HFAN conference. (Thanks to Dr. Ruth Chambers for starting the point of discussion). How can those of us involved in Health for All since those early days, and for so long on the outside of policy makers vision, communicate with those professionals considered to have been working on the inside? Due to policy changes they may be faced with applying new methods of working, such as community development. The conference demonstrated that there are plenty of new hearts and minds eager to listen, on how to do it. But the art is to find a common language. For too long Health for All 'devotees' have been beating the drum. There was a tendency evident at the conference, that we may also be prone to beating others over the head with that drum.

All of us are on different positions along the continuum of beliefs and standpoint. Taking the principled high ground is appropriate at times. But the successful co-ordinators and caretakers of partnership working over the last decade have had to find the middle ground and a common language that respects diversity, different experiences and different starting points.

Those new to the Health for All Network made it clear they were ready to be won over to HFA principles as an entrenched way of working. Some also expressed how difficult it was to engage with some Health for All members. The HFAN accepts it has a responsibility to look at new strategies for engaging other professions such as GPs, Community Nurses and Environmental Health Officers. As individuals we also have a responsibility to consider how we communicate with others. Maybe it is time to change the beating of the drum. Even dispense with it altogether. Communication is the key to winning hearts and minds in local areas. How we do it, to achieve sustainable solutions for reducing inequalities in health, is so very important.

Jane Bowdenleigh, National Co-ordinator

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Tackling Health Issues at a Neighbourhood level - lessons from South Africa

"If the ideals of HFA are to be realised, we need to work together in tackling the health issues at neighbourhood level"

In the Health For All Strategy, the member states of the WHO committed themselves to creating the conditions which will enable all people to enjoy a healthy life by the year 2000. Primary health care became the principal means of achieving this objective. The strategy's focus was on prevention of ill health, the maintenance and promotion of good health and the capacity to resist disease. It soon became evident that the health goals cannot be realised through the services delivered by the health sector alone. As improvements in health are perceived as a multisectoral responsibility, in which the main development sectors would need to collaborate with the health sector, the quest for more effective strategies of inter-sectoral joint working has become apparent.

Five "Community Partnerships" located in five provinces in the Republic of South Africa were recently examined by Dr. Walid El Ansari from the University of Wolverhampton. These US-funded Partnerships were alliances between professionals - the medical/ nursing training and teaching institutions along with the local and regional health service providers - and lay people - the community leaders, organisations and individual members. The following discussion focuses on three inter-related issues which emerged to be highly relevant in the context of the partnerships that were studied: capacity building, sustainability and community development.

Capacity Building

For many professionals, there seems to be a frequently unstated belief that their education prepares them to assume leadership roles in a variety of settings. In parallel, top leadership roles are often given to activists in the community, whether or not they posses leadership skills. The partnership concept is relatively new, mulifaceted and complicated and often poorly understood or agreed upon. The parties - professionals and lay community members alike - are sometimes struggling with the short and long-term implementation of the concept.

Human resource development, where the partner members need be empowered with the skills needed for collaborative work is critical. Human resource development helps enhance quality of staff, which in turn is important to resolving the continuity/ sustainability dilemma. The set of skills required as the partnership moves from initiation, to implementation, to maturation are not necessarily the same. Skills required vary from the budding-stage entrepreneurial skills, to the early-stage catalyst, facilitator, and champion skills to the later organisational, managerial, and implementation skills, and eventually, more routine management and administrative leadership skills.

Research participants in the Transkei region of South Africa with Walid Al Ansari (third from left)

Investing in building the capacity of the partner members of the alliance seems to be a sound investment. When the community is one of the stakeholders - as often is the case - then building the foundation of partnership through its social capital, whether by way of transfer of skills or empowerment becomes critical. The cultivation of leaders needs to have a sense of the required future vision, to be able to think creatively and to generate ideas, and to identify the essence of challenges. They need to want to be, and become, winners.

Investing in the social capital will affect the quality of the involvement of the parties so it is effective and poses a real contribution. Mere attendance at a meeting can wrongly be equated with participation, as even though the community are participants, they may largely be observers. Groups will be reluctant to collaborate if they are at a disadvantage to adequately represent their interest or if they believe their interest will be deemed secondary to more powerful ones who posses abundant skills.

Community Development

The substance of a partnership warrants both early attention and thought. Alliances addressing narrow health issues are likely to face only short-term success. As for the hard-pressed communities, health on its own is frequently not their top priority. Therefore. partnerships and alliances may sometimes need to embrace a more encompassing approach to health: the community development approach. where a wide range of community concerns are addressed and met. This approach, however, has two drawbacks: it renders the energies of the partner groups more dispersed and consequently. their accomplishments are less visible. Community development is a lengthy process whereby communities are empowered to be able to take responsibility for their own health.

The five partnerships that were examined, being engineered on broad-based community consultations, resulted in a colourful spectrum of development activities: health sciences students training programme and bridging programmes in science and maths coupled with bursary assistance for students; community development programmes such as community gardens, water & water accessing projects, carpentry, brick making and sanitation projects.

Research took place in different settings within the new South Africa

From formal & non-formal education programmes as well as vocational training programmes to youth activities, leadership courses, youth health desks, youth skills training, development and entrepreneurial skills. The message is clear: addressing a wide range of perceived needs.

Sustainability

Increasing the likelihood of long-term viability and sustainability of partnerships are difficult issues. However, there seem to be few strategies for accommodating and addressing the issues of continuity.

The full time employees that a partnership usually hires to get jobs done are usually the first to leave the alliance when the funding ends. This frequently results in a sharp "drop" in the partnership's activities, sometimes to irretrievable levels. Early due thought as regards this group seems to pay back later. At times they are absorbed into the different partners agencies. In other occasions the appointments are kept as joint appointments between two or more participating agencies. Yet on other occasions a partnership may, desperately, search for an alternative funder who might have more interest in long term delivery of partnerships as opposed to the shorter-term demonstration projects.

A related issue is how far has the innovation or health promotion intervention been embedded into the participating agencies i.e. how much has it been institutionalised and routinised into their day-to-day activities?. Has, the innovation and the host agencies both sufficiently changed to accommodate each other? A related question is: has the innovation/ intervention reached its maximum expansion within its host organisations?

A frequently overlooked component here is time frames. Partnerships are not created overnight but rather they evolve over time. So time frames and funding cycles need to allow for a gradual and slow process. The need to do things with the community as opposed to doing things for the community, dictates that time frames and donor cycles need be realistic. Partnership work is slow and time consuming, and has to proceed step-by-step at the pace of the participating agencies, many of whom already have a heavy workload. Empowerment of communities is a learning process, development is a lengthy cause and inclusion of the relevant parties is usually built on incrementalism and gradualism. The time pressure that might be exerted on a partnership and the need for timely reports and evaluations by funding agencies may work against the best interests of an alliance trying to gradually and cautiously find its appropriate niche in the participating health agencies, so that it gets institutionalised.

Developing partnerships needs time to build trust and confidence between the diverse partners. The interaction of all these effects is an evolutionary process, so stakeholders had better be committed for the long haul.

Walid El Ansari, MD

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PUBLIC HEALTH FORUM

Association for Public Health; Health Education Authority; King's Fund; Public Health Alliance; Faculty of Public Health Medicine; NHS Confederation; Royal College of Nursing; Royal Institute of Public Health & Hygiene and Society of Public Health; Society for Social Medicine; Society of Health Education/Promotion Specialists; Institute of Health Education

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What should we do about salt?

Michael Marmot

Head of International Centre for Health and Society, University College London

AMERICANS, I WAS TOLD recently by an American colleague, don't have to worry about salt in their diet any more. This, she said, was the consensus of a group of (non-medical) academics at a Northern California dinner party. It would appear that the source for this cook's comfort was, like most health information, the *New York Times* and equivalent media.

The general feeling is that, once again, the experts disagree. And, of course, as long as experts disagree, there is no pressure on government or industry to do anything about the problem. For those who have a vested interest in maintaining a high level of salt in our diet, it is important to sustain the perception that experts disagree. This is what the Salt Manufacturers Association calls 'a balanced view'.[1]

Do the experts disagree? There is disagreement, but actually less of it is about what the data actually show (see, for example, the series of papers in *BMJ*[2]). To take a recent example, a paper in *JAMA*[3] reported a meta-analysis of reducing sodium in 58 trials in hypertensive persons, and 56 trials in normotensives. The authors concluded that their 'results do not support a general recommendation to reduce sodium intake'. What did the data show? Consequent upon a mean reduction in sodium of 118 mmol/24 hours, the mean reduction in systolic pressure was 3.9 mmHg in hypertensives and 1.2 mmHg in normotensives. Other meta-analyses of trial data have had some disagreement about the size of the effect but have reached similar conclusions qualitatively: salt restriction lowers blood pressure in hypertensives and normotensives. The effect in normotensives makes less credible the argument that there is a special population of salt-sensitive individuals and salt restriction should be limited to them.

The relatively modest reduction in normotensives, compared to hypertensives, is likely to be an underestimate of the true effect. The normotensives were younger (median age 27) than the hypertensives (median 49) and the median trial duration was eight days in the normotensives compared to 28 days in the hypertensives. Both age and duration modulate the effect of salt restriction. These trials therefore tell us little of the effect of *prolonged* reductions in sodium. Observational studies such as INTERSALT show that populations with lower mean salt intake have a shallower rise of blood pressure with age.

COMA reviewed the evidence then available, and in 1994 recommended a one-third reduction in the salt content of the British diet. Later evidence, such as that referred to above, supports this. Disagreement of the experts will lack credibility as an argument against taking action to lower the salt intake of the population. There is, however, the argument that until we know that lower sodium intake is associated with reduced incidence of cardiovascular disease, rather than simply blood pressure level, there is no basis for policy. This counsel of perfection is unrealistic. There are no reliable data relating salt intake of individuals to their mortality. A paper in the *Lancet*[4] produced conflicting results on this score but was subject to such heavy methodological criticism that the results are not readily interpretable.

Why should there be vested interests against lowering salt intake? More than 80 per cent of salt in the British diet comes from processed food. If people are not to change radically the way they eat, the vehicle for reduction in salt intake in the national diet is reduction of salt in processed food. This entails the co-operation of food manufactures and Nanny statism. Telling people what is good for them is not the issue. People do not know how much salt they eat. They are not aware how much they eat with their breakfast cereal, with their bread, with their biscuits, with their tomato ketchup, crisps and peanuts, their canned soups and vegetables, quite apart from with their bacon, pizza and kebabs. With the advent of the refrigerator, salt is no longer necessary for storage. Nor, it turns out, does it appear to be 'necessary' for taste.

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Partnerships in health: the pressing challenges

Walid El Ansari, Lecturer in Public Health, University of Wolverhampton

Health strategy is no longer seen as the NHS's job. The importance of the wider determinants of health is recognised. The emphasis is on closer working links between local and health authorities. Green and White Papers highlight the need for partnerships both within the NHS and between the NHS and other stakeholders. Four out of 11 health action zones explicitly mention partnerships as a mode of action; another two refer to 'integrated approach' and 'holistic approach'. With this background it is perhaps time to examine critically the notion of partnership and the most pressing challenges to the components of its viability: initiating, maintaining momentum and sustaining progress.

Can recent experience in South Africa provide insight? What were the components of success? These are summarised in the box below.

- **Early vision: the need for an understanding, and an agreed-upon interpretation, of the partnership concept, along with the means of its operationalisation and practicalisation.**
- **Clarity: of roles, responsibilities, rules, procedures and operational understanding.**
- **Wide representation: from both the professionals and the participating lay/community organisations as a means to increase the 'critical mass' behind the partnership.**
- **Leadership: the skills, the visibility, the composition and the legitimacy of the partnership's leadership all affect the quality of participation of stakeholders.**
- **Quality of involvement of the parties so each makes a real contribution.**
- **Time frames and funding cycles: empowerment of the communities is a learning process, development is a lengthy cause and inclusion of the relevant parties is usually built on incrementalism and gradualism.**

The substance of a partnership warrants both early attention and thought. Alliances addressing narrowly and solely health issues are likely to face only short-term success, as for the hard-pressed communities, health on its own is frequently not their top priority. Therefore, partnerships and alliances could be wiser to embrace a more encompassing approach to health: the community development approach, where a wide range of community concerns are addressed and met. This approach, however, has two drawbacks: it renders the energies of the partner groups more dispersed and consequently, their accomplishments less visible. Community development is a lengthy, arduous process whereby communities are empowered to be able to take responsibility for their own health.

The above conclusions emerged from a study of five partnerships in health situated in various provinces in post-apartheid South Africa. Wide community consultation yielded a broad spectrum of activities: from health sciences students' training programmes and bridging programmes in science and maths, coupled with bursary assistance for students, to community development programmes, such as community gardens, water and water accessing projects, carpentry, brick making and sanitation projects. From formal and non-formal education programmes as well as vocational training programmes to youth activities, leadership courses, youth health desks, youth skills training, development and entrepreneurial skills.The message is clear: address a wide range of perceived needs.

'. . . need for a . . . culture . . . which values people and aims to replace criticism with consultation, irritation with understanding and inspection with education'

Of particular interest in those partnerships was the local government facilitation programme, where the aim was to develop accountable and more active local government structures in health, environment and education. Such 'modernisation' of local government in both its organisation and structure, its functions, place and contributions *vis-à-vis* other structures brings many players to bear on inter-related problems faced by the community.

The resulting culture is one of a clear understanding that embraces the different origins and backgrounds of the various stakeholders and recognises their mutual roles, responsibilities, resources and limits. It must value highly an attitude of simple patience, tolerance, persistence, willingness to share, open-mindedness, respect for and sensitivity to the involved parties. There is the need for a positive open culture of affirmation, which values people and aims to replace criticism with consultation, irritation with understanding, and inspection with education. The aim is to bridge the cultures of the professionals and the cultures of communities, blending professional expertise with community experience and advocacy. □

partnerships mental health

The West Midlands Partnership for Mental Health Newsletter April 1999

"The Biggest Policy Agenda Facing Mental Health Services Ever (?)"

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Partnerships in Mental Health

Well, if it isn't, it certainly feels like it!

The launch of "Modernising Mental Health Services" was only the beginning. A succession of developments over the forthcoming months, including, of course, the Mental Health National Service Framework (MHNSF), means even more busy times ahead. This gives us all the opportunity to press for the development of modern mental health services our services users deserve. **(continued on page 7)**

The West Midlands response to the policy agenda

Above are some of the members from the West Midlands Partnership for Mental Health Development Group. The group is forming the basis of the mental health agenda. left to right they are:
Jackie Lynton, Antony Sheehan, Lesley Lilley, Dr David Shiers, Angela McHarron, Colin Marsh, Sally Hall, Duncan Henderson and Roslyn Hope. Others from the group are: Alistair Howie, Sue Cox and Dave Pearson. See pages 2 and 3 for more details.

Produced by **Kaleidoscope** ....."*a mental health employment initiative*"
on behalf of Partners in the community of Mental Health in the West Midlands.
Supported by the NHS Executive West Midlands.

developing service

Partnerships in Mental Health. Guidelines to Good Practice.

Walid El Ansari shares...... "broad principles for productive partnerships" in mental health.

The Beverage report in 1942 which was to provide the framework for the welfare state and within it the NHS put forward the importance of inter-sectoral working. As a consequence, there was a set of inter-linked, cross-governmental policies related to social policy. This highlighting of the "joint working" principle by Beveridge is very much the key to the government's thinking about health today.

Encouraging partnerships between various stakeholders representing different policy arenas is emphasised in the Government's White Paper on The New NHS and the Green Paper, Our Healthier Nation. Similarly, the Health Action Zones, announced in March last year, recognise the clear need for local partnerships both within the NHS and between the NHS and other players.

The Guidelines that follow are the conclusions of a recent three-year study of five 'Community Partnerships in Health' in South Africa. These partnerships were between the academic training institutions, the health service providers and the beneficiary communities. The study was carried out jointly between Walid El Ansari, MD Lecturer in Public Health, University of Wolverhampton and Dr. Ceri Phillips, Senior lecturer, University of Swansea. The key summaries which emerged were:

>**The Concept, Vision and Understanding:** the partnership concept is complicated, confusing and often poorly understood or agreed upon. This is even more so when the lay community is one of the stakeholders. Early vision is thus needed to articulate the concept and in making sure that all participants are in the same "wavelength".

> **Wide Representation** from both the professionals and the participating lay community organisations as a means to increase the "critical mass" behind the partnership, coupled by clarity of the roles and responsibilities of the forthcoming partners is important. Formal links and early attention to written and signed protocols or a constitution helps formalise rules and procedures and make them explicit.

>**The Quality of Participation Needs to be Effective.** If real contribution is limited then participation may merely provide a platform for the acceptance of a decision made elsewhere in the system, it may simply validate or legitimate the status quo rather than promote change.

>**Leadership Skills:** Frequently, top roles often are given to activists in the community, whether or not they possess leadership skills, and there seems to be an unstated belief that for the professionals, their education prepares them to assume leadership roles.

>Another crucial element in smooth operation and success is **Communication**. Everybody needs to get the same information. A regular newsletter, written and verbal reports at meetings and outside of meetings helps update everyone. A good quality, frequent, nonselective information flow is often needed in order to ensure that the partners do not become 'strange bedfellows' due to lack of communication.

