

The size, characteristics and partnership networks of the health-related non-profit sector in three regions of South Africa: implications of changing primary health care policy for community-based care

Ermien van Pletzen,¹ R Zulliger,² M Moshabela³ and H Schneider⁴

¹Centre for Higher Education Development, University of Cape Town, Rondebosch, 7701, South Africa, ²Department of Health, Behavior and Society, Johns Hopkins Bloomberg School of Public Health, ³School of Public Health, University of Witwatersrand, Johannesburg and Earth Institute, Columbia University, NYC and ⁴School of Public Health, University of the Western Cape, South Africa

*Corresponding author. Centre for Higher Education Development, University of Cape Town, Private Bag X1, Rondebosch, 7701, South Africa. E-mail: ermien.vanpletzen@uct.ac.za

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Background	Health-related community-based care in South Africa is mostly provided through non-profit organizations (NPOs), but little is known about the sector. In the light of emerging government policy on greater formalization of community-based care in South Africa, this article assesses the size, characteristics and partnership networks of health-related NPOs in three South African communities and explores implications of changing primary health care policy for this sector.
Methods	Data were collected (2009–11) from three sites: Khayelitsha (urban), Botshabelo (semi-rural) and Bushbuckridge (semi/deep rural). Separate data sources were used to identify all health-related NPOs in the sites. Key characteristics of identified NPOs were gathered using a standardized tool. A typology of NPOs was developed combining level of resources (well, moderate, poor) and orientation of activities ('Direct service', 'Developmental' and/or 'Activist'). Network analysis was performed to establish degree and density of partnerships among NPOs.
Results	The 138 NPOs ($n=56$ in Khayelitsha, $n=47$ in Bushbuckridge; $n=35$ in Botshabelo) were mostly local community-based organizations (CBOs). The main NPO orientation was 'Direct service' ($n=120$, 87%). Well- and moderately resourced NPOs were successful at combining orientations. Most organizations with an 'Activist' orientation were urban. No poorly resourced organizations had this orientation. Well-resourced organizations with an 'Activist' orientation were highly connected in Khayelitsha NPO networks, while poorly resourced CBOs were marginalized. A contrasting picture emerged in Botshabelo where CBOs were highly connected. Networks in Bushbuckridge were fragmented and linear.
Conclusions	The NPO sector varies geographically in numbers, resources, orientation of activities and partnership networks. NPOs may perform important developmental roles and strong potential for social capital may reside in organizational networks operating in otherwise impoverished environments. A uniform approach to policy implementation may not accommodate variations in the NPO sector. Considerations for adaptation may be necessary in light of the observed differences between urban and rural settings.

Keywords Health-related non-profit organizations, community-based care, policy on primary health care, South Africa

KEY MESSAGES

- Health-related non-profit organizations are significant providers of community-based care in South Africa.
- The health-related NPO sector varies from area to area, not only in numbers, but in degree of resourcing, orientation of activities and partnership networks.
- NPOs perform important developmental and activist roles in communities and a strong potential for social capital resides in organizational networks operating in impoverished environments.
- Current policy developments in primary health care reform which aim at formalizing relationships between civil society and the state may direct funding away from health-related NPOs and in other ways limit their ability to respond independently and critically to the interests of marginalized communities.

Introduction

Non-profit organizations (NPOs), including large international or national non-governmental organizations (NGOs), faith-based organizations (FBOs) and local community-based organizations (CBOs), have a long history of providing health-related care in South Africa, especially in impoverished communities. They form part of a vast and diverse group of civil society organizations that have fundamentally contributed to the shaping of modern South Africa (Swilling and Russell 2002).

Estimates of the size of the health-related NPO sector in South Africa have differed, depending on survey methods used and time periods studied. In 1999, Swilling and Russell (2002) estimated that there were 6499 health-related NPOs, of which the majority (4191 or 64%) were informal organizations, almost a quarter (1570 or 24%) were 'Section 21' companies (associations not for gain) and the rest (738 or 11%) religious, political or other organizations associated with health care. Just over a decade later, an audit conducted by the national Department of Health focusing on NPOs providing community-based services in a formal relationship with government counted 2963 community-based NPOs (Government of South Africa 2011a). Despite the different estimates, the studies confirm a significant and ongoing NPO presence in the health sector.

Overall, there is a scarcity of literature on community-based organizations with a focus on health in low- and middle-income countries (Wilson *et al.* 2012). At the same time, international policy and research increasingly emphasize the importance of community participation and mobilization in responding to the health needs of marginalized communities, especially in the contexts of the HIV/AIDS epidemic and human resource shortages in formal health systems (Birdsall and Kelly 2005; Schwartländer *et al.* 2011). In this respect, Campbell and Cornish (2010) point to the 'relational context' that enable community-based organizations to build up constructive networks in marginalized communities. Similarly, Wilson *et al.* (2012) indicate that networks of community-based organizations can become influential actors in policy decision-making, contributing to shaping the health system of a country by offering opportunities for public engagement and collective action.

The health-related NPO sector in South Africa, and in particular its regional characteristics and partnership networks, has been under-researched. Despite the large numbers and wide spectrum of NPOs currently associated with community-based care in South Africa, the Department of Health's new policy guidelines on 'Re-engineering Primary Health Care' (Government of South Africa 2011b; Pillay and Barron 2011; Pillay 2012), which includes new arrangements for community-based care, have mostly been silent about the future role of NPOs. Implementation guidelines (Government of South Africa 2011b) single out 'social mobilization' as an important role for NPOs. Policy-makers and researchers, however, have not sufficiently explored the implications and unintended consequences that new policy guidelines may hold for the sector or for its partnership networks.

In this article, we profile the health-related NPO sector in three distinct communities of South Africa so as to address some of these silences and gaps. We attempt to answer three pertinent questions:

- What is the size and character of the NPO sector, based on a typology measuring level of resources and orientation of activities in organizations providing community-based care in different geographic regions?
- What are the partnerships between organizations providing community-based care, assessed by measuring the degree and density of NPO partnership networks in different geographic regions?
- Based on findings generated by these two questions, what are potential implications and consequences of the new policy guidelines on revitalizing primary health care (PHC) for the size, characteristics and partnership networks of the health-related NPO sector?

Background and policy environment

Historically, NPOs played an important role in South Africa in counteracting the inequities of the Apartheid health system, as well as in supplementing and helping to reform the health

system in the period before and after the democratic election in 1994 (Van Ginneken *et al.* 2010). Many organizations, however, ceased to operate post-1994 as donor funding was channelled into the new government's facility-based PHC programmes, which did not include a national community health worker programme (Friedman 2005). Since the late 1990s numbers of health-related NPOs have again been on the rise, primarily in response to HIV/AIDS (Kelly and Birdsall 2010) and an overburdened public health system (Schneider *et al.* 2008).

The contemporary growth of the NPO sector in South Africa has been supported by enabling legal and fiscal environments, which in the late 1990s included tax and funding reforms (Habib 2005) and formal recognition in the Non-Profit Organisations Act No 71 of 1997 (Government of South Africa 1997). In 2004 the Departments of Health, Social Development and Education collaborated with the government's Expanded Public Works Programme to promote home and community-based care. The aims were to expand service delivery to resource-limited communities, build skill and capacity, and relieve poverty (Friedman 2005; Schneider *et al.* 2008). Until recently the state relied on partnerships with NPOs to enrol and supervise large numbers of community care workers providing basic community-based care. Some organizations, usually the better resourced international and national organizations, have also emerged to fulfil the developmental tasks of training community-care workers, integrating organizations' activities with formal health and social services, building capacity in smaller community-based organizations, or acting as stipendiary pay masters for the government (Van Pletzen *et al.* 2009).

The focus in policy discussions on community-based care in the last decade has largely been on community care workers¹ themselves, and not on the health-related NPO sector. Thus, in 2004, the Department of Health produced a Community Health Worker Policy Framework which focused on formalizing the scope of practice and management of community-based health workers (Government of South Africa 2004). This was followed by the Community Care Worker Policy Management Framework (Government of South Africa 2009a), jointly written by the Department of Health and the Department of Social Development. Some of the problems with existing programmes mentioned in this document were untenable management models, irregular funding flows and fragmented, programme-specific approaches to service delivery instead of an integrated, comprehensive approach. Further problems identified in the broader literature and reflected in policy documents were inadequate levels of support and supervision for community care workers, random distribution of care workers resulting in poor coverage, and poor target setting and quality assurance of community-based care programmes (Lehmann and Sanders 2007; Barron *et al.* 2010; Health Systems Trust 2011).