>Partnerships are wise to steer clear of issues that tend to polarise their members, but rather build upon strengths and assets of the partners. Activities need to be designed to 'fill the gaps" between the existing services of the participating agencies.

>Partnerships members need to be empowered with skills needed for collaborative work. **Human Resource Development** helps enhance the manpower quality which in turn is important for sustainability. Finding the appropriate niche where the partnerships activities can become routine within the participating agencies will also help institutionalisation of activities and therefore continuity.

>Finally - Partnerships are not created overnight but rather they evolve. **Time Frames and Funding Cycles** need to allow for the interaction of all these effects in a gradual evolutionary process.

Walid El Ansari, MD

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OUR HEALTHIER NATION
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ISSUE 29 JULY 1998

Partnerships In Health: How's It Going To Work?

One of the areas highlighted in the Green Paper *Our Healthier Nation* is local partnerships, and partnerships both within the NHS and between the NHS and other partners are emphasised in the recent White Paper *The new NHS* (1997). Knowledge about effective partnerships is therefore critical, and Tessa Jowell, Minister for Public Health, in her speech at the West Midlands Regional Consultation Day urged people in their consultation responses 'to be generous with your experience, ... to be tough in your questions about how it's going to work.' (see Target No 28)

To respond to this request and to disseminate examples of good practice in building and fostering partnerships, Dr Walid El Ansari, Lecturer in Public Health at Wolverhampton University has formulated some broad principles which have emerged from his recent three year study examining several 'Community Partnerships In Health' and asking the question 'how is it going to work?' The key messages which emerged were:

- **Early vision and understanding** are imperative, given that partnerships are a relatively new concept and area for many. The concept is complicated, often poorly understood and not agreed upon, and the parties - professionals and lay community members alike - are often unclear about how to achieve their aims. Articulating the concept and ensuring all participants are on the same 'wave length' need numerous meetings, consultations and canvassing of good leaders in all sectors who would be involved in the collaborative effect.

- **Clarity of roles, rules, procedures and responsibilities** needs to be high on the agenda, as well as the expected rewards, goals and commitment. Clear objectives and expectations are important for equity within a partnership. Clear understanding that embraces the different origins and cultures of the stakeholder groups and recognises their mutual roles, responsibilities, resources and limits is fundamental.

- **Wide representation of the stakeholders and a strong membership** base is critical. Member recruitment that is based largely on pre-existing networks may exclude important constituencies and define the level to which member organisations become involved in the effort.

- **Leadership skills** are necessary. Leadership is visionary, inclusive, facilitative, enabling and open. Leaders need to have vision, think creatively, generate ideas, identify challenges and want to be winners. The skills required as the partnership moves from initiation to implementation to maturation are not necessarily the same. Entrepreneurial skills seem to be needed at the building stage followed by facilitator and champion skills. Later, organisational, managerial, and implementational skills, seem to be required.

- **Communication between the diverse parties** is key. Clear communication lines between the partners contribute to visibility and transparency and help avoid misunderstandings or difficulties. Releasing timetable information enables effective monitoring by beneficiaries and reduces grievances. Good quality, frequent, non-selective information flow is often needed to prevent partners becoming 'strange-bedfellows' due to lack of communication. The partnership convenor's role is pivotal for the collaborative process in promoting a culture of open communication.

- **Human resource development** helps enhance the manpower quality which is important for sustainability. Partnership members need to be empowered with the skills needed for collaborative work. Finding the appropriate niche where the partnership activities can become routine within the participating agencies will also help the continuity of activities.

- Partnerships are wise to **build upon the identified strengths and assets of the partners** and steer clear of polarising issues. Activities need to be designed to 'fill the gap' between the existing services of participating agencies. New solutions can emerge from successful collaboration that no single party could have envisaged.

- **Realistic timeframes and funding cycles** are needed in recognition that partnerships are not created overnight but evolve and need to proceed in a step-by-step fashion at the pace of the participating agencies.

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PHA News

NEWSLETTER OF THE PUBLIC HEALTH ALLIANCE

Autumn 1998 Number 28

Warwick conference: New PH organisation proposed

On two days in July, 24 people, half from the PHA and half from the Association for Public Health, met together at Warwick University to try to arrive at a clear agreement to set up a new public health organisation. They explored a shared vision of what sort of an organisation this should be and provided a brief for a working party to put together a development plan for further consultation with PHA/APH members. **Angela Fisher,** the facilitator of the meeting, reports.

The event began by an attempt to establish best and worst case scenarios for the world of public health in a decade's time. The aim was to establish a 'vision' for any new public health organisation inhabiting this future world and to establish its tasks, functions, character and style, its priorities and its structure.

The significant outcome of the event - what follows are some of the matters discussed - was that there was broad agreement to recommend to the members of the APH/PHA that a new public health organisation should be established. It was noted that there were no significant differences between APH and PHA on the vision, tasks and structure of the new organisation although some individual participants expressed some reservations about elements of what was proposed. The meeting mandated a working party made up of senior officers and staff from APH and PHA to begin work on developing the plan for consultation. The working party will meet on September 9. The proceedings from the event were as follows.

Vision

The joint vision established at the meeting included the following points: mobilising and focusing the public health movement, bringing together what were described as its 'three dimensional' jigsaw pieces: championing public health and social justice; identifying, influencing and shaping policy; supporting communities and ensuring implementation. The values of the new organisation were to include the development of a holistic definition of health. The keywords to include are: social inclusivity, accessibility, equity, solidarity, anti-discrimination, popular appeal, and the values underlying the Ottawa Charter and Local Agenda 21.

Tasks and functions

Working at different levels and in different 'constituencies' the new organisation would:

- Promote understanding of public health issues through research, publications, training.
- Promote awareness of public health issues through advocacy, lobbying and campaigning, and through effective communication and publicity.
- Shape and influence public policy.
- Ensure effective networking and collaboration between the statutory, voluntary and private sectors.
- Ensure participation through encouragement and support for individuals and communities.
- Build capacity and strengthen all participants and interested people. Become multidimensional through support of other major radical organisations.
- Network at all levels.
- Evaluate its own activities and facilitate evaluation of the health impact of activities of other agencies.
- Manage and resource itself effectively.

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AGM '98

Saturday 19th September 1998 1:45 pm - 5:00 pm

The Ninth Annual General Meeting of the Public Health Alliance takes place in London at the premises of the Health Education Authority. We will be celebrating the 150th anniversary of the Public Health Act 1848 with short presentations and an audience discussion and debate, entitled

150 years of local public health: what comes next?

The speakers are:

Dr Charles Webster, official historian of the NHS

Cath Cunningham, health policy officer of the Local Government Association

Stockport Health Visitors, describing community development work in Stockport as part of joint working between the local authority and health authority.

Public

Health Act

1848-1998

150 **YEARS**

Partnering for health

Drawing on his research of five community partnerships in South Africa Dr Walid El Ansari of the University of Wolverhampton discusses the components of successful partnership working.

Health Alliances are being developed in many cities in the UK as the government's public health strategy with its emphasis on joint working gets under way. The recognition that 'wicked issues' cannot be solved by one agency on its own has encouraged diverse stakeholders to come together and, with a greater stress on community participation, everyone is on a steep learning curve. Given that the elements of partnership work are intricately interlaced and difficult to isolate the question is: what are the issues embroiled in the partnership concept?

Despite many years of lip service being paid to it, partnership working is a relatively new concept for many people. It is complicated, confusing, and often poorly understood, even more so when the lay community is one of the stakeholders. Early on in the partnership a vision of what joint working means needs to be articulated, to make sure that all participants are on the same wave length. It is like organising a symphony where many instruments play a part. Failure of one instrument creates a discordant note. A first step should be to identify how stakeholders' concerns are intertwined and the reasons why they need each other to solve the problem.

Lack of clarity frequently leads to confusion and consequently non involvement. Clear objectives and expectations of rewards, as well as commitment from the partners, are important, so parties feel equal in the partnership. Early attention to a written and signed constitution helps formalise roles, rules, procedures and responsibilities and makes them explicit, thus binding all the partners and contributing to accountability.

Wide representation of the stakeholders and a strong membership base is critical. Member recruitment that is based largely on pre-existing networks may result in the exclusion of important constituencies and may restrict the level to which member organisations become involved in the effort. The quality of participation needs to be effective. If real contribution is limited then participation may merely provide a platform for the acceptance of a decision made elsewhere in the system; it may simply legitimise the status quo rather than promote change. Continuity of membership with regular attendance, rather than a high turnover of representatives, is another factor in avoiding tedious repetition of arguments already gone over. Participants need to have the authority to take binding decisions on behalf of the organisations they represent rather than becoming 'rubber stampers'.

Leadership skills are similarly critical. Leaders need a sense of vision - to think creatively and to identify the essence of challenges. For many professionals, there is an unstated, and frequently mistaken belief that their education prepares them to assume leadership roles in a variety of settings. In parallel, top leadership roles often are given to activists in the community, whether or not they posses leadership skills. Related to the issue of leadership is the partnership's convenor, a crucial factor for success. An unsuitable convenor can cause conflicting messages, unnecessary tensions and a decline in staff morale. Good convenors need not have authoritative styles and are vital in a well functioning partnership where jobs are done, deadlines met and committees are working.

Another important element is communication. Everybody needs to get the same information. A regular newsletter, written and verbal reports at meetings and outside of meetings help update everyone. A good quality, frequent, non-selective information flow is essential to ensure that the partners do not become 'strange bedfellows' due to lack of communication.

Power, people and power struggles are at heart of partnerships. Wide and genuine consultation is essential if decision making is to be on an equal basis and not dominated by strong personalities or cliques. Respect for the other partners' autonomy and their different views is fundamental. Reaching consensus in a partnership is difficult at the best of times. Dealing constructively with differences is an easy virtue to champion, but much more difficult to put into practice on a day-to-day basis.

Partnership members need to be equipped with the skills required for collaborative work. Human resource development helps enhance the manpower quality, which in turn is important for sustainability. Finding the appropriate niche where the partnership activities can become absorbed into the mainstream of participating agencies will also help ensure continuity.

Short time frames may be appropriate to start the collaborative process, but not for sustained joint working. Partnership work is slow, and has to proceed step-by-step at the pace of the participating agencies.

Funding cycles and time frames need be sufficient to develop strategies for accommodating and addressing all these issues, thus raising the likelihood of long-term viability and sustainability of partnerships.

Further information and a more detailed exposition of his research can be obtained from:

Dr Walid El Ansari MD, Lecturer in Public Health, School of Health Sciences, University of Wolverhampton, 62- 68 Lichfield Street, Wolverhampton WV1 1SJ

Tel: 01902 321145; Fax: 01902 321146/ 321161; Email: walid.ansari@usa.net or in5912@wlv.ac.uk

NHS MAGAZINE

ISSUE No. 15 WINTER 1998 • £2.95

Millennium solution: Bringing Year 2000 deadline forward

Self-care: Avoiding ills of the 'white coat syndrome'

Add wit: John Cleese on explaining the diagnosis

and focus ·oving ce's lot

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Tackling major health issues will mean forging effective partnerships between many agencies. Seven key principles are essential, says Dr Walid El Ansari, lecturer in Public Health at the University of Wolverhampton, who has recently returned from a three-year study of five Community Partnerships in Health in post-apartheid South Africa.

Partnerships and new ways of learning

As South Africa emerged from the apartheid era, American seed funding was used to help establish five demonstration community partnerships with the aim of influencing the education of health personnel so as to be more responsive to the communities they serve.

The partnerships between the medical and nursing training, teaching institutions, the health services and the beneficiary communities were encouraged as part of the new atmosphere of equality and joint working to build a new nation.

At the heart of the initiative is interdisciplinary and innovative ways of learning. The idea is to expose medical, nursing and allied health professions students to each other and to the community settings early and, through training in the community, help develop health care teams that are highly sensitive to local needs.

A spectrum of educational programmes emerged, including teacher training, career guidance, bursary assistance, training for health sciences students, formal and informal education programmes, exposure of students to rural settings, a community health worker training programme, and a community college.

Many lessons emerged from the initiative applicable to developing partnerships in any setting. While working together to achieve a holistic approach to public health and community care is appealing to most health agencies, the practice of collaboration is far from straightforward. Experience shows following some key principles can help agencies avoid the pitfalls littering the path to a successful partnership.

Firstly, partners need to have agreed their mission, goals and outcomes. They need to have a shared vision of how the various partners inter-link and why they need each other to solve the problem. Short- and long-term objectives must be balanced, perhaps defined by a written 'constitution' for the partnership.

The second and related component is clarity: objectives, expectation of outcomes, roles, rules, procedures, responsibilities and level of commitment from the partners must all be explicit. Without such clarity, confusion and failure to get involved beckon. With it, the partnership can move on to identify what services are needed and the local resources available, and select the proven core programmes – with measurable outcomes – to tackle the issues confronting the partnership.

A third factor is the relationship between the partners. They must be genuine; characterised by mutual trust, respect, and long term commitment. Bridging across organisational and community cultures, blending professional expertise with community experience and advocacy is not easy. Patience, tolerance, persistence, willingness to share, open-mindedness, and respecting the sensitivities of partners are vital. Promise less and deliver more might prove to be an appropriate motto in a partnership setting.

Effective communication is the fourth ingredient. Partnerships must talk a common 'language' and develop feedback loops to avoid misunderstanding, to allow concepts to be refined, and to ensure that all partners have a voice.

Everybody sharing the same information, at the same time, through clear lines of communication between the parties, helps avoid misunderstanding, helps effective monitoring of progress and improves the quality of participation because all partners feel they have a voice.

Leadership is the fifth component. The skills, visibility, composition and legitimacy of the partnership's leaders are all factors that affect the quality of participation of the stakeholders. Top leadership roles often are given to activists, whether or not they possess leadership skills, or to professionals because of the belief that their education prepares them to assume leadership roles. The choice must be more carefully made to get the skills required, remembering they may vary as the partnership moves from initiation through implementation to routine management and administration.

The sixth critical constituent is consultative decision making. Wide consultation is essential and decision-making must not be dominated by a single partner or inner circle. Respecting other partners' autonomy and different views, and avoiding 'tokenism' is easy to champion, but difficult to put into practice.

Setting realistic time scales for action is the final, and often forgotten component.

Partnership work is slow and time consuming, and may have to proceed, step-by-step, at the pace of the slowest participating agency, recognising many will already have a heavy workload. Partnerships are not created overnight but rather, they evolve taking the time to build trust and confidence between the partners.

Time frames and funding cycles need allow for the interaction of all these effects in a gradual evolutionary process, so be committed for the long haul.

■ *Dr Walid El Ansari, Lecturer in Public Health, School of Health Sciences, University of Wolverhampton, Wolverhampton WV1 1DT. Tel 01902 321145. Fax 01902 321161. E-mail walid.ansari@usa.net*

Capacity concerns for implementing EPR

I am delighted to see the amount of discussion generated by the publication (at last!) of "Information for Health".

However, it seems to me that most of this ignores one major problem – the capacity of the UK Healthcare IT industry to supply the necessary expertise within the quoted timescales. One of the largest Healthcare IT suppliers is currently implementing an Electronic Patient Record ("EPR") system in a hospital in Edinburgh, and I understand they estimate needing 25 of their staff on site for around two years. That hospital has approaching 1000 beds. Given the need for such support it is certain that all of the suppliers, in total, will not have sufficient staff to implement EPR in the acute sector in England and Wales to the level specified in the Strategy i.e 35% rather because of the lack of sufficient numbers of appropriately skilled and experienced people within the supplier community.

This of course has been exacerbated over recent years as a result of the decimation of the supplier base, caused not only by general under-investment in NHS IT, but also by the arcane, convoluted and extremely long winded procurement process. Whilst the strategy is beginning to address this, it does not yet go far enough, and, in any event, it will take time for skilled Healthcare IT staff levels, especially in the supplier industry, to get re-established.

Ted Woodhouse
Director of Information Services
The Leeds Teaching Hospitals NHS Trust

LETTERS

pital ward without seeing a heap of white coats rolling around plastered – a frightening concept.

The fact is that of course this isn't the case. The truth is even more frightening. Drink and drug problems are far more insidious and tend to lurk hidden below the surface – one may not be able to tell the drinker or drug abuser from the teetotaller.

However, I for one know at least one colleague who I would class as having a serious drink problem and another who is probably well on her way. I'm sure that most people in the NHS would also know at least one person who would require help. However, we continue to work with these people – because they often continue to be good doctors.

So what is it that makes doctors such a high-risk group – long hours, difficult decisions, pressure of continuing high standards of performance, the consequences of the odd mistake even! There is an enormous investment in training a doctor, however, when one reacts to the pressure of work – perhaps because of a single event or series of incidents and this pressure then manifests itself as a drink or drug

The levels of addiction in health professionals is dangerously high. We will never know the effects it has on patient care. Perhaps before we begin to look after our patients, we should learn to look after ourselves.

Dr Camilla Bull
General Practitioner/locum
Hounslow

Pharmacists need to be taken seriously

Congratulations on a great publicationa and thank you for printing the interview with Hemant Patel the President of the Royal Pharmaceutical Society.

I totally agree with his words. My concerns are also that pharmacists will never be taken seriously for two main reasons. The first is that we are perceived as being 'glorified shopkeepers' disappearing behind a mountain of hair lacquers and nappies. One minute we are seen selling toiletries or negoti

'NO'! This is borne out of good business keeping, the way we are remunerated and a sense of survival. However these conceptions are greatly exaggerated and these images will need to be addressed if we are to market ourselves as the profession that can make all the difference.