In the latest round of policy developments, which started in 2010 (Barron *et al.* 2010), the Department of Health reaffirmed the intention to formalize community-based care work as one part of re-engineering PHC within the District Health System (Government of South Africa 2011b; Pillay and Barron 2011; Pillay 2012). The policy guidelines describe a country-wide deployment of state-employed PHC outreach teams operating from formal PHC facilities in each electoral ward. The main

tasks of these teams would be to profile the population by identifying 'at risk' individuals, families and households, as well as to make referrals, prevent ill-health and promote good health. Each team would consist of six community health workers, environmental health practitioners and health promoters, supervised by a professional nurse. The target coverage figure was estimated at 250 households per community health worker, while the number of outreach teams per ward would be decided by district management, based on population density and health needs (Pillay and Barron 2011; Pillay 2012).

Although led by government, ideas around the greater formalization of community-based care evolved in 2010 and 2011 through stakeholder participation that included strong representation from the NPO sector (Community Care Workers Symposium 2010, 2011). Government policy and implementation guidelines, however, only briefly mention the importance of communicating with the NPO sector about changes in the organization of community-based care and the need for working with the NPO sector in enacting the transition (Government of South Africa 2011b). Within this context, our analysis aims to deepen understanding of the complex and changing environment where civil society and government intersect at community level. Our overall objective is to help inform the transitional process by focusing the attention of both policy-makers and civil society on opportunities and risks that may come with implementation of current reforms to community-based care in South Africa.

Study context

The three geographic regions covered in this study are Khayelitsha (Western Cape), Botshabelo (Free State) and Bushbuckridge (Mpumalanga). They represent marginalized and impoverished environments in South Africa where community-based care programmes run by health-related NPOs have an established presence. The sites demonstrate substantial differences in geographic, economic and sociocultural resources and access to services.

Khayelitsha is a dense urban settlement with a population of around 500 000 (Médecins Sans Frontières 2008) situated 32 kilometres from the Cape Town city centre. It was established in 1984 through the struggles of Xhosa-speaking migrants from the Eastern Cape to live and work in Cape Town (Worden 1994). Fifty percent of the economically active population are unemployed (Government of South Africa 2005). The township has the highest mortality rates in Cape Town (Groenewald *et al.* 2008) and in 2007 the HIV prevalence rate in pregnant women attending antenatal clinics was 32% (Médecins Sans Frontières 2008). However, Khayelitsha is also at the heart of the AIDS social movement in South Africa, where in the late 1990s, with support from Médecins Sans Frontières (MSF) and the Treatment Action Campaign, some clinics pioneered the delivery of antiretroviral therapy in resource-limited settings and provided powerful evidence on treatment adherence that set agendas not only in South Africa, but globally (Coetzee *et al.* 2004). Health services consist of three community health centres (including two maternity services), eight clinics, and a district hospital, provided by a combination of local and provincial government authorities.

Botshabelo is a semi-rural town situated 60 kilometres from the Free State provincial capital of Bloemfontein. Its creation in 1979 was an act of Apartheid social engineering which limited the number of black people settling closer to Bloemfontein (Tomlinson and Krige 1997). The population was 166 705 in 2010 and unemployment 56% in 2011 (Mangaung Metropolitan Municipality 2011). Government transport subsidies have turned Botshabelo into a dormitory town, with many commuters returning only at night or over weekends from jobs in Bloemfontein. The 2007 HIV antenatal prevalence in the health district was 27.4% (Government of South Africa 2009b), but this figure may be much higher for some areas, including Botshabelo (Hattingh *et al.* 2009). The town has 13 clinics and a district hospital.

Bushbuckridge is a rural sub-district in north-eastern Mpumalanga. The population is difficult to estimate, with figures ranging between 500 000 and 900 000 (Government of South Africa 2007). The inhabitants are distributed in 235 villages and rural areas and there are four small urban settlements (Government of South Africa 2007). The region has known much political and social instability, having had its borders redrawn several times during and after Apartheid. The area has very high unemployment levels—79.9% of those aged 15–65 (Government of South Africa 2008)—and has been designated a poverty node, among 22 of the poorest areas of South Africa (Government of South Africa 2008). In 2007, the larger district had an HIV antenatal prevalence of 36.1% (Government of South Africa 2009b).

Methods

The study is a descriptive qualitative study conducted in three purposively selected sites representing distinct geographic regions in three provinces of South Africa.

Constructing a list of NPOs in the study sites

The study aimed to include all known organizations with a self-identified focus on health-related community-based care in the defined geographic regions. Different data sources were used to establish a comprehensive list of NPOs in each study site. In the first place, NPOs in the sites were identified through existing lists acquired from government and civil society sources, for instance from the provincial Departments of Health and Social Development, from NPOs acting as stipendiary pay masters in the region, or from attendance registers of local co-ordinating bodies. In the second place, each NPO identified was asked to identify further NPOs with a health-related focus in their area. The process was continued until no new organizations emerged. In the third place, inclusion criteria were applied to the identified NPOs: they had to have a clear health-related focus and a physical presence in the community, for instance premises or a regular meeting place. From these three steps it was possible to establish the number of health-related NPOs providing community-based care and to estimate their density per population in each of the sites.

Data collection

Managers or co-ordinators of NPOs identified were contacted and invited to respond to a standardized questionnaire, combining open and closed type questions. The questionnaire was

administered by a fieldworker and participants' oral responses were noted down in writing. The questionnaire collected information on whether the organization was a local, provincial, national or international organization; its inception date; activities; the numbers and types of care workers enrolled; the numbers and types of managerial staff; remuneration (if any) of managerial staff and care workers; the settings where the organization conducted its activities (clients' homes, community settings like schools, formal health care facilities like clinics or a mixture of these); the number and identity of the organization's funding sources; its reporting obligations and structures; the organization's partnerships with other NPOs; and participation in co-ordinating structures. Interviews were conducted mostly in English, but also in Xhosa, Xitsonga, Siswati, Sepedi and Southern Sotho when participants preferred using another language. In cases where a fieldworker could not speak the preferred language, an interpreter was used. Fieldworkers used English to note down responses. There were two fieldworkers in Khayelitsha, one in Botshabelo and two in Bushbuckridge. Participation was voluntary and all participants gave written informed consent. Ethical clearance was obtained from the University of Cape Town Faculty of Health Sciences Human Research Ethics Committee (HREC REF 042/2010). The study was conducted over a period of 16 months, from late 2009 to early 2011.

Data analysis

NPO characteristics in the three study sites

Organizations' responses from the three study sites were entered into spreadsheets using the standardized questions on the questionnaire as column headings. Based on this information, the health-related NPO sectors in the three regions could be described in terms of general characteristics.

Developing a typology of NPOs

Responses to questionnaire items were then grouped according to a dual coding system which was used to develop a typology of NPOs for each region.

The first part of the coding system focused on NPO resources—their staffing, remuneration of staff, funding sources, whether they were international, national, provincial or local, and monitoring and evaluation (M&E) structures—to classify organizations as 'Well-resourced', 'Moderately resourced' or 'Poorly resourced'. These three categories were mutually exclusive.

The second part of the coding system focused on organizations' activities, the setting where activities took place, and an adaptation of the 'charity-development-empowerment' typology described by Habib (2005) to classify organizations' orientations as 'Direct service' (which included providing psychosocial support and relieving poverty through providing access to resources), 'Developmental' and/or 'Activist'. These orientations were not mutually exclusive.

The typology of NPOs derived from these two coding systems was constructed to avoid inflexible and rigid categorization of organizations. Table 1 summarizes the dual coding system used to develop the typology.

Establishing partnerships networks among NPOs

Organizations' responses to the question 'Who are the partners that you work with in Khayelitsha/Bushbuckridge/Botshabelo?'