The new white paper mentions pharmacists but does not adequately recognise our expertise. That is a shame. Currently it takes five years of rigorous training for us to become pharmacists with the capability of providing an all round medicinal management service. Our rightful place is at the front line in the battle against ill health. Our unique arsenal includes extensive knowledge in regards to health promotion, medicines, economies of scale, disease states and ease of accessibility amongst other things. Whilst we may have the weaponry we just don't have the ammunition. Ammunition in the form of patient registration, alternative remuneration packages that do not centre around prescription numbers, access to patient medical files and full involvement in the NHS. Why is it is that phar

late to start utilising their skills in Health Improvement Programmes, NICE etc.

Pharmaceutical knowledge is a rich resource much like an oil reserve which is as yet untapped and it is that dream car in your driveway that you don't know how to drive. Why then ignore a substantial workforce of 42000 in the UK. All these pharmacists are present in all the sectors of the medical fields (and outside it) and they see over a million people daily. They understand the intricate workings of the NHS, provide an effective network, have the capability of getting mechanisms in action and they speak the language of all health professionals and patients. To ignore any of this is at the cost of the patients' health, the welfare of the NHS, the tax payer, the GPs' workloads and everyone's interests.

Sultan I. Dajani
Bpharm., MRPharmS, Dipl CommPharm, ACPP

Your views on general NHS matters or

NEWS LETTER

PARTNERSHIPS FOR CHILD WELFARE

Vol. 6, No. 1
February 1999

From the Editor

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Partnerships for Child Welfare
Volume 6, Number 1

EDITOR
Joan Levy Zlotnik

This newsletter is published three times annually by the Council on Social Work Education as part of a subcontract with the University of Utah Graduate School of Social Work, with support from the U.S. Children's Bureau.

An electronic version of the newsletter is also available through the Publications and Projects sections of the Council's website, visit http://www.cswe.org.

The deadline for materials for the next issue is April 15, 1999. Please send all submissions to the editor at the address below.

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This sixth edition of *Partnerships for Child Welfare,* published by the Council on Social Work Education (CSWE), welcomes a new partner in its publication. The newsletter is now supported through a subcontract from the University of Utah Graduate School of Social Work as part of its efforts to disseminate partnership activities. CSWE welcomes the collaboration with colleagues at the University of Utah, especially Katharine Briar-Lawson and Norma Harris, who, for more than a decade, have been key leaders in efforts to improve outcomes for children and families by creating strategic university–community partnerships. They also served as the first editors of the newsletter, when it was published from Florida International University.

We also express our appreciation for the support we received from the California Social Work Education Center (CALSWEC) at the University of California at Berkeley for the newsletter between 1996 and 1998. Former CALSWEC executive directors Bart Grossman and Nancy Dickinson, as well as current executive director Sherrill Clark, recognized the critical value of a national exchange of ideas, research, and resources, and helped ensure that *Partnerships for Child Welfare* was sustained. *Partnerships* has been published since 1992—first by Florida International University, then Florida Atlantic University, and now CSWE.

The newsletter continues to serve as a critical dissemination vehicle for partnership efforts, especially those occurring between child welfare agencies and social work education programs. This will also be the third edition of the newsletter that appears also in electronic format, through CSWE's website, http://www.cswe.org. Moving the newsletter into cyberspace has built new readership and has expanded the audience across the globe. Thus, in this edition you will find an article on partnerships written by a physician in England based on his work in South Africa. It attests to the universality of the attributes of successful partnerships.

The number of state and local child welfare agencies working collaboratively with social work education programs to develop and implement training, research, evaluation, and program initiatives, and which prepare social work students for child welfare careers, continues to grow. The Children's Bureau funded 29 new child welfare training grants in FY 1998 (see p. 6) and will have $1 million in new funds to support additional grants in 1999.

Continued on page 9. . .

Adoption and Safe Families Act Brings New Challenges to Educators

After a period of relatively low involvement in public child welfare, academe has reinvested in the field, spurred on by federal government leadership. The Adoption and Safe Families Act (ASFA) of 1997 brings new opportunities and challenges for academe's involvement in public child welfare. A few are suggested here in relation to the three primary components of the academicians' role: teaching, service, and research.

Teaching

Several curriculum areas should include material on ASFA. Policy courses might include analysis of ASFA, which was created through a blend of political interests, advocacy, and professional knowledge. While thorough analyses of the legislation are not yet available, it is clear, for instance, that child advocates played an important role, as many believed that the Family Preservation and Support Services Program had tipped the scales too much in favor of maintaining children in their birth families and compromised safety. Thus, safety is riddled throughout the reauthorization. In addition, attachment theory, which underlies much of the knowledge base in child welfare, is evident in ASFA's shortened time frames and expedited adoption, reflecting the child's sense of time and the importance of stability. The legislation also has undercurrents that some families are "deserving" and some "undeserving."

Practice courses may be affected by ASFA, as well. While shortened time frames might be appropriately responsive to the child's sense of time, they may also be punitive if staff lack the practice skills for using the shortened time frames productively with families. In addition, educators need to train students to practice more intelligently. Practice in a new and rapidly changing environment demands that workers approach practice as researchers; each practitioner is a scientist, constantly gathering data about the effect of interventions and adapting them as needed. Research courses in single-subject design can help students bring this kind of analytic thinking to their practice.

Service

Two service areas in which facul might be involved are advocacy an agency-based training. As states r shape their statutes to be consister with federal legislation, academ cians, working jointly with the stat agency, law schools, and other i terested parties, can advocate fo best practice and social work value to ensure that new legislation is sup portive of families, rather than pu nitive.

In terms of training, academ must also continue to work with th state agencies, through state co tracts and federal university-base child welfare training grants, to f cus on salient issues related to ASF many of which are reflected in th research questions below.

Research

ASFA's emphasis on accountabi ity and the outcomes of child safet permanence, and well-being pr vides important opportunities f agency-university collaboratio around research and evaluation.

Continued on page 14

Critical Components of Successful Partnerships Cross Countries

In many policy areas the call for partnerships across sectors, and the recognition that difficult issues cannot be solely solved by any one agency, has encouraged public participation and joint cooperation. Diverse stakeholders are being increasingly involved in intersectoral initiatives to improve peoples' health. Because a health strategy is no longer largely considered the health service providers' job, and because service providers are increasingly recognizing the importance of the wider determinants of health, the emphasis on closer working links between local agencies and health authorities is high on the agenda.

In an attempt to disseminate examples of good practice in building and fostering partnerships, some broad principles have emerged from a recent study undertaken by Dr. Walid El Ansari of the University of Wolverhampton, United Kingdom. El Ansari spent two years examining five "Community Partnerships in Health" located in various provinces in South Africa, asking "How do successful partnerships work?" Among the key messages that emerged from his work:

- An up-front vision and understanding are imperative, given that partnerships are a relatively new concept and area for man Although encouraging, the co cept is complicated and ofte poorly understood or agree upon, and the parties—profe sionals and lay community me bers alike—sometimes are n strictly clear about how goals wi be achieved. Articulating the co cept and making sure that all pa ticipants are on the same wav length require numerous meeting consultations, and canvassing good leaders in all sectors wh would be involved in the collab rative effort.

Continued on page 10.

Selected Research on Child Welfare Practice and Social Work Education

Ed Sites, professor at the University of Pittsburgh School of Social Work, Section 426 Training Grant Project Director, and longtime collaborator with public child welfare agencies, has identified these additional research studies that provide data about child welfare staffing. The first list of studies appeared in the previous issue (August 1998, p. 11).

Anderson, D. G. (1994). *Coping strategies and burnout among veteran child protection workers.* Doctoral Dissertation, University of South Carolina.

A study of 151 seasoned frontline child protective caseworkers and their supervisors from all areas of South Carolina corroborates the findings of other researchers that "excessive workload, poor administrative support and bureaucratic constraint" contributed to worker stress, burnout and turnover. The study also finds that social work education (particularly graduate social work education) reduces workers burnout, a major cause of staff turnover.

Cicero-Reese, B., & Black, P. (1998, February). Research suggests why child welfare workers stay on the job. *Partnerships for Child Welfare, 5*(5), 5, 8-9.

This study examines the reasons child welfare workers remain in their positions longer than two years. It finds that two factors, aside from concern for children and satisfaction in helping children, were decisive: social work education and climate of the work environment, including supportiveness of supervisors and peers. Eighty-one percent of those who stayed had completed at least one social work degree.

Glisson, C., & Hemmelgarn, A. (1998). The effects of organizational climate and interorganizational coordination on the quality and outcomes of children's service systems. *Child Abuse and Neglect, 22*(5), 401-421.

This quasi-experimental, longitudinal study finds that positive organizational climate, rather than increased interorganizational service coordination, is a significant factor in improving the psychosocial functioning of children involved in the system of care. Findings suggest that caseworkers have improved success when they can make decisions based on the child's unique needs, can respond to unexpected problems, and have the tenacity to navigate bureaucratic and judicial hurdles. Organizational climate was measured by assessing fairness, role clarity, role overload, role conflict, cooperation, growth and advancement, job satisfaction, emotional exhaustion, personal accomplishment, and depersonalization.

Harrison, S. G. (1995). *Exploration of factors related to intent to leave among child welfare caseworkers.* Doctoral dissertation, Ohio State University.

This study of 226 public child welfare workers in Franklin County, Ohio, finds 9 variables which predicted worker retention. Among the most important of these are training, having had an internship in public child welfare as part of one's preparation, agency support (including strong supervision), and psychological rewards. Workers who believed their knowledge, skills, and professional education were underutilized were most likely to leave.

Smith, E. M., & Laner, R. (1990). *Implications of prior experience and training for recruiting and hiring CPS staff.* Arizona Department of Economic Security, Administration for Children, Youth and Families.

This cross-sectional survey of 179 child welfare supervisors and case managers finds that MSWs have lower burnout rates than BSWs or other MAs.

Whelley, J., & Mericle, H. (1994). Practicum Education: A practice partnership for family preservation. In *Empowering Families: Papers from the Seventh Annual Conference on Family-Based Services.* Riverdale, IL: National Association of Family-Based Services.

This study was part of a training initiative designed to place MSW students in public child welfare agencies for their internships and recruit them to agency practice following graduation. It finds that some of the major reasons why MSWs leave public child welfare practice are a sense of being alone with major responsibility, high caseloads, excessive time spent in "paperwork," and the lack of a supportive supervisor. Workers often moved to programs offering similar services, but were characterized by support and openness to change.

Partnership Success Factors

Continued from previous page.

instead build upon the identified strengths and assets of the partners. Activities need to be designed to "fill the gaps" between the existing services of the participating agencies. When collaboration is successful, new solutions emerge that no single party could have envisioned: a weaving of diverse viewpoints into a mosaic with new insights and direction for action agreed on by all stakeholders.

- Partnerships are not created overnight, but should proceed in a step-by-step fashion at the pace of the participating agencies. Time frames and funding cycles need be realistic to allow for the interaction of all these effects in a gradual evolutionary process.

For more information on the findings, contact: Walid El Ansari, MD, School of Health Sciences, University of Wolverhampton, 62-68 Lichfield Street, Wolverhampton WV1 1DJ, United Kingdom; e-mail: walid.ansari @usa.net or W.Elansari @wlv.ac.uk.

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School of Health Sciences
University of Wolverhampton

Education and training for better health

ISSUE NO 3 SUMMER 1998

pd news

The newsletter of the HEA Professional Development Programme

Inside

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New Health Agenda

The HEA's first national conference on professional development for some years began an important dialogue between the many different players with an interest in health and health promotion. We were delighted that so many people made such enthusiastic contributions to the day and now plan to hold more events to bring these networks together. Your views are welcome on the many ways this might be done!

The new health agenda is creating precious opportunities for us all to share learning and key skills for health and change. Since the last issue, the HEA has made its response to the Green Paper, warmly welcoming the increased emphasis on health as a resource for living and on the importance of quality of life and not only length of life. Tackling inequalities in health and regarding health improvement as an investment and not a cost are also applauded.

However, there are challenges and obstacles in responding to the contract set out in the Green Paper. Education and training does not feature prominently yet much of what needs to be done will

depend on professionals and others who are charged with improving health whether they are in the NHS, local government, or the voluntary sector. We have stressed the need for national "players" to support local "players" with a menu of options ranging from research and development support in evaluating partnerships to support for professional development. The HEA is also responding to the Chief Medical Officer's review of public health and has facilitated a review of health promotion.

Pam Naylor
Programme Manager
Professional Development

National Conference Success

The Professional Development team's first major national conference in March this year was judged a great success by those attending. Over 80 delegates took part from a wide range of settings and disciplines, such as local health promotion services, universities, research institutions and voluntary organisations. Among the many positive comments noted on evaluation forms were "very interesting, good speakers"; "very entertaining and informative" and "a lot of information packed into one day".

The conference aims were to raise awareness of initiatives in professional education and development in the last five years; to open and widen the debate on the future of professional education and development in health promotion and to reflect on the government's new health strategy and its implications for professional development.

During a very intensive day, key themes in the discussion were:

- Changes affecting the future of health promotion;
- What is the profession of health promotion;
- What type of education and training is most appropriate;
- Evaluation and research;
- Balancing knowledge and competence, theory and practice;
- International perspectives.

A full conference report is available from Catherine Aldred on 0171 413 1945.

in brief

Look After Yourself

All LAY tutors and trainers should by now have decided on insurance options if they wish to continue to be active in LAY until end June 1999 and should have received the letter outlining the legal terms and conditions for operating LAY until that time.
Contact Shireen Mathrani.

Nurse Education

Nurse tutors responsible for preparing nurses to promote health are often concerned at the lack of suitable networks for sharing experiences and good practice. The PD team plans to set up a designated network and information service this year to help address this need.
Contact Pamela Holmes.

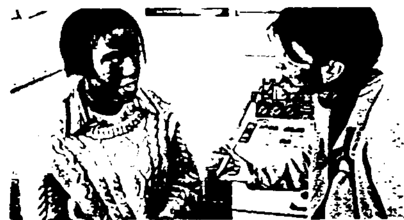
Mentoring and Coaching in Health Promotion

A series of case studies of mentoring practice in health promotion is being commissioned in order to develop guidelines for mentors and a quality framework.
Contact Barbara Wren.

GP Vocational Training Learning Materials

A new series of learning aids is being produced for vocational tutors to prepare GP trainees for their future role within local commissioning for health. Based where appropriate on the existing lecturer support materials within basic education, these will be developed in partnership with vocational tutors and piloted in vocational training schemes.
Contact Barbara Wren.

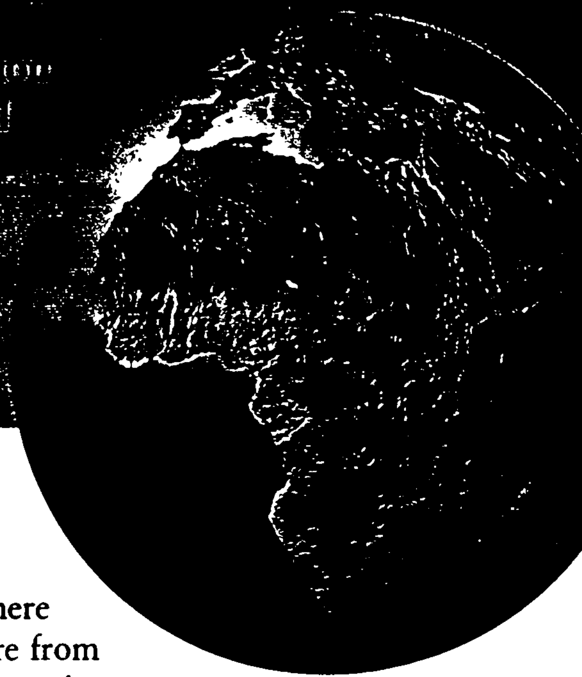
Medical Education



The HEA is actively supporting the development of a health promotion focus in undergraduate medical education. A report on approaches to health promotion in three English medical schools will appear in the summer. Materials are also being produced to support medical lecturers in their work with undergraduates and a Special Study Module to help learners undertake an in-depth exploration of the theory and practice of health and health promotion.
Contact Gill Cowburn.

International Focus

In this occasional slot featuring health promotion work overseas, Dr Walid El Ansari discusses the lessons learned from a study of multi-agency partnerships in South Africa



Our study examined five urban and rural community partnerships in various provinces of South Africa, where the stakeholders involved were from medical and nursing academic and teaching bodies, and regional health service providers. The intended beneficiaries were the various communities in which the partnerships were based.

From our study we are able to draw a number of conclusions. The first is the need to involve as wide a range of stakeholders as possible from the start, not only from among professionals but also from the communities themselves. This builds up a critical mass of support for the initiative. To be effective there must be clear vision and understanding of different roles and responsibilities among the partners. Strong leadership skills are essential here. The training of professionals does not necessarily equip them with such skills.