Table 1 Dual coding system used in developing typology of NPOs

Code 1: NPOs classified in terms of 'resources' (These categories are 'mutually exclusive')	<p><i>Well-resourced</i>: stable funding; salaried and stipended staff; established monitoring and evaluation (M&E) systems; mostly national or international NPOs</p> <p><i>Moderately resourced</i>: fairly stable funding, usually from more than one source; most of staff on regular stipends; emerging M&E systems; mostly provincial or local community-based organizations</p> <p><i>Poorly resourced</i>: very little or no reliable funding; no or irregular stipends, very little accountability and very basic M&E systems; mostly local community-based organizations</p>
Code 2: NPOs classified in terms of 'orientation' of activities (These orientations are 'not mutually exclusive')	<p>'Direct service' orientation, which includes providing psychosocial support and relieving poverty through providing access to resources; activities mostly take place in clients' homes, but also in community settings or formal health facilities</p> <p>'Developmental' orientation, involving capacity-building in communities for instance by training or supervising groups or organizations to conduct health education programmes or income generating projects; activities mostly take place in community settings like NPO premises, schools</p> <p>'Activist' orientation, mobilizing communities to become aware of and exercise their health rights; activities mostly take place in community settings or formal health facilities</p>

were used to establish partnership networks in each study site. Partners were defined as any person(s), organization(s), government department(s) or institution(s) with whom organizations worked. For the purposes of this analysis only information on partnerships with other NPOs was used. Partnerships among NPOs were recorded as a symmetrical matrix and basic network analysis was performed on the self-reported partnerships in each site using UCINET software (Borgatti *et al.* 2002). Two kinds of partnership tie were included in the analysis: NPOs either declared partnership ties with other organizations (out-degree ties) or were identified as partners by fellow organizations (in-degree ties). The networks were compared in terms of mean degree of actor connectedness and the density of networks. Network density was defined as 'the proportion of all possible ties that are actually present' (Hanneman and Riddle 2005, pp. 104–5).

Findings

Size and general characteristics of the health-related NPO sector in the study sites

Table 2 describes the NPOs in the three study sites in terms of the size of the sector, inception dates of NPOs, whether they are international, national, provincial or local organizations, their funding sources and the main settings of their activities (home, community or facility).

Overall, health-related NPOs in Khayelitsha were more established, more securely funded and more likely to be international or national organizations than NPOs in the semi-rural and rural sites. Khayelitsha had a larger number of NPOs than the other sites, although Botshabelo had the highest density of organizations at approximately 5 organizations per 10 000 people compared with 1 organization per 10 000 people in the other sites. The median inception dates of NPOs were 2001 and 2002. Khayelitsha had a more established NPO sector, with 23 organizations (41%) starting before 2000 compared with 11 (31%) in Botshabelo and 9 (19%) in Bushbuckridge. In all three sites local community-based organizations (CBOs) predominated (89 organizations, 65%).

The main sources of funding were similar across the sites, with a higher proportion of organizations receiving funding from the Department of Social Development (51%) than from the Department of Health (34%). While four organizations

operated without funding in Khayelitsha and one in Botshabelo, 16 organizations (one-third) in Bushbuckridge received no funding.

Urban organizations' care activities were more formalized, with the activities of 24 (43%) NPOs in Khayelitsha taking place in community settings like community or early childhood centres, and the activities of 11 (20%) NPOs in formal health facilities like government clinics. In contrast, in the semi-rural and rural sites NPO activities were predominantly based in clients' homes, with 54% of organizations in Botshabelo and 79% in Bushbuckridge exclusively delivering home-based care services.

Typology of NPOs in the study sites

Table 3 captures the typology of NPOs derived from the dual coding system of organizations' level of resources and the orientation of their activities towards a 'Direct service', 'Developmental' and/or 'Activist' orientation.

Overall, well-resourced NPOs were in the minority (24, 17%), with the urban site supporting more well-resourced NPOs than the semi-rural and rural sites. Overall about half of the NPOs were moderately resourced, while around a third was poorly resourced.

The activities of a large majority (120, 87%) of NPOs across all sites were oriented towards 'Direct service', which included providing psychosocial support and relieving poverty through providing access to resources. Half of the organizations (70, 51%) had a 'Developmental' orientation, while only 12% (17) had an 'Activist' orientation. More specifically, there were very few organizations with an 'Activist' orientation in the semi-rural and rural contexts (two and five organizations, respectively).

Figure 1 captures the relationship between level of resources and orientation of activities in NPOs.

Well-resourced and moderately resourced organizations were more likely to have more than one orientation, and more likely to have a 'Developmental' or 'Activist' orientation than poorly resourced organizations. Almost all well-resourced organizations had a 'Developmental' orientation (22 out of 24), while more than half also had an 'Activist' (14) or 'Direct service' (13) orientation. In contrast, the most common orientation for organizations with moderate and poor resources was 'Direct service'. Almost all (60 out of 64) moderately resourced organizations had a 'Direct service' orientation, approximately

Table 2 Comparison of NPO profiles in study sites ($n = 138$).

	Khayelitsha	Botshabelo	Bushbuckridge	Total
Overall number of NPOs	56	35	47	138
Number of NPOs/10 000 population	1.1	4.7	0.9	-
Inception date				
Median start year	2001	2001	2002	2001
Started before 2000	23 (41%)	11 (31%)	9 (19%)	43 (31%)
Nature of organization				
International	15 (27%)	1 (3%)	4 (9%)	20 (15%)
National	4 (7%)	5 (14%)	3 (6%)	12 (9%)
Provincial	11 (20%)	6 (17%)	0	17 (12%)
Local CBO	26 (46%)	23 (66%)	40 (85%)	89 (65%)
Funding profile				
Average number of funders per NPO	2	2	1	-
Number of NPOs with DSD funding	32 (57%)	21 (60%)	18 (38%)	71 (51%)
Number of NPOs with DOH funding	23 (41%)	10 (29%)	14 (30%)	47 (34%)
Number of NPOs with DSD and DOH	15 (27%)	2 (6%)	10 (21%)	27 (20%)
Number of NPOs with other donors	37 (66%)	25 (71%)	16 (34%)	78 (57%)
No funding	4 (7%)	1 (3%)	16 (34%)	21 (15%)
Setting of activities				
Home (exclusively)	18 (32%)	19 (54%)	37 (79%)	74 (54%)
Community (exclusively)	24 (43%)	5 (14%)	6 (13%)	35 (25%)
Facility (exclusively)	11 (20%)	1 (3%)	3 (6%)	15 (11%)
Mix of settings	3 (5%)	10 (29%)	1 (2%)	14 (10%)

DSD: Department of Social Development; DOH: Department of Health.

Table 3 Typology of NPOs in study sites – level of resources and orientation of activities ($n = 138$)

	Khayelitsha	Botshabelo	Bushbuckridge	Total
Level of resources				
Well-resourced NPOs	13 (23%)	3 (9%)	8 (17%)	24 (17%)
Moderately resourced NPOs	24 (43%)	18 (51%)	22 (47%)	64 (46%)
Poorly resourced NPOs	19 (34%)	14 (40%)	17 (36%)	50 (36%)
Orientation of NPOs' activities				
'Direct service'	49 (88%)	31 (89%)	40 (85%)	120 (87%)
'Developmental'	32 (57%)	14 (40%)	24 (51%)	70 (51%)
'Activist'	10 (18%)	2 (6%)	5 (11%)	17 (12%)

two thirds (37) had a 'Developmental' orientation, while only three had an 'Activist' orientation. Organizations with poor resources focused heavily on 'Direct service' (47 out of 50). Only nine poorly resourced organizations had a 'Developmental' and none had an 'Activist' orientation.

Partnership networks among NPOs in the study sites

Table 4 presents summary statistics for the NPO partnership networks in the three selected sites.

NPOs in Botshabelo on average had almost double the number of ties with one another than NPOs in Khayelitsha and triple the number of ties than NPOs in Bushbuckridge. The partnership network for organizations in Botshabelo, therefore,

has a much higher density (15.3%) than the networks in Khayelitsha (4.9%) and Bushbuckridge (3.7%), a result that supports the previous measure of density for Botshabelo presented in Table 2.

Figures 2, 3 and 4 illustrate the partnership networks among NPOs in the three sites. To deepen analysis of the networks, the figures indicate NPOs' levels of resources and also identify organizations with an 'Activist' orientation.