Effective partnerships require the commitment of all parties, and high quality participation by the stakeholders. This depends on continuous attendance by delegates, on the expertise and skills they bring and on their authority to take decisions on behalf of the organisations they represent. Partnerships are wise to steer clear of issues which may divide the partners. Activities need to be designed to fill the gaps between the existing services offered by participating agencies. Considering decision making processes, we conclude that these need to take into account authority, power structures and accountability. Major inequalities in power between partners are a barrier to effective collaboration, and a model of shared power works better. Good communication between partners is essential. Clear lines of communication between partners avoid misunderstandings, which may lead to conflict. A culture of open communication ensures all partners are kept fully informed.

Finally, we know that partnerships are not created overnight, but rather they evolve over time. Planned timescales and funding for partnership initiatives should take this into account.

This study was carried out jointly by Walid El Ansari, MD, Lecturer in Public Health, University of Wolverhampton and Dr Ceri Phillips at the Department of Nursing and Health Care, University of Swansea.

For further information contact Dr Walid El Ansari, School of Health Sciences, University of Wolverhampton, 62-68 Lichfield Street, Wolverhampton WV1 1SB. Tel 01902 32 1145. Fax 01902 321146. E-mail walid.ansari@usa.net

HEALTH ACTION !

A newsletter produced on behalf of the North West Public Health Association *Issue 6 Summer 1998*

Message From The Chair

Hello, I was elected as the new Chair of the Association at the AGM in Lancaster in March. I must express thanks to Joyce Leeson, the first Chair of the NWPHA, who has steered us through the initial two years and laid the ground for our future developments. Joyce, I know, intends to give the Association her continued support.

I have been asked to add a little something about myself. I am, by qualification, an environmental health officer and except for a two year break in the 1970s I have worked continuously in the North West of England. My career had included a period of teaching as well as practice. In 1993 I took early retirement from my post as Director of Environmental Health with Manchester City Council. Since then I have worked part time and currently I am based at the Department of Public Health at Liverpool University where I act an environmental health advisor to the NHS Executive North West. I have always had an interest in environmental pollution issues and currently serve as a member of the Regional Environmental Protection Advisory Committee of the Environment Agency. I have been a member of the management committee of a local Housing Association since 1982.

I had the privilege of serving on the Committee of Enquiry into the Future of Public Health in the 1980s. From that experience one thing became very clear to me - public health, if it is to be effective, has to embrace a multidisciplinary and integrated approach, and it must be seen to do that, not just talk about it.

This leads me to the NWPHA. Still a fledgling, but now with its wing feathers developed, it should, I hope, be able to be seen around the region as an organisation which is in tune with the region's problems and which can offer an independent voice. Our strength has to be the mix of skills and experience which our members share. I have recently been reading the proceedings of the Seventh International Congress of the World Federation of Public Health Associations held in 1994. I think the following, taken from the background document for that Congress, is so relevant to what we should be about in this region:

" Public Health Associations (PHAs) have great potential to provide the leadership needed to safeguard and improve the public's health. PHAs are multidisciplinary in nature and understand that health improvements encompass much more than providing health care services. They are committed to calling attention to inequalities with respect to health, protecting the environment and guarding the most vulnerable population groups. They are in a position to influence national policies to ensure that the needs and desires of local people be taken into consideration. Their member based organisational capacity enables them to bring about judicious change."

There are many challenges we face over the coming twelve months. Some are what I would call structural - meeting the needs of establishing an organisation which is valued, and some are to do with delivering something positive to add to the case for improved health in this region. We will not able to achieve progress on all fronts, but I want us to become less involved with structure and more concerned with pursuing ways in which we can be the independent advocate. I see us becoming more focused and hope that with the support of the members and the committee the NWPHA can take some positive steps to achieving some of the aims outlined above.

I am aware of the need to stay attuned to members' views and want to hear from as many of you as possible. If there is anything you want to say please leave a message at our office, we will take note of what you have to say, or get back to you if need be.

Mike

Mike Eastwood

Celebrate 50 Years of the NHS...

A small selection of local events are listed along with some information about the NHS 50 website:
http://www.nhs50.nhs.uk

See page three for further details

Partnerships in Health

With the recent White Paper the emphasis on partnerships both within the NHS and between the NHS and other stakeholders reveals anticipation of intersectoral alliances.

In order to establish a well functioning collaborative process, a myriad of ingredients are involved that need continuous nurturing and attention. Maintaining the active support of the stakeholders is an art as well as a science. Given that partnerships are a relatively new concept for many, early vision and understanding are imperative. The concept is complicated, often poorly understood or agreed upon and the parties - professionals and lay community alike - sometimes wonder what it is exactly that they are trying to achieve. Articulating the concept and making sure that all participants are on the same wave length may need numerous meetings, consultation and canvassing of good leaders in all sectors who are to be involved in the collaborative effort.

Clarity of roles, rules, procedures and responsibilities need to be high on the agenda. Not only the clarity of the expectations of rewards, but also of goals and commitment. Clear objectives and expectations are important to achieve equity in partnership. Clear understanding that embraces the different origins and cultures of the stakeholder groups and recognises the mutual roles, responsibilities, resources and limits is fundamental.

A strong membership base accomplished by wide representation of the stakeholders and coupled with building up formal links is critical. A strong partnership needs to be representative so from the inception, involvement of individuals and organisations from the various collaborating institutions and from the grass roots could pay off later.

The quality of the involvement of the parties so it is effective and poses a real contribution is worth paying attention to. Mere attendance at a meeting can wrongly be equated with participation as even though they are participants they may largely be observers. Groups will be reluctant to collaborate of they are at a disadvantage to adequately represent their interest or if they believe their interest will be deemed secondary to more powerful ones.

Leadership skills are necessary. Leaders need to have a sense of the required future vision, to think creatively and to generate ideas, to identify the essence of challenges and want to be - and are - winners. Skills from early-stage catalyst, facilitator, champion, organiser, manager, implementer and eventually, more routine management and administrative leadership skills are all needed.

Communication and regular flow of information through a regular newsletter, written and verbal reports both at meetings and outside of meetings help update everyone. Avoidance of long meetings and technical jargon, choosing convenient meeting times and perhaps rotating the meeting place between the various partners to keep an even balance could prove worthwhile. A misunderstanding or difficulty will lead to rampant conflict.

This photograph shows the author with two participants of a study he was undertaking in Transkei, South Africa. When a health centre is this remote and the community so dispersed, a successful partnership can work to everyone's benefit.

Consultative decision making that brings the parties on board and hears from them what they think is good for the partnership. It may be difficult to reach a consensus in a partnership, but wide consultation is essential and decision making need not be dominated by a certain party, or a small gathering of leaders, but rather on an equal basis. Interactions based on respect for autonomy is fundamental as is the recognition of different views. Sensitivity to the dynamics of the parties and culture of the participating groups and acceptance of criticism need not be limited. The basis on which participation takes place - is it willing, voluntary, coerced? - will affect the quality of input and impact on lines of accountability.

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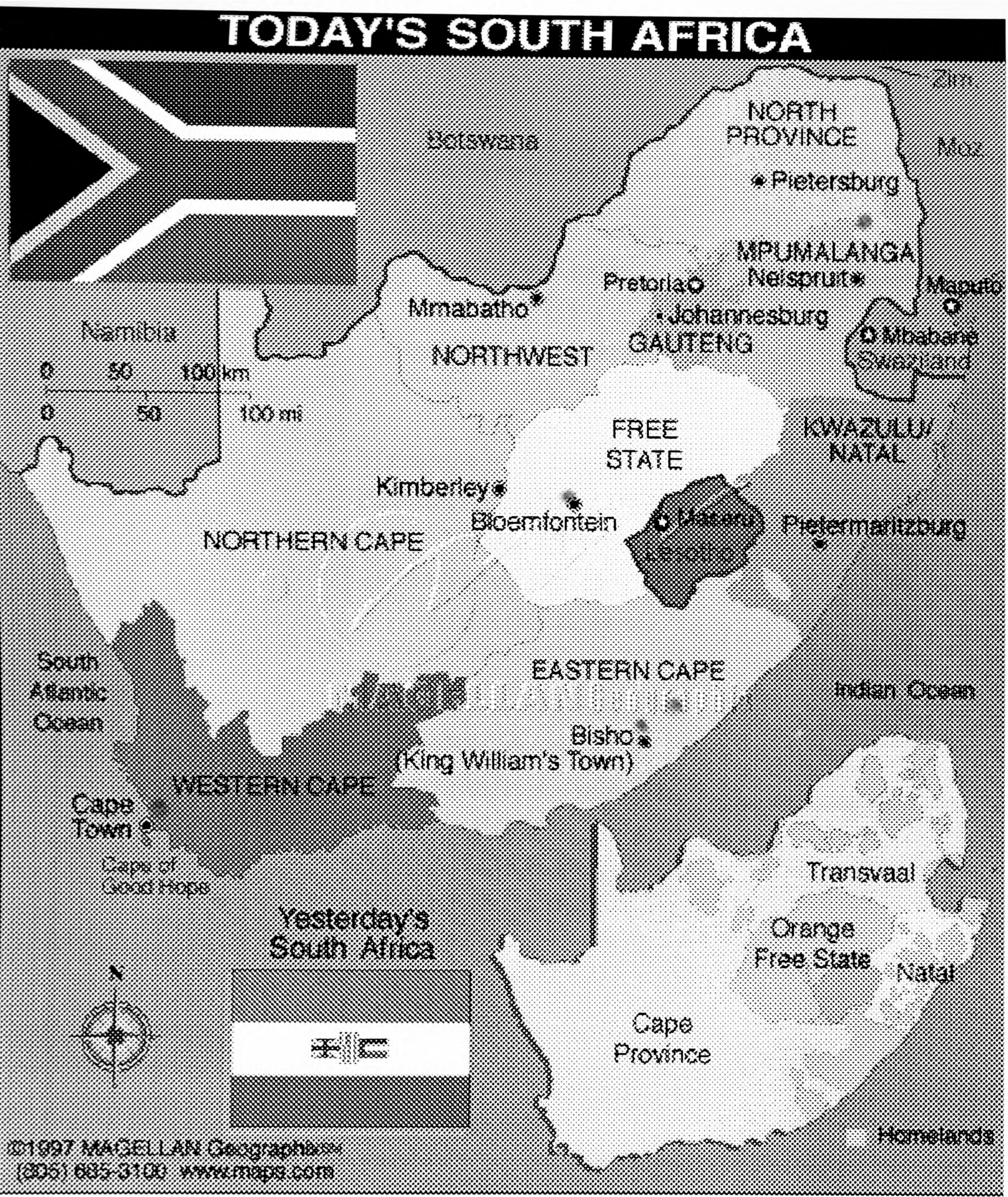
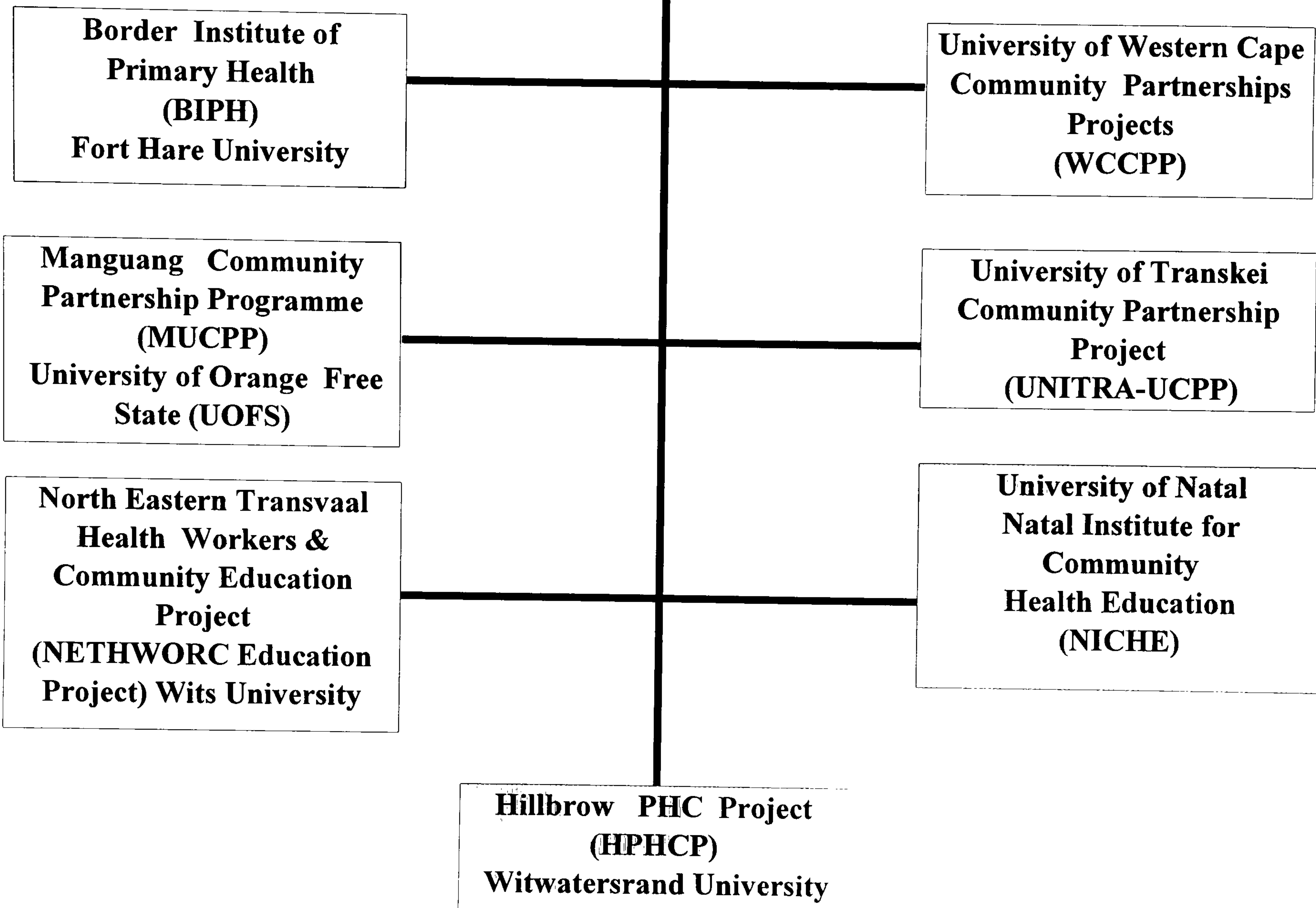
Annexes

Annex (1)




Annex (2). The South African Community Partnerships In Health
Border Institute of Primary Health (BIPH) Fort Hare University
University of Western Cape Community Partnerships Projects (WCCPP)
Manguang Community Partnership Programme (MUCPP) University of Orange Free State (UOFS)
University of Transkei Community Partnership Project (UNITRA-UCPP)
North Eastern Transvaal Health Workers & Community Education Project (NETHWORC Education Project) Wits University
University of Natal Natal Institute for Community Health Education (NICHE)
Hillbrow PHC Project (HPHCP) Witwatersrand University

Annex (3). Participating Community Partnerships In Health Personnel Education (CP-HPE)

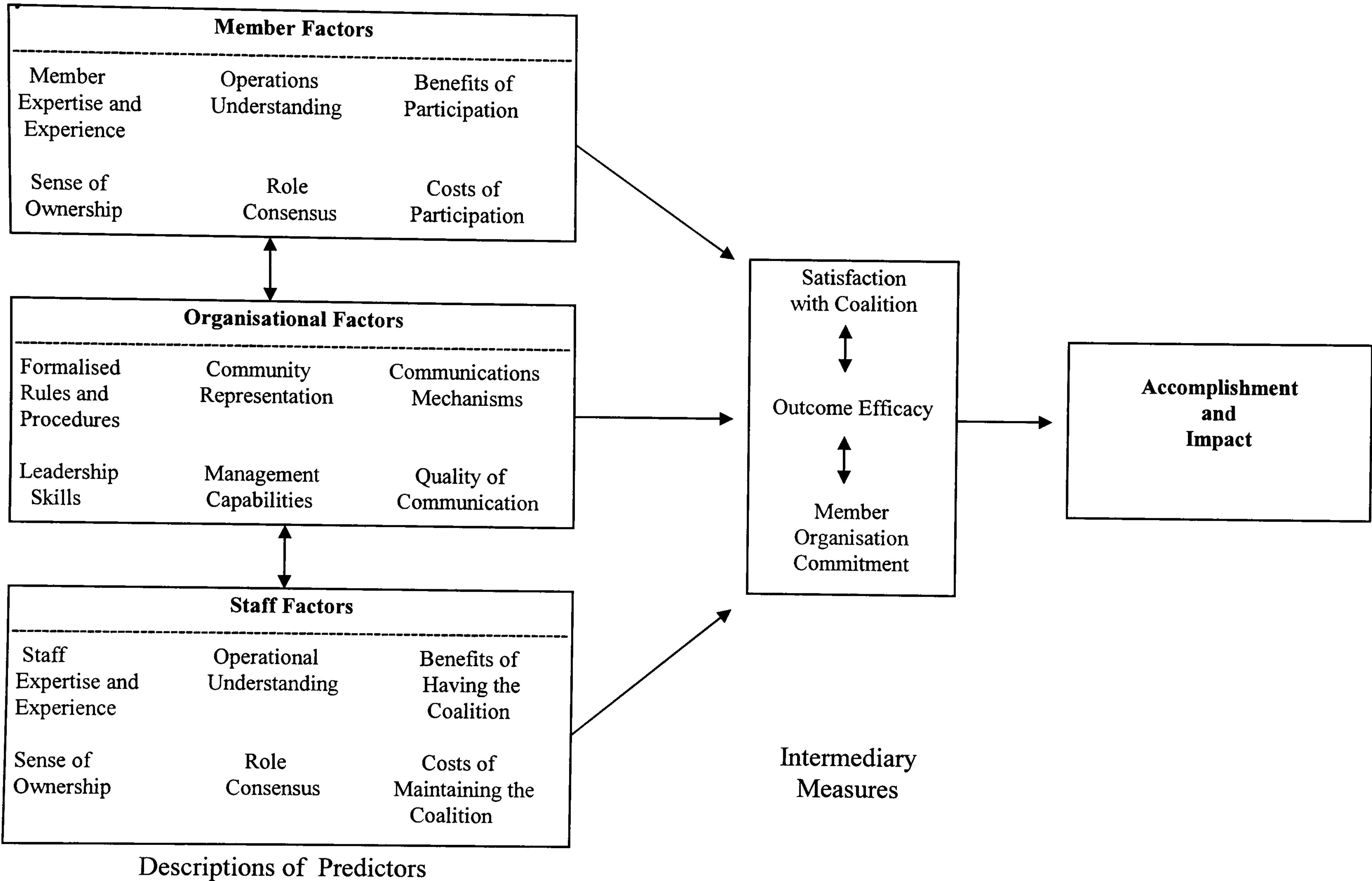
Project	Components			
	Teaching Institution/s	**Health Service/s**	**Communities**	**Activities**
1.Transvaal Health Workers & Comm. Education Project (NETHWORC)	Witwatersrand University	Local H.Services; Mapulaneng & Tintswalo Hospitals	Bushbuckridge Community	Acornhoek Community College
2. Transkei Com. Partnership Project (UNITRA-CPP)	University of Transkei	Deptartment of Health The Municipality	Four Local Communities; Baziya, Mbekweni, Ngangelizwe, Mhlakulo	Academic Com-based PHC Centres, Dept. of HealthPersonnel Education
3. Border Institute of Primary Health (BIPH)	Ciskei Nursing College Fort Hare University--Nursing Science Dept.	Cape Provincial Administration Ciskei Dept. of Health Dept. of National Health	Newlands Community	Newlands Community Profile Workshops: Com. Involvement in Health & H. professionals
4. Manguang Community Partnership Program (MUCPP)	University Of Orange Free State	Municipality Of Bloemfontein	Manguang Community	Community Health Centre in Manguang
5. Western Cape Com. Partnership Projects (WCCPP)	University of Western Cape Peninsula Technicon(PenTech)	Regional Services Council Cape Provincial Administration	Mitchel's plain, Belleville and Mfuleni Communities	Commmunity Involvement; interdisciplinary traning of Health professionals

Annex (4). Programmes and major activities of the CPs-HPE under study

Partnership	Programmes & Major Activities
Partnership (1)	***Bridging programmes***: in science and maths, teacher training, career guidance, securing places at tertiary institutions ***Bursary assistance***: and bursary information for students from participating communities ***Health sciences students training programme***: inter-disciplinary community based education and rural exposure for students ***Health worker programmes***: formal & non-formal education programmes (nursing & community-based rehabilitation worker programmes) ***Vocational training programme***: adult basic education, organizational skills (book keeping, management) and specific job training (car maintenance). ***Local government facilitation programme***: aims to develop accountable local government structures in health, environment and education ***Community college***: center piece of the project, to fill gap between school and university/ Tecknikon education. Initial focus is literacy and organizational skills training, book keeping, management and leadership training.
Partnership (2)	***Health personnel training***: university has established a HPE department, student placement in participating communities and hospitals ***Bursaries***: for students from effected communities for studies in health ***Community development programme***: community gardens, water & water accessing projects, carpentry, brick making, sanitation project, youth skills training ***Academic community based PHC centers***: building and preparation of the sites, posting of medical, nursing and health education students
Partnership (3)	***Community Health worker training programme***: establishing career paths, develop skills, attitudes & treatment of minor ailments ***Community development programme***: income generating projects, leadership training, sewing, gardening, problems of malnutrition ***Multi purpose health center***: increase community accessibility, brick laying training, plumbing & building skills for the center & future employment ***Educational programmes***: ***Health programmes***: upgrading of existing health center, additional health centers
Partnership (4)	***Community health center***: multi - purpose center strategically placed in the community to provide PHC service component, promotive, preventive and rehabilitative care. Maternal & child health, health education, sexually transmitted diseases, minor ailments ***Community Coordination programmes***: entrepreneurial skills, business and economical development: coffin making, welding, chicken project, car service skills, food gardens, sewing and knitting, cultural development ***Health services coordination***: community health, traditional health and education health committees, the aged, clean up campaigns, regional and local and provincial government committees ***Education and training programmes***: continuing education in PHC and maternity nursing, early development stimulation, Schools counseling project.. ***Youth Activities***: student representative leadership course, youth health desk, youth development, entrepreneurial skills ***Sport and recreation programme***: recreation, sport development and sport specialization at schools and within the community
Partnership (5)	***Community based education***: coordination & facilitation, student placement at heath centers, day hospitals, schools, clinics & community, joint tutorials ***Health personnel education development***: curriculum development, interdisciplinary core courses, workshops, capacity building ***Community development programme***: income generating project, brick making, sewing ***Youth development programme***: ***The aged***: day centers, students, rehabilitative services to improve mobility and self esteem ***Adult literacy programme***: ***Health & development programme for vulnerable groups***: geriatrics and disabled children, crèche and stimulation, areas of play ***Educare programme***: principals forum, training teachers, arrange toy workshops, input from psychology Department, receives students, nutrition working group, educare center, meals and food funding, involvement of community, networking, parent meetings ***After school programme***: education, meals, networking with school principals and parents, ongoing training

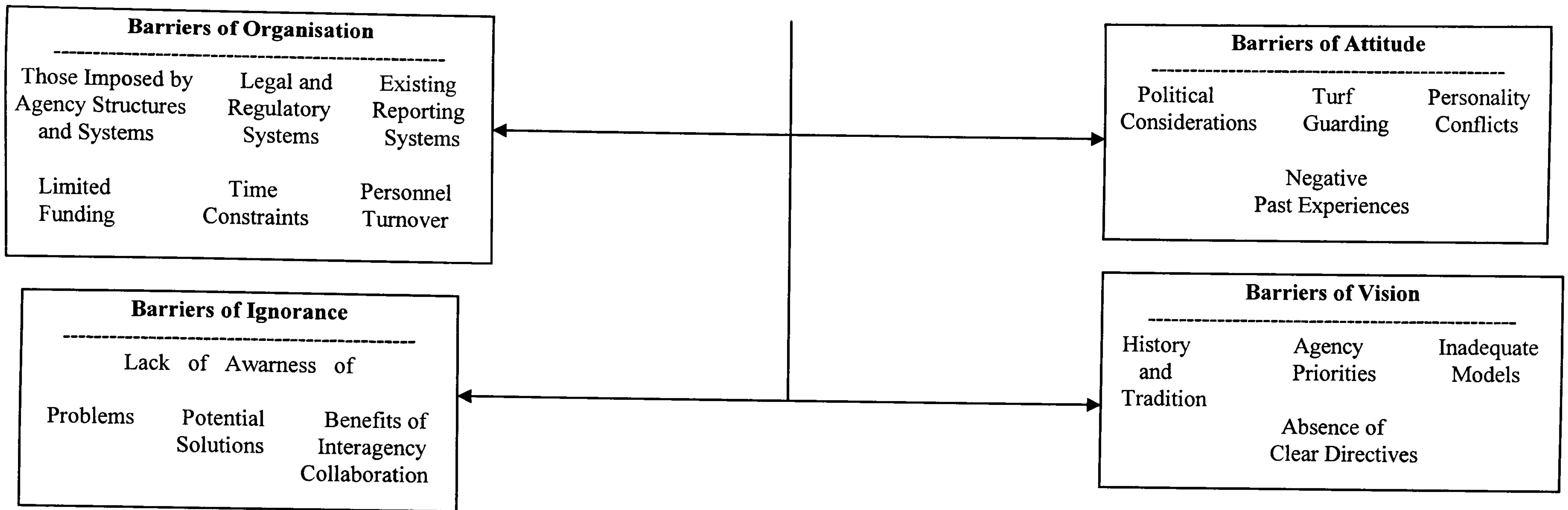
Annex (5)
Questionnaire, First Conceptual framework

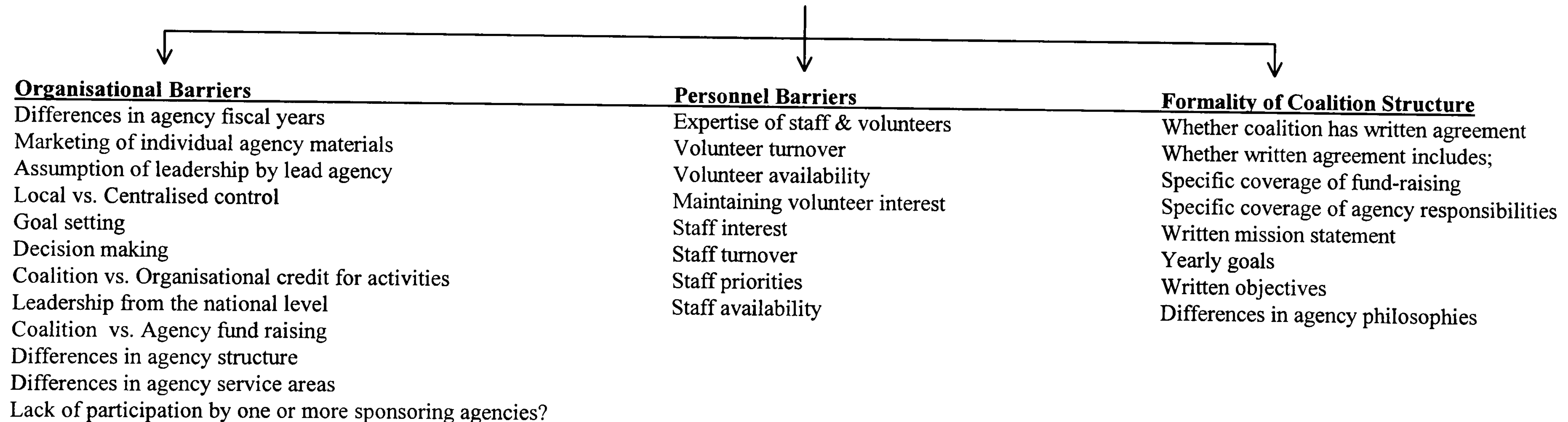
(after Rogers *et al.*, 1993)



Annex (6)

Questionnaire; Second Conceptual framework; Barriers addressed by coalitions (after Gottlieb *et al.*, 1993)