The network image for Khayelitsha illustrates an area of dense interrelationship, but also a relatively high number of NPOs (9) with no or only one tie. Of the 10 activist organizations, 6 were positioned in the densest part of the network, creating powerful nodes of connection, mostly with moderately resourced

organizations. Few poorly resourced organizations lay within the dense centre, and approximately half lay towards the periphery and had few ties.

The image for Botshabelo indicates a high degree of actor connectedness. Only one organization had no partnerships, and two had only one tie with others. The moderately resourced organizations dominating the left side of the image (up to organization 27) and forming ties mainly with one another were mostly FBOs (7 out of 10). Well- and moderately resourced

organizations dominated the dense right hand side of the image. The two organizations with an ‘Activist’ orientation had multiple ties with other organizations. Poorly resourced organizations remained strongly connected to one another and to better resourced organizations, even towards the periphery.

The image for Bushbuckridge is fragmented and linear. There were 6 isolates and 14 organizations had ties with only one other organization. All the activist organizations were on the periphery and had only one or two ties with other organizations. They furthermore connected mainly with other activist or well-resourced organizations. Nine of the organizations with only one partnership tie were poorly resourced organizations, while moderately resourced organizations lay in the denser section of the network.

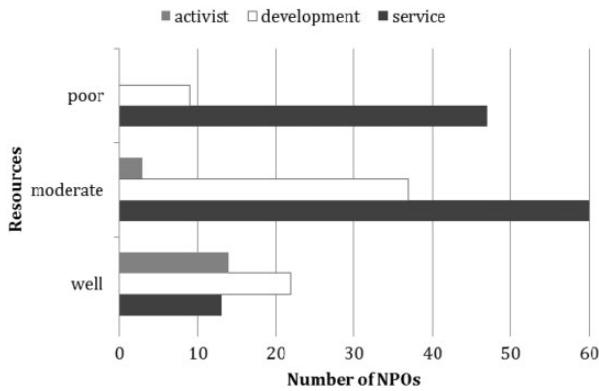


Figure 1 The relationship between NPO resources and orientation (*n* = 138)

Table 4 Network characteristics of health-related NPO sector in each study site (*n* = 138)

	Khayelitsha	Botshabelo	Bushbuckridge
Mean degree of actor connectedness	2.7 ties	5.2 ties	1.7 ties
Density of network	4.9%	15.3%	3.7%

Discussion

Our research found a sizable sector of NPOs offering community-based care in three distinct regions of South Africa. We developed a 3-fold approach to characterizing the health-related NPO sector—resources, orientation(s) and partnership networks. Overall, almost half of the NPOs were moderately resourced, just over a third poorly resourced, and less than one-fifth well-resourced. Important regional differences were observed. Resources were skewed towards the urban area, with more than half of the well-resourced organizations located there. Well- and moderately resourced organizations were successful at combining orientations, while poorly resourced organizations were mostly limited to direct service provision. There were few organizations with activist orientations, and by far the majority of these were well-resourced and urban. In an urban setting, such organizations tended to form strong nodes of interaction, tying many organizations with good to moderate resources into a dense network of partnerships, from which poorly resourced organizations tended to be excluded. A