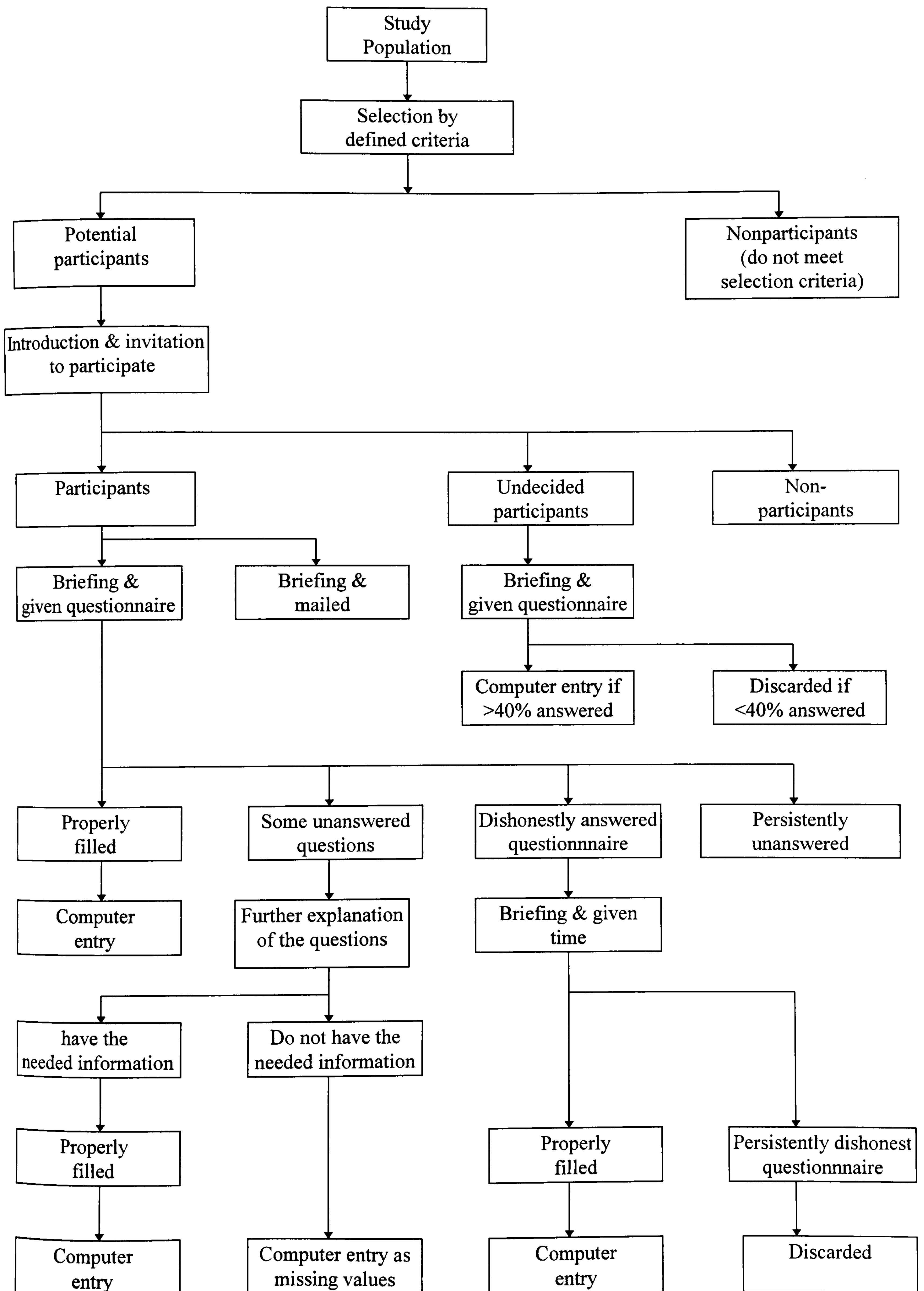




Annex (7). Number of items in each section the LV and SV of the questionnaire

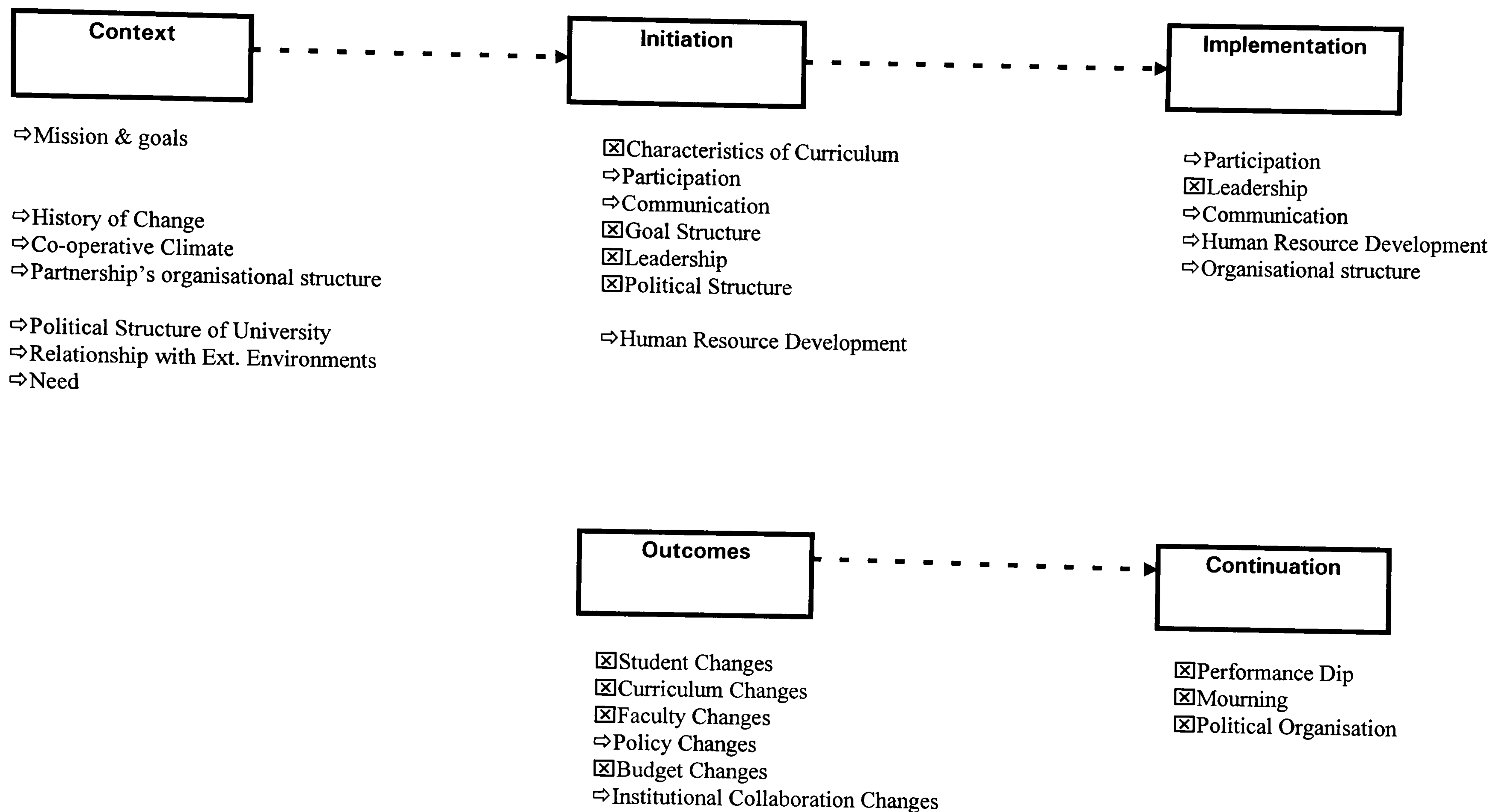
Variables	Description	No. of Items	
		Long V	Short V
Descriptive Measures			
Involvement	Involvement in P'ship cosponsored activities, meetings, etc.	11	1
Contributions	Extent to which partners/organizations make contributions	4	2
Structural Features	Factual information about P'ship meetings, structure,members, etc		
Personal Features	Gender, age, ethnicity, partner group	4	4
Predictive Measures			
Member predictors			
Member Experience	Months worked in this or similar P'ships	2	-----
Member Expertise	P'ship management abilities	11	-----
Operational Understanding	Knows P'ship mission, structure, operations	5	1
Sense of Ownership	Committed, feels pride, cares about P'ship	4	1
Role Clarity	Role perception matches that of staff	4	1
Participation Costs	P'ship participation is difficult	5	1
Participation Benefits	P'ship participation benefits my organization	11	2
Costs/Benefits comparison	Compare benefits and difficulties of being member of P'ship	1	1
Resource Allocation satisfaction	Satisfied with use of P'ship funds in the community	1	1
Organizational			
Management Capabilities:	Effective management processes and policies	23	3
Rules and Procedures	Operating principles, member orientation, mission, etc.	10	1
Community Representation	Perception that P'ship is representative	1	1
Staff-Community Communication	Quality of staff-community member communication	5	-----
Comm. Members Communication	Quality of community member-member communication	5	-----
Leadership Skills	Leaders use incentive management skills	11	1
Communication Mechanisms	Use of newsletters, reports, meetings, etc.	8	1
P'ship Interaction	Interactions, conflict, differences and control among partners	7	1
Decision Making	Attitudes & beliefs related to participation in the P'ship	9	1
Flow of Information	Amount, accuracy, timing and relevance of information	5	1
Staff predictors			
Staff Experience	Months worked in this or similar P'ships	2	-----
Staff expertise	P'ship management abilities	11	-----
Operational Understanding	Knows P'ship mission, structure, operations	5	1
Sense of Ownership	Committed, feels pride, cares about P'ship	4	1
Role clarity	Role perception matches that of members	4	1
Participation Costs	P'ship participation is difficult	5	1
Participation Benefits	P'ship participation benefits my organization	11	2
Costs/Benefits comparison	Compare benefits and difficulties of being member of P'ship	1	1
Resource Allocation Satisfaction	Satisfied with use of P'ship funds in the community	1	1
Intermediary Measures			
Satisfaction with P'ship	Satisfied with P'ship operations and accomplishments	5	3
Member org'zation Commitment	Endorsed/adopted P'ship missions; cosponsored efforts	3	1
Outcome Efficacy	Confidence that P'ship will influence HPE/PHC	16	2
Organizational Barriers	Structure & systems, limited funding, lack of common vision	18	2
Personnel Barriers	Staff/vol'teer expertise,priorities, interest, availability, turnover	9	1
Perceived Effectiveness	Communication, decisions, coordination, improved services	15	3
P'ship Activities	Description of Policy, advocacy and educational work by the P'ship	9	1
Perceived Activity	Rating of P'ship activity over 1994 & 1995	2	2

Annex (8). Data collection and entry procedures



Annex (9). Interview Guide; Factors likely to relate to successful projects

(after Bland *et al.*, 1992)



Annex (10). Interview Guide – Questions that were asked to the respondents

(This guide was revised after the first four interviews)

A. Demography & the collaborative initiative

1. Please introduce yourself, your age and administrative title.
(focus is on demographic data)

2. What collaborative effort is your organization involved in and with who? How long have you been involved in this effort?
(focus is on the stakeholders, nature and scope of the collaboration along with period of involvement of the respondent)

B. Structural Characteristics of collaborative initiative

3a. What are your concerns in relation to the Structural Characteristics of this collaborative effort?
(focus is on the structural obstacles perceived as non-conducive to collaboration: development of mission statement and by-laws; informal agreements; clearly defined rules; member roles and responsibilities; organizational structure; authority for decision making etc.)

3b. What are your recommendations to remedy the points that you have mentioned in the previous question?
(focus is on collecting remedies for the points that the respondent perceives as obstacles to effective collaboration)

C. Operational Parameters of collaborative initiative

4a. What are your concerns in relation to the Operational Parameters of this collaborative effort?
(Focus is on operational obstacles perceived as non-conducive to collaboration: leadership and management skills; human factors- expertise, personality and personnel barriers; turnover; communication quality and mechanisms; flow of information; organisational commitment; interaction and decision making processes, costs and benefits, organizational climate etc.)

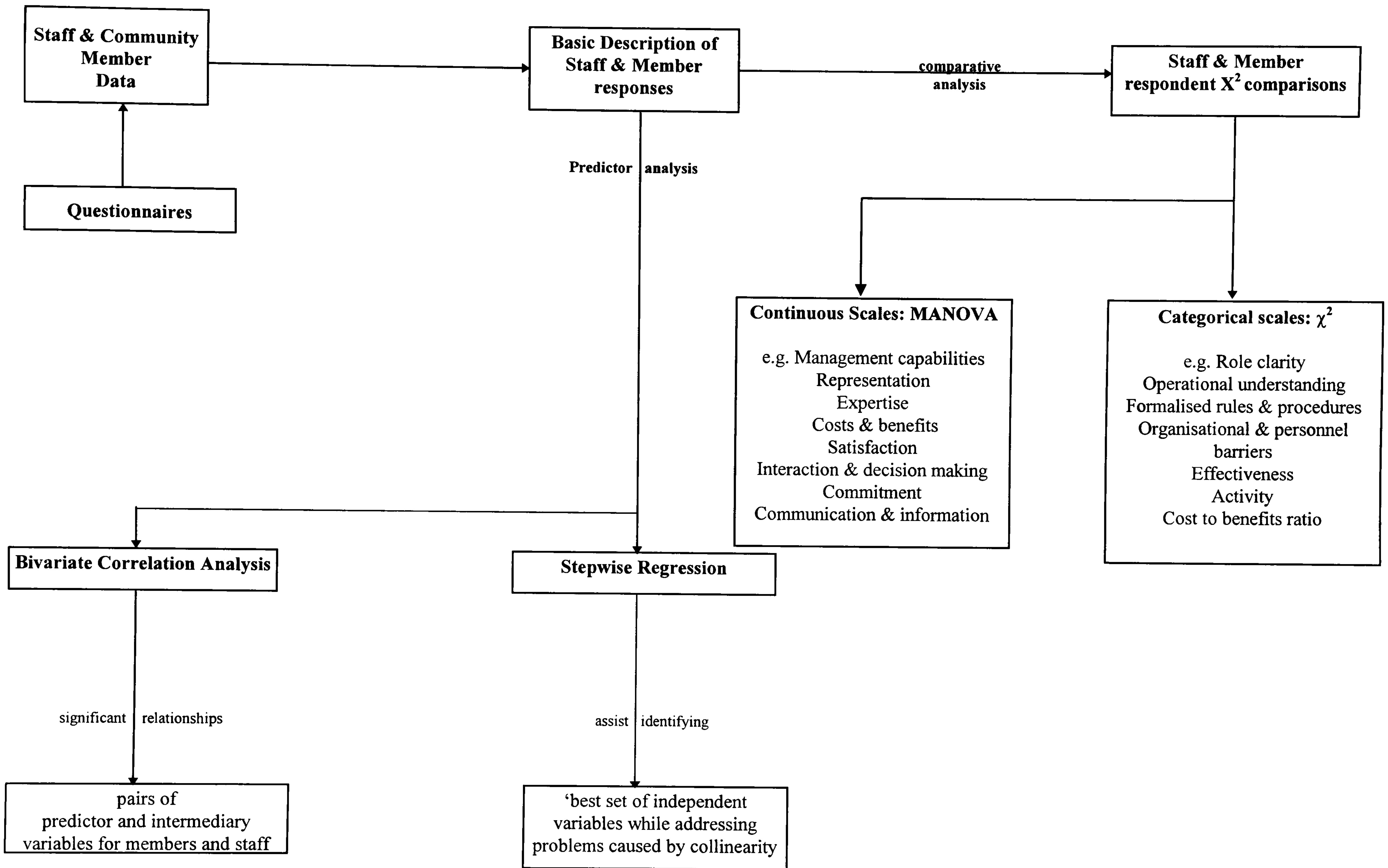
4b. What are the points in this collaborative effort that you perceive as successful or conducive to effective collaboration?
(focus is on collecting remedies for the points that the respondent perceives as obstacles to effective collaboration)

D. Others

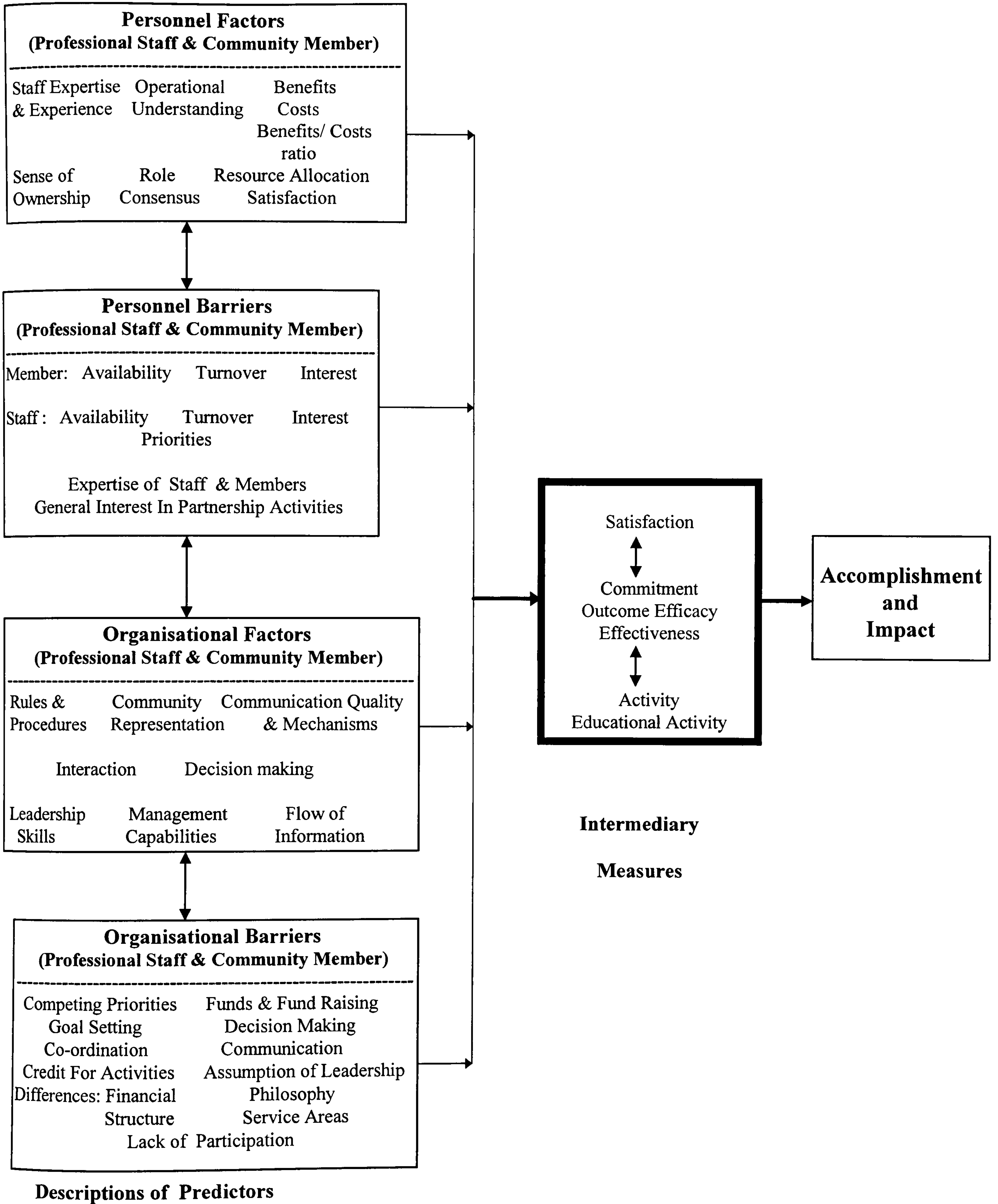
5. Do you have any other comments?

Annex (11)

Questionnaire; General Flow of Analysis



Annex (12). Flow of Regression Analysis
(modified from Rogers *et al*, 1993; Gottlieb *et al.* 1993)



Annex (13). **Data for the Radar Graph Questionnaire Sections with Continuous Scores**

Variable	Academic Institutions	Health Services	Community	Partnerships' Core Staff
1. Community Representation	4.67	4.45	4.89	4.98
2. Commitment	4.91	4.87	5.19	5.55
3. Contributions	3.84	3.5	3.85	4.68
4. Sense of ownership	5.09	4.86	5.48	5.51
5. Resource allocation satisfaction	4.14	3.66	3.68	4.43
6. Satisfaction	4.33	4.38	4.87	4.23
7. Management Capabilities	4.63	4.8	5.1	4.79
8. Professional Staff Expertise	4.98	5.06	5.04	5.17
9. Community member Expertise	4.21	4.23	4.81	5.17
10. Interaction	4.72	4.54	4.76	4.52
11. Decision making	4.32	4.22	4.24	4.37
12. Communication	4.51	4.36	4.81	4.67
13. Flow of information	4.44	4.35	4.74	4.84
14. Outcomes	4.42	4.48	4.83	5.03
15. Educational activities	5.44	5.27	5.35	5.83
16. Benefits	4.79	4.83	5.31	5.61
17. Costs	3.4	3.49	3.61	3.06

Annex (14). Data for the Radar Graph: Questionnaire Sections with Categorical Scores

Variable	Academic Institutions	Health Services	Community	Partnerships' Core Staff
1. Leadership Skills	68.1	65.63	66.68	73.31
2. Communication Mechanisms	54.05	49.44	45.05	70.91
3. Involvement	73.4	75.3	77.4	87.7
4. Role Clarity	67.32	66.5	69.6	83.1
5. Rules & Procedures	56.44	49.51	60.85	71.4
6. Operational Understanding	64.42	54.34	59.26	83.24
7. Organisational Barriers	60.81	64.86	58.91	63.82
8. Personnel Barriers	64.52	66.03	55.17	67.14
9. Perceived Effectiveness	75.04	68.72	67.76	67.00
10. Perceived Activity	90.4	82.5	84.15	86.85
11. Benefits to difficulties ratio	77.3	56.6	68.00	66.8
12. Authority to make decisions	85.5	84	65.67	81.8

Annex (15). Number of significant contributions of each predictor

Variable	Number of appereances as a significant predictor
Professional Staff & Community Member Variables	
Professional staff expertise	8
Sense of Ownership	6
Community expertise	6
Participation Benefits	4
Participation Costs	3
Role Clarity	1
Resource Allocation satisfaction	1
Costs/Benefits Ratio	1
Operational Understanding	0
Contributions	0
Organisational Variables	
Community Representation	5
Partnership Interaction	5
Community Members Communication	3
Management Capabilities	2
Rules and Procedures	2
Staff-Community Communication	2
Leadership Skills	2
Flow of Information	2
Communication Mechanisms	0
Decision Making	0
Barriers	
Organizational Barriers	5
Personnel Barriers	3

Appendices

Centre for Research In Human Services Management, UK.

HEALTH PERSONNEL EDUCATION

1995 COMMUNITY PARTNERSHIPS STUDY

PARTNERSHIP MEMBER SURVEY

PARTICIPANTS QUESTIONNAIRE

Community Partnerships

Long Version

All responses to this questionnaire will be kept strictly confidential.
Should you have any questions about the survey, please contact:
Dr. Walid El Ansari

COMMUNITY PARTNERSHIPS STUDY

Purpose of the Survey: This survey assesses your current views of the activities, roles, responsibilities, and outcomes of your Community Partnership.

It asks for YOUR OWN BELIEFS AND VIEWS (not what stereotypes say about Partnerships, or what some professionals say or do).

General Instructions

This questionnaire is being administered to the various categories of partners involved in the Community Partnership. In completing the questionnaire, please select the response option that comes closest to representing you and your views. In most cases you are asked to circle the number beside the response that is most applicable. Where appropriate, please write in your answers in the space provided.

Some of the questions contain terms that may have different meanings to different individuals. The meanings of these terms *as intended for this questionnaire* are provided below. Please consider these definitions as you respond to the questions.

Partnership: Group of organizations and individuals who share some interests and are working toward one or more common goals while maintaining their own agendas. A Partnership effort can enable members to engage in activities and accomplish goals beyond the reach of any one organization or individual.

Teaching - institutions Staff: any personnel from a university , faculty, college, training or teaching institution whether it is a technical , medical, nursing, agricultural establishment or otherwise, involved with the Partnership.

Health-services staff: any personnel from any branch or sub-branch of the national, regional, provincial or district health department/services involved in some way with the Partnership.

Project-staff: any personnel working/ stationed full time in the Partnership, with no other responsibility except the Partnership.

Community members: any personnel/ leaders from the community, s/elected on any of the committees/ subcommittees/ societies subserving the Partnership, also includes 'solo' individuals from the community.

Community HealthWorkers (CHWs): any s/elected personnel from the community, aware of the local culture, paid or unpaid, acting as a change agent/ catalyst between the Partnership and the broader community.

Government-services staff: Any personnel from any branch or sub-branch of the national, provincial, regional or district government services, apart from the health services, involved in some way with the coalition (eg. agriculture, education, water works, sewage etc.)

To which Partnership do you belong?

1. ____ ______

(Write in full name) (code)

Please show whether you agree or disagree with the statements below by circling the number on the scale that best represents your experience with any Partnership meeting(s) you have attended (1 indicates that you strongly disagree and 7 indicates that you strongly agree with the statement).

A) Management capabilities

		Strongly disagree						**Strongly agree**
2.	Meetings start and stop on time	1	2	3	4	5	6	7
3.	The purpose of each task or agenda item is defined and kept in mind	1	2	3	4	5	6	7
4.	Technical terms are clear and understood by all	1	2	3	4	5	6	7
5.	Routine matters are handled quickly	1	2	3	4	5	6	7
6.	Sub-committee and / or other reports are routinely made to the entire Partnership	1	2	3	4	5	6	7
7.	Materials for meetings are prepared adequately and in advance of meetings (agendas, minutes, study documents)	1	2	3	4	5	6	7
8.	Minutes correctly reflect the meetings	1	2	3	4	5	6	7
9.	Notification of meetings is timely	1	2	3	4	5	6	7
10.	Members have a good attendance at meetings	1	2	3	4	5	6	7
11.	Everyone (not just a few) participates in discussions	1	2	3	4	5	6	7
12.	Members stay with the subject being discussed	1	2	3	4	5	6	7
13.	Interest is generally high	1	2	3	4	5	6	7
14.	Members seem well-informed and understand what is going on at all times	1	2	3	4	5	6	7
15.	Meetings have free discussion	1	2	3	4	5	6	7
16.	Meetings run smoothly, without interruptions or blocking	1	2	3	4	5	6	7
17.	The meeting is friendly, cooperative , and pleasant	1	2	3	4	5	6	7
18.	There is no fighting for status or hidden agendas	1	2	3	4	5	6	7
19.	Partnership members feel safe in speaking out	1	2	3	4	5	6	7
20.	The Partnership uses the resources of all , not just a few	1	2	3	4	5	6	7
21.	Meeting times are convenient	1	2	3	4	5	6	7
22.	Location of meetings is convenient	1	2	3	4	5	6	7
23.	I am usually clear about my role as a Partnership member	1	2	3	4	5	6	7

B) <u>Rules and Procedures</u>: (tick the box that corresponds best to your view)

24. Does your Partnership:

		Yes (1)	No (2)	Don't know (3)
a.	have a written mission statement?	☐	☐	☐
b.	have written by-laws or operating principles ?	☐	☐	☐
c.	review its by-laws or operating principles periodically ?	☐	☐	☐
d.	engage in strategic planning ?	☐	☐	☐
e.	have a long - range plan beyond Kellogg funding ?	☐	☐	☐
f.	have written objectives ?	☐	☐	☐
g.	review its mission, goals, and objectives periodically ?	☐	☐	☐
h.	have clear procedures for leader selection ?	☐	☐	☐
i.	provide orientation for new members ?	☐	☐	☐

C) <u>Operational Understanding</u> (tick the box that best represents your view)

25. Do you know:

		Yes	No
a.	how new members are chosen ?	☐	☐
b.	how committees and task forces are formed ?	☐	☐
c.	the organizational structure of the Partnership and its staffing ?	☐	☐
d.	the mission of the Partnership and clearly understand it ?	☐	☐
e.	what your role in the Partnership is ?	☐	☐

D) <u>Experience with Partnerships</u>: please answer the following questions.

	Yes	No
26. Have you worked in/with any Partnerships before ?	☐	☐

If yes; for how many <u>months</u> ? (round to whole months) ----- -----

27. How many <u>months</u> have you served on the present "Health Personnel Education" Partnership ? ----- -----

E) <u>Involvement in the Partnership</u>: please answer the following questions.

28. How involved have you been in the Partnership ?

not very involved (1)	moderately involved (2)	very involved (3)
☐	☐	☐

29. What percentage of regular Partnership meetings have you attended over the past 12 months ?
_________ %

30. On average , in any given month, about how many hours of your time do you spend on Partnership activities ? (e.g., regular Partnership meetings, committee work, Partnership sponsored activities, preparation for meetings and activities)

_________ hours per/month

31. Since joining the this Partnership, how many times have you: (write a number from 0 to 99)

a. recruited new members to the Partnership? _____

b. served as a spokesperson for the Partnership? _____

c. worked on implementing educational/cultural activities or events sponsored by the Partnership (other than meetings)? _____

d. served as a representative of the Partnership to other groups ? _____

and since joining,

e. how many different committees have you worked on ? _____

f. how many committee or team leadership positions have you held ? _____

32. Do you have the authority to make decisions on behalf of the organization you represent at Partnership meetings ? **(please tick one box only)**

(0) Do not represent an organization ☐

(1) Yes ☐

(2) Not without approval of other staff in my organization ☐

(3) Not without approval of my board of membership ☐

(4) Not at all ☐

F) <u>Community representation in the Partnership</u>; please answer the following questions.

33. How representative do you think the Partnership is of the people in your local health district? **(please circle the number that best represents your view)**

Not at all representative			Moderately representative			Very representative
1	2	3	4	5	6	7

34. In your opinion, which groups are **not** well - represented on the Partnership that should be ? **(please tick up to three)**

a. ____ Families (women, parents)

b. ____ Medical community

c. ____ Low income / unemployed

d. ____ Specified work groups (e.g., fieldworker, blue collar, professional)

f. ____ Worksites, business

g. ____ Youth

h. ____ Elderly

i. ____ Schools (teachers, students)

j. ____ Media

k. ____ Community based organizations

l. ____ Policy makers

m. ____ Volunteer Agencies

n. ____ Rural population

o. ____ Indian

p. ____ Asian

q. ____ Black / African

r. ____ White

s. ____ Other ________________

G) Staff- community member communication

35. Please rate communication between the staff (teaching institutions and health services) and other partners over the past year on the following scales **(circle one number for each)**

a. poor — good

1	2	3	4	5	6	7

b. not often — often

1	2	3	4	5	6	7

c. bad at giving information — good at giving information

1	2	3	4	5	6	7

d. uncomfortable — comfortable

1	2	3	4	5	6	7

e. ineffective — effective

1	2	3	4	5	6	7

H) Community members communication

36. Please rate communication among the community members over the past year on the following scales

a. poor — good

1	2	3	4	5	6	7

b. not often — often

1	2	3	4	5	6	7

c. bad at giving information — good at giving information

1	2	3	4	5	6	7

d. uncomfortable — comfortable

1	2	3	4	5	6	7

e. ineffective — effective

1	2	3	4	5	6	7

I) Contributions to the Partnership; For each of the following, to what extent have you or your organization contributed to the activities of the Partnership? (circle the number that best represents your view)

		Not at all 1	2	3	4	5	6	Quite a lot 7
37.	Time of yourself and of others	1	2	3	4	5	6	7
38.	Money to support joint activities	1	2	3	4	5	6	7
39.	In - kind resources such as publicity, printing, equipment, facilities, etc.	1	2	3	4	5	6	7
40.	Facilitate access to special populations	1	2	3	4	5	6	7

J) Participation Benefits; To what extent have each of the following been a benefit to your participation or your organization's participation on the Partnership ?

		Not at all 1	2	3	4	5	6	Quite a lot 7
41.	Getting to know other agencies and their staff	1	2	3	4	5	6	7
42.	Gaining recognition and respect from others	1	2	3	4	5	6	7
43.	Developing cooperative relationships with other agencies	1	2	3	4	5	6	7
44.	Getting help from or helping other organizations	1	2	3	4	5	6	7
45.	Making our community a better place to live	1	2	3	4	5	6	7
46.	Helping my organization move towards our goals	1	2	3	4	5	6	7

		Not at all						Quite a lot
47.	Learning about community events, services, etc.	1	2	3	4	5	6	7
48.	Having access to target populations with whom we've previously had little contact	1	2	3	4	5	6	7
49.	Building my organization's capacity	1	2	3	4	5	6	7
50.	Helping my organization get funding	1	2	3	4	5	6	7
51.	Building my own skills in partnership work	1	2	3	4	5	6	7

K) <u>Participation Costs</u>; To what extent have each of the following been a <u>difficulty</u> for your participation or your organization's participation in the Partnership ?

		Strongly disagree						Strongly agree
52.	Partnership activities do not effectively reach my primary district/area	1	2	3	4	5	6	7
53.	Time spent on the Partnership keeps me from doing my work	1	2	3	4	5	6	7
54.	My organization doesn't get enough public recognition for our work on the Partnership	1	2	3	4	5	6	7
55.	Being involved in setting up the Partnership's activities is a problem	1	2	3	4	5	6	7
56.	My skills and time are not well - used	1	2	3	4	5	6	7

L) <u>Role clarity</u>; Recognizing that the Steering Committee/ Executive Board of Trustees of the Partnership has authority, what type of contribution does your organization/ agency typically have in the following areas? (tick <u>one</u> answer for each question)

57. What type of contribution do you or your organization/ agency typically have in **setting the budget for** the Partnership's programs? **(tick one box only)**

no role	advice only	develop	recommend	approve
(1)	(2)	(3)	(4)	(5)
☐	☐	☐	☐	☐

58. What type of input does your organization/ agency typically have in **designing program goals and objectives** for the Partnership's programs?

no role	advice only	develop	recommend	approve
(1)	(2)	(3)	(4)	(5)
☐	☐	☐	☐	☐

59. What type of input does your organization/ agency typically have in **selecting local contractors and subcontractors** for the Partnership's programs?

no role	advice only	develop	recommend	approve
(1)	(2)	(3)	(4)	(5)
☐	☐	☐	☐	☐

60. What type of input did your organization/ agency have in **developing the Partnership's overall plan? (tick one box only)**

no role	advice only	develop	recommend	approve
(1)	(2)	(3)	(4)	(5)
☐	☐	☐	☐	☐

M) Satisfaction with the Partnership; Please indicate how much you agree or disagree with the following statements (circle the number that best represents your view)

		Strongly disagree						Strongly agree
61.	I would not like to change anything about the Partnership	1	2	3	4	5	6	7
62.	I am satisfied with how the Partnership operates	1	2	3	4	5	6	7
63.	This Partnership is a worthwhile effort	1	2	3	4	5	6	7
64.	The work accomplished by the Partnership has met my expectations	1	2	3	4	5	6	7
65.	I am satisfied with what is accomplished by the Partnership	1	2	3	4	5	6	7

N) Sense of ownership; Please indicate how much you agree or disagree with the following

		Strongly disagree						Strongly agree
66.	I am committed to the work of the Partnership	1	2	3	4	5	6	7
67.	I feel that I have a voice in what the Partnership decides	1	2	3	4	5	6	7
68.	I feel a sense of pride in what the Partnership accomplishes	1	2	3	4	5	6	7
69.	I really care about the future of this Partnership	1	2	3	4	5	6	7

O) Member organization commitment

	To what extent:	Not at all						Very much
70.	has your organization agreed on or adopted the mission and goals of the Partnership?	1	2	3	4	5	6	7
71.	does your organization participate in Partnership sponsored activities?	1	2	3	4	5	6	7
72.	has your organization publicly agreed on or cosponsored Partnership activities?	1	2	3	4	5	6	7
73.	To what extent does the community see the Partnership as a resource for influencing health personnel education?	1	2	3	4	5	6	7

P) leadership skills (please tick the box that best represents your view)

74. The Partnership leadership:

		(1)Yes	(2)No
a.	provides me with a lot of good information	☐	☐
b.	makes me feel welcome at meetings	☐	☐
c.	gives praise/ recognition at meetings	☐	☐
d.	intentionally seeks out and welcomes my views	☐	☐
e.	provides me with continuing education opportunities	☐	☐
f.	reports our achievements through newsletters, etc.	☐	☐
g.	holds social gatherings for Partnership members	☐	☐
h.	Listens to my opinions and comments during meetings	☐	☐
i.	intentionally seeks out the views of other people outside the Partnership	☐	☐

		Yes	No
j.	asks me to assist with organizational tasks	☐	☐
k.	offers group activities (tours of other Partnerships, etc.) to Partnership members	☐	☐

Q) Communication mechanisms; (please tick the box that best represents your view)

75. In which of the following ways does the Partnership communicate?

		Yes	No
a.	regularly published newsletters	☐	☐
b.	written reports from staff	☐	☐
c.	written reports from funded projects	☐	☐
d.	spoken reports at Partnership and committee meetings	☐	☐
e.	opportunities to talk with funded projects and staff at meetings	☐	☐
f.	talking with other Partnership staff outside of meetings	☐	☐
g.	talking with funded projects outside of meetings	☐	☐
h.	Other (please specify) ________________________________	☐	☐

R) Staff and member expertise; Please rate the level of expertise/ability of: a) the professional staff (teaching institutions/ health services) and b) the Partnership's community members in the following areas.

	a. Professional Staff							b. Community Members						
	low ability						high ability	low ability						high ability
76. Designing/ implementing educational activities	1	2	3	4	5	6	7	1	2	3	4	5	6	7
77. Maintaining an effective and active Partnership	1	2	3	4	5	6	7	1	2	3	4	5	6	7
78. Working with community groups	1	2	3	4	5	6	7	1	2	3	4	5	6	7
79. Community organizing	1	2	3	4	5	6	7	1	2	3	4	5	6	7
80. Planning	1	2	3	4	5	6	7	1	2	3	4	5	6	7
81. How to bring about change in the community	1	2	3	4	5	6	7	1	2	3	4	5	6	7
82. How to bring about change in the teaching institutions	1	2	3	4	5	6	7	1	2	3	4	5	6	7
83. How to bring about change in the health department	1	2	3	4	5	6	7	1	2	3	4	5	6	7
84. Health personnel education policy	1	2	3	4	5	6	7	1	2	3	4	5	6	7
85. Budget management	1	2	3	4	5	6	7	1	2	3	4	5	6	7
86. Reaching target populations	1	2	3	4	5	6	7	1	2	3	4	5	6	7

S) Resource allocation satisfaction

87. How satisfied are you with the allocation of funds in your Partnership?

Not at all satisfied			Moderately satisfied			Very satisfied
1	2	3	4	5	6	7

T) Participation benefits/difficulties

88. Overall for your organization, how would you compare the benefits with the difficulties of being a member of this Partnership? (**please tick one box only**)

(1) Many more difficulties than benefits ☐

(2) A few more difficulties than benefits ☐

(3) About the same amount of benefits and difficulties ☐

(4) A few more benefits than difficulties ☐

(5) Many more benefits than difficulties ☐

U) Partnership Activities; Health Personnel Education policy/advocacy work

89. How much has the Partnership engaged in policy/advocacy work?

Not at all						**A great deal**
1	2	3	4	5	6	7

90. Which of the following is true for your Partnership?

(1)True (2) False

☐ ☐ The role of the Partnership in public policy has been clearly identified and accepted by the Partnership and the health department.

91. Think of one of the more important **policy actions** accomplished by your partnership in your local jurisdiction.

x. ☐ tick here if none accomplished to date (skip 91 a and 91 b)

To what extent were the partners;	**Not at all**						**Very much**
a. involved in action	1	2	3	4	5	6	7
b. effective in their work?	1	2	3	4	5	6	7

92. What were the contributions you made in this policy action? **(please tick all that apply)**

Local organizing/community action/public education

a. ____ meetings with local people, organizations, or government officials
b. ____ making presentations to community or government officials
c. ____ letter writing
d. ____ phone calling
e. ____ mailings (e.g., stuffing envelopes)
f. ____ help organize events and presentations
g. ____ organizing support
h. ____ participate in planning
i. ____ other ____________

Media relations

j. ____ spokesperson
k. ____ press conference
n. ____ other ____________
l. ____ arranging media
m. ____ developing media packages

Campaigning

o. _____ drafting policy
p. _____ lobbying, contact governmental organizations
q. _____ developing campaign strategy
r. _____ gathering petitions signatures
s. _____ serving on task force
t. _____ organizing speakers
u. _____ attending Board meetings
v. _____ meeting in support of ordinance
w. _____ Other ____________

V) Partnership Activities; educational activities

93. How much has the Partnership engaged in **educational** activities?

Not at all						**A great deal**
1	2	3	4	5	6	7

94. Think of one of the more important **educational activities** accomplished by your Partnership (e.g. sponsoring/ implementing seminars, workshops, conferences, Health Day, Awarness Day).

To what extent were Partnership members:	Not at all						Very much
a. involved in the action?	1	2	3	4	5	6	7
b. effective in their work?	1	2	3	4	5	6	7

95. What were the contributions you made to this educational activity? **(tick all that apply)**

a. ☐ Planning and organization
b. ☐ Speaking/presenting
c. ☐ Staffing event or program
d. ☐ Set up/clean up
e. ☐ Recruitment and community outreach
f. ☐ Provide materials or funding
g. ☐ Distribution of information
h. ☐ Conducting surveys
i. ☐ Media (marketing, public relations)
j. ☐ other ______________________

W) Partnership interaction; (please circle the number that best represents your view)

	Strongly disagree						Strongly agree
96. There are established ways to settle most differences that arise in the Partnership	1	2	3	4	5	6	7
97. Conflict is handled effectively in the Partnership	1	2	3	4	5	6	7
98. The Partnership team is tolerant of differences or disagreements	1	2	3	4	5	6	7
99. Partners of this project have a shared vision of what they would like to accomplish	1	2	3	4	5	6	7
100. The Partnership has a feeling of togetherness and teamwork	1	2	3	4	5	6	7
101. The Partnership's professional staff (university or health services) are too controlling	1	2	3	4	5	6	7
102. The Partnership's professional staff encourages participation in decision making	1	2	3	4	5	6	7

X) Decision making; (please circle the number that best represents your view)

103. It is easy to get my ideas across to the project leadership if I have a suggestion	1	2	3	4	5	6	7
104. I feel I have many opportunities for participation in the Partnership	1	2	3	4	5	6	7
105. Participation in decision making by community representatives is high	1	2	3	4	5	6	7
106. Participation in decision making by university representatives is high	1	2	3	4	5	6	7
107. Participation in decision making by health services representatives is high	1	2	3	4	5	6	7
108. Decisions are made only by a small group of leaders	1	2	3	4	5	6	7
109. In general, university representatives have a lot of influence in major decisions	1	2	3	4	5	6	7
110. In general, community representatives have a lot of influence in major decisions	1	2	3	4	5	6	7
111. In general, health services representatives have a lot of influence in major decisions	1	2	3	4	5	6	7

Y) Flow of information **(please circle the number that best represents your view)**

	Strongly disagree						Strongly agree
112. Far too little information on important topics is shared among the partners	1	2	3	4	5	6	7
113. The information I receive about the Partnership gives me a clear understanding of the Partnership	1	2	3	4	5	6	7
114. The information I receive about the Partnership is accurate	1	2	3	4	5	6	7
115. I receive information about the Partnership in a timely fashion	1	2	3	4	5	6	7
116. The information I receive about the Partnership is relevant to my needs	1	2	3	4	5	6	7

Z) Outcomes; (please circle the number that best represnts your view)

117. Thinking about all the work accomplished in influencing Health Personnel Education in your area or local health district over the past year/s, how important was the Partnership in getting this work accomplished?

Not very important						Very important
1	2	3	4	5	6	7

In your area / local health district; How certain are you that your Partnership **will be able to do what it has planned** related to the following activities

	Not at all certain						Totally certain
118. the curriculum	1	2	3	4	5	6	7
119. providing primary health care services	1	2	3	4	5	6	7
120. continuation of the Partnership as an identifiable organization	1	2	3	4	5	6	7
121. that Partnership efforts will influence health personnel education	1	2	3	4	5	6	7
122. the Partnership existing beyond Kellogg funding	1	2	3	4	5	6	7

How certain are you that the Partnership's activities/changes that are planned in relation to curriculum, primary health care service, or organizational changes, will achieve the Partnership's goal for the increased number of

	Not at all certain						Totally certain
123. medical students who will enter primary health care practice	1	2	3	4	5	6	7
124. nursing students who will enter primary health care practice	1	2	3	4	5	6	7
125. other health professions students who will enter primary health care practice	1	2	3	4	5	6	7

How certain are you that the Partnership's activities and changes that are planned will actually increase the number of;

	Not at all certain						Totally certain
126. medical students who will practice in underserved areas once they finish their training	1	2	3	4	5	6	7
127. nursing students who will practice in underserved areas once they finish their training	1	2	3	4	5	6	7
128. other health professions students who will practice in underserved areas once they finish their training	1	2	3	4	5	6	7

129. How certain are you that the Partnership's activities will increase community involvement in health care reforms?

Not at all certain			Moderately certain			Totally certain
1	2	3	4	5	6	7

130. How certain are you that the community Partnership will have an influence on public policy such as state or province legislation, or funding decisions, with respect to health professions education?

Not at all certain			Moderately certain			Totally certain
1	2	3	4	5	6	7

131. How certain are you that your organization or community is ready to implement permanent structural changes (changes in policies, reward systems, funding mechanisms) to sustain the Partnership's goals?

Not at all certain			Moderately certain			Totally certain
1	2	3	4	5	6	7

132. How certain are you that as a result of the way activities in this Partnership are structured there will be an increase in the use of multi-professional teams of physicians, nurses, social workers and others in providing health care to patients?

Not at all certain			Moderately certain			Totally certain
1	2	3	4	5	6	7

A1) <u>Organizational Barriers</u>; Please rate the extent to which each of these barriers presents a problem in how your Partnership functions. **(tick one box that best represents your views)**

	Major problem (1)	Minor problem (2)	Not problem (3)
133. Competing priorities among partners	☐	☐	☐
134. Partnership versus organization fund-raising	☐	☐	☐
135. Partnership versus organization credit for activities	☐	☐	☐
136. Assumption of leadership by a lead partner	☐	☐	☐
137. Marketing of individual partners' materials	☐	☐	☐
138. Differences in partners' financial/tax years	☐	☐	☐
139. Differences in partners' philosophies	☐	☐	☐
140. Coordination of activities among partners	☐	☐	☐
141. Goal setting	☐	☐	☐
142. Differences in partners' service areas	☐	☐	☐
143. Differences in partners' structure	☐	☐	☐
144. Leadership from the national level	☐	☐	☐
145. Lack of participation by one or more partners	☐	☐	☐
146. Availability of funds	☐	☐	☐
147. Conflict between local versus centralized control	☐	☐	☐
148. Decision making	☐	☐	☐

	Major problem	Minor problem	Not problem
149. Communications between partners	☐	☐	☐

B1) <u>Personnel Barriers</u> Please rate the extent to which each of the following barriers presents a problem in how your Partnership functions. **(tick the box that best represents your views)**

	Major problem (1)	Minor problem (2)	Not problem (3)
150. Staff availability for the Partnership	☐	☐	☐
151. Staff changing	☐	☐	☐
152. Staff interest	☐	☐	☐
153. Volunteer availability	☐	☐	☐
154. Volunteer changing	☐	☐	☐
155. Keeping volunteer interest	☐	☐	☐
156. Expertise of staff and volunteers	☐	☐	☐
157. Interest in Partnership activities	☐	☐	☐
158. Staff priorities	☐	☐	☐

C1) <u>Percieved Effectiveness</u>; How effective would you rate your Partnership functioning in each of the following areas:

	Extremely Effective (1)	Effective (2)	Ineffective (3)	Extremely Ineffective (4)
159. Communication between partners	☐	☐	☐	☐
160. Goal setting	☐	☐	☐	☐
161. Making decisions	☐	☐	☐	☐
162. Focus on Primary Health Care	☐	☐	☐	☐
163. Training Community Health Workers	☐	☐	☐	☐
164. Volunteer coordination	☐	☐	☐	☐
165. Fundraising	☐	☐	☐	☐
166. Public relations/ media	☐	☐	☐	☐
167. Involving Minorities in Partnership activities	☐	☐	☐	☐
168. Evaluation of its performance	☐	☐	☐	☐
169. Making health planning more responsive to community needs	☐	☐	☐	☐
170. Helping the community emerge as a political force on issues of health	☐	☐	☐	☐
171. Improving the quality of local health services	☐	☐	☐	☐

	Extremely Effective	Effective	Ineffective	Extremely Ineffective
172. Increasing the accessibility of local health services	☐	☐	☐	☐
173. Raising public awarness of health issues and planning	☐	☐	☐	☐

D1) <u>Percieved Activity</u> (tick the box that best represents your views)

174. Please indicate your assessment of the level of Partnership activity over the past year (1994).

Very active	Moderatley active	Inactive	Very inactive
☐	☐	☐	☐

175. Please indicate your assessment of the level of Partnership activity over this year (1995)?

Very active	Moderatley active	Inactive	Very inactive
☐	☐	☐	☐

Please answer a few questions about yourself;

176. Your gender: ☐ (1) female ☐ (2) male

177. Your ethnicity:

☐ (1) African / Black ☐ (2) Asian ☐ (3) Indian

☐ (4) White ☐ (5) Other (please specify)________________________

178. Which one of the following groups do you represent primarily on the Partnership ? **(tick one only; please revisit the definitions on the first page of this questionnaire)**

☐ (1) University / college /teaching institutions staff ☐ (2) Health services staff

☐ (3) Government services staff (other than health services) ☐ (4) Community health worker

☐ (5) Project staff (stationed at the project) ☐ (6) Broader community

☐ (7) Voluntary agency/ community-based / Non-Governmental organization

☐ (8) other (please specify)____

179. The following statements concern personal attitudes. Please read each statement and decide whether it is true or false in relation to you. **(tick the box that best represents your view)**

		(1)True	(2)False
1.	I always try to be considerate of the feelings of my friends	☐	☐
2.	I have a number of health problems	☐	☐
3.	I often have the feeling that I am doing something evil	☐	☐
4.	I am seldom ill	☐	☐
5.	I almost always feel sleepy and lazy	☐	☐
6.	Most of my teachers were helpful	☐	☐
7.	My life is full of interesting activities	☐	☐
8.	I am able to make correct decisions on difficult questions	☐	☐
9.	I believe people tell lies anytime it is to their advantage	☐	☐

180. Listed below are some statements rergarding public issues, with which some people agree and others disagree. Please give us your opnion about these items as related to you. **(tick the box that best represents your view)**

		Strongly agree	Agree	Disagree	Strongly disagree
1.	I usually prefer to do things alone	☐	☐	☐	☐
2.	I have many friends	☐	☐	☐	☐
3.	I tend to be shy	☐	☐	☐	☐
4.	I am very sociable	☐	☐	☐	☐
5.	I make friends very quickly	☐	☐	☐	☐

Thank you!

Centre for Research In Human Services Management, UK.

HEALTH PERSONNEL EDUCATION

1995 COMMUNITY PARTNERSHIPS STUDY

PARTNERSHIP MEMBER SURVEY

PARTICIPANTS QUESTIONNAIRE

Community Partnerships

Short Version

All responses to this questionnaire will be kept strictly confidential.
Should you have any questions about the survey, please contact:
Dr. Walid El Ansari

To which Partnership do you belong?

1. ____

(Write in full name)

Please indicate your agreement or disagreement with the statements below by circling the number on the scale that best represents your experience with any Partnership meeting(s) you have attended (1 indicates that you strongly disagree and 7 indicates that you strongly agree with the statement).

		Strongly disagree						**Strongly agree**
9.	Notification of meetings is timely	1	2	3	4	5	6	7
10.	Members have a good record of attendance at meetings	1	2	3	4	5	6	7
23.	I am usually clear about my role as a Partnership member	1	2	3	4	5	6	7

Please tick the box that corresponds best to your view

24. Does your Partnership:

	Yes	No	Don't know
a. have a written mission statement?	☐	☐	☐

25. Do you know:

	Yes	No
a. how new members are chosen ?	☐	☐

28. How involved have you been in the Partnership ?

not very involved	moderately involved	very involved
☐	☐	☐

33. How representative do you think the Partnership is of the people in your county / local health jurisdiction ? **(please circle the number that corresponds best to your view)**

Not at all representative			Moderately representative			Very representative
1	2	3	4	5	6	7

For each of the following, to what extent have you or your organization <u>contributed</u> to the activities of the Partnership? (circle the number that corresponds best to your view)

		Not at all						**Quite a lot**
37.	Time of yourself and of others	1	2	3	4	5	6	7
38.	Money to support joint activities	1	2	3	4	5	6	7

To what extent have each of the following been a <u>benefit</u> to your participation or your organization's participation on the Partnership ?

		Not at all						**Quite a lot**
41.	Getting to know other agencies and their staff	1	2	3	4	5	6	7
51.	Building my own skills in partnership work	1	2	3	4	5	6	7

To what extent have each of the following been a <u>difficulty</u> for your participation or your organization's participation in the Partnership ?

		Strongly disagree						**Strongly agree**
53.	Time spent on the Partnership keeps me from doing my work	1	2	3	4	5	6	7

60. What type of input did your organization/ agency have in **developing the Partnership's overall plan? (tick one type of input only)**

no role	**advice only**	**develop**	**recommend**	**approve**
(1)	(2)	(3)	(4)	(5)
☐	☐	☐	☐	☐

Please indicate how much you agree or disagree with the following statements (circle the number that corresponds best to your view)

	Strongly disagree 1	2	3	4	5	6	**Strongly agree** 7
62. I am satisfied with how the Partnership operates	1	2	3	4	5	6	7
63. This Partnership is a worthwhile effort	1	2	3	4	5	6	7
66. I am committed to the work of the Partnership	1	2	3	4	5	6	7

To what extent:	**Not at all** 1	2	3	4	5	6	**Very much** 7
72. has your organization publicly agreed on or co-sponsored Partnership activities?	1	2	3	4	5	6	7

74. The Partnership leadership:

	Yes	No
a. provides me with a lot of good information	☐	☐

75. In which of the following ways does the Partnership communicate?

	Yes	No
a. regularly published newsletters	☐	☐

87. How satisfied are you with the allocation of funds in your Partnership?

Not at all satisfied			Moderately satisfied			Very satisfied
1	2	3	4	5	6	7

88. Overall for your organization, how would you compare the benefits with the difficulties of being a member of this Partnership? **(please tick one box only)**

(1) Many more difficulties than benefits ☐

(2) A few more difficulties than benefits ☐

(3) About the same amount of benefits and difficulties ☐

(4) A few more benefits than difficulties ☐

(5) Many more benefits than difficulties ☐

Please circle the number that corresponds best to your view

93. How much has the Partnership engaged in **educational** activities?

Not at all						**A great deal**
1	2	3	4	5	6	7

	Strongly disagree 1	2	3	4	5	6	**Strongly agree** 7
97. Conflict is handled effectively in the Partnership	1	2	3	4	5	6	7
108. Decisions are made only by a small group of leaders	1	2	3	4	5	6	7
115. I receive information about the Partnership in a timely fashion	1	2	3	4	5	6	7

How certain are you that your Partnership **will be able to do what it has planned** related to the following activities

	Not at all certain 1	2	3	4	5	6	**Totally certain** 7
121. that Partnership efforts will influence health personnel education	1	2	3	4	5	6	7
122. the Partnership existing beyond Kellogg funding	1	2	3	4	5	6	7

Please rate the extent to which each of these barriers presents a problem in how your Partnership functions. **(tick one box that best represents your views)**

	Major problem	Minor problem	Not problem
133. Competing priorities among partners	☐	☐	☐
140. Coordination of activities among partners	☐	☐	☐
157. Interest in Partnership activities	☐	☐	☐

How effective would you rate your Partnership functioning in each of the following areas:

	Extremely Effective	Effective	Ineffective	Extremely Ineffective
160. Goal setting	☐	☐	☐	☐
161. Making decisions	☐	☐	☐	☐
168. Evaluation of its performance	☐	☐	☐	☐

Tick the box that best represents your views

174. Please indicate your assessment of the level of Partnership activity over the past year (1994).

Very active	Moderatley active	Inactive	Very inactive
☐	☐	☐	☐

175. Please indicate your assessment of the level of Partnership activity over this year (1995)?

Very active	Moderatley active	Inactive	Very inactive
☐	☐	☐	☐

Please answer a few questions about yourself;

176. Your gender:

☐ (1) female ☐ (2) male

Your age: ____ ____ years

177. Your ethnicity:

☐ (1) African / Black ☐ (2) Asian ☐ (3) Indian

☐ (4) White ☐ (5) Other (please specify) ____________________

178. Which one of the following groups do you represent primarily on the Partnership ? **(tick one only; please revisit the definitions on the first page of this questionnaire)**

☐ (1) University / college /teaching institutions staff ☐ (2) Health services staff

☐ (3) Government services staff (other than health services) ☐ (4) Community health worker

☐ (5) Project staff (stationed at the project) ☐ (6) Broader community

☐ (7) Voluntary agency/ community-based / Non-Governmental organization

☐ (8) other (please specify)____

179. The following statements concern personal attitudes. Please read each statement and decide whether it is true or false in relation to you. **(please tick the box that corresponds best to your view)**

	True	False
4. I am seldom ill	☐	☐
6. Most of my teachers were helpful	☐	☐

180.	Strongly agree	Agree	Disagree	Strongly disagree
1. I usually prefer to do things alone	☐	☐	☐	☐
4. I am very sociable	☐	☐	☐	☐

Thank You!