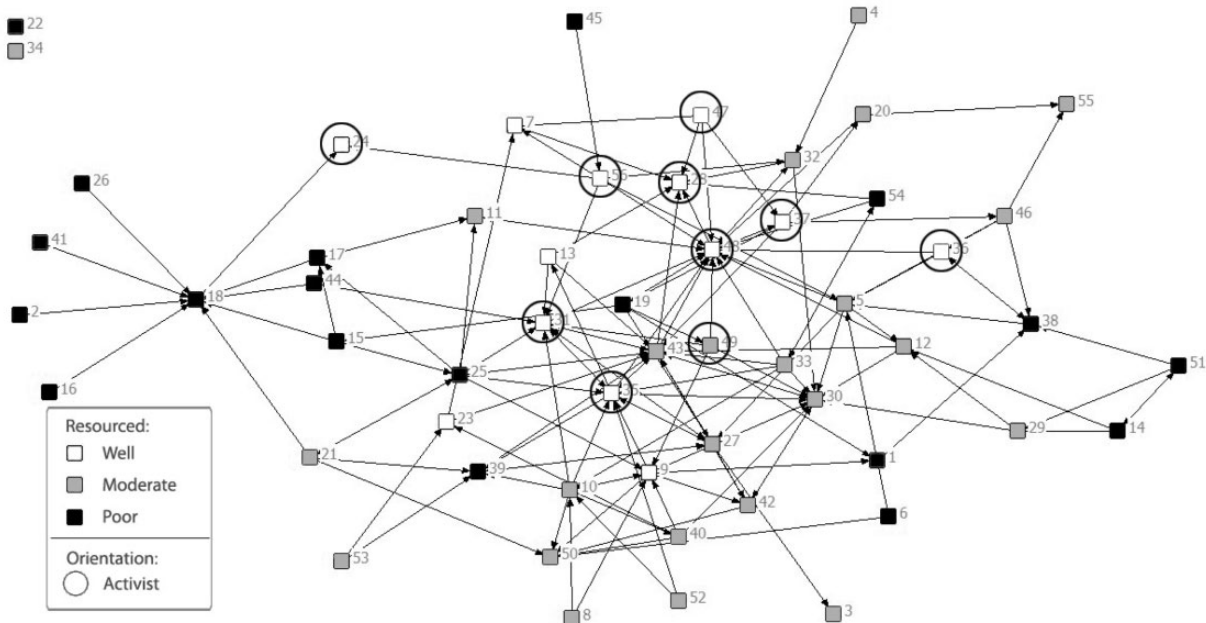


Figure 2 Partnership networks among NPOs in Khayelitsha (*n* = 56)

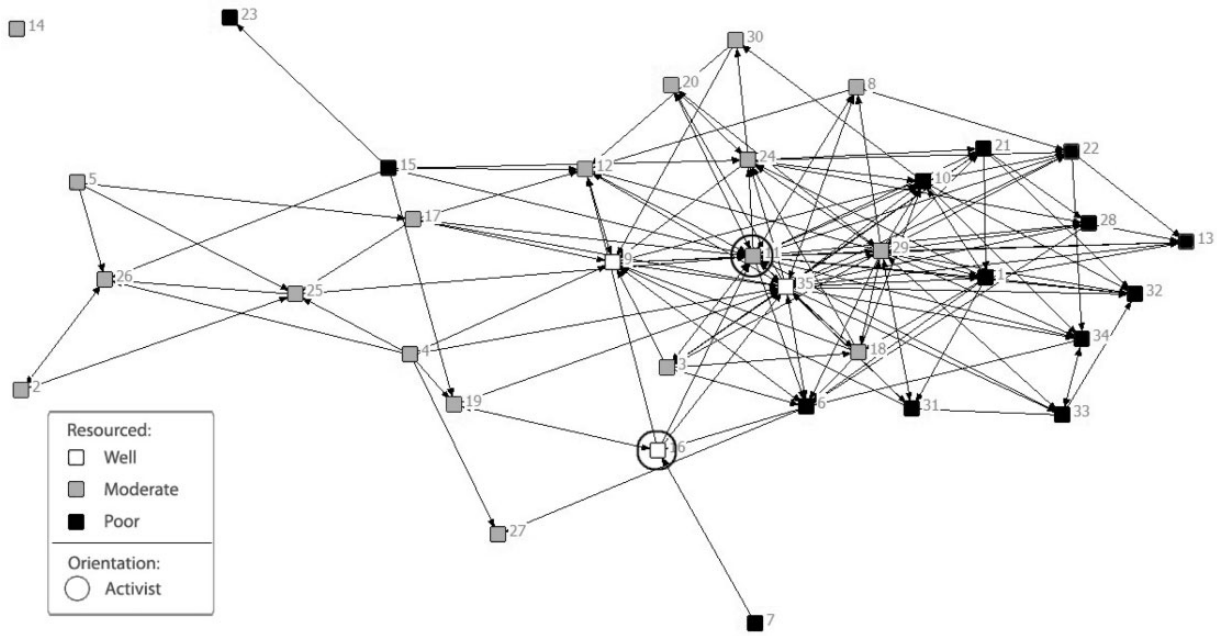


Figure 3 Partnership networks among NPOs in Botshabelo ($n = 35$)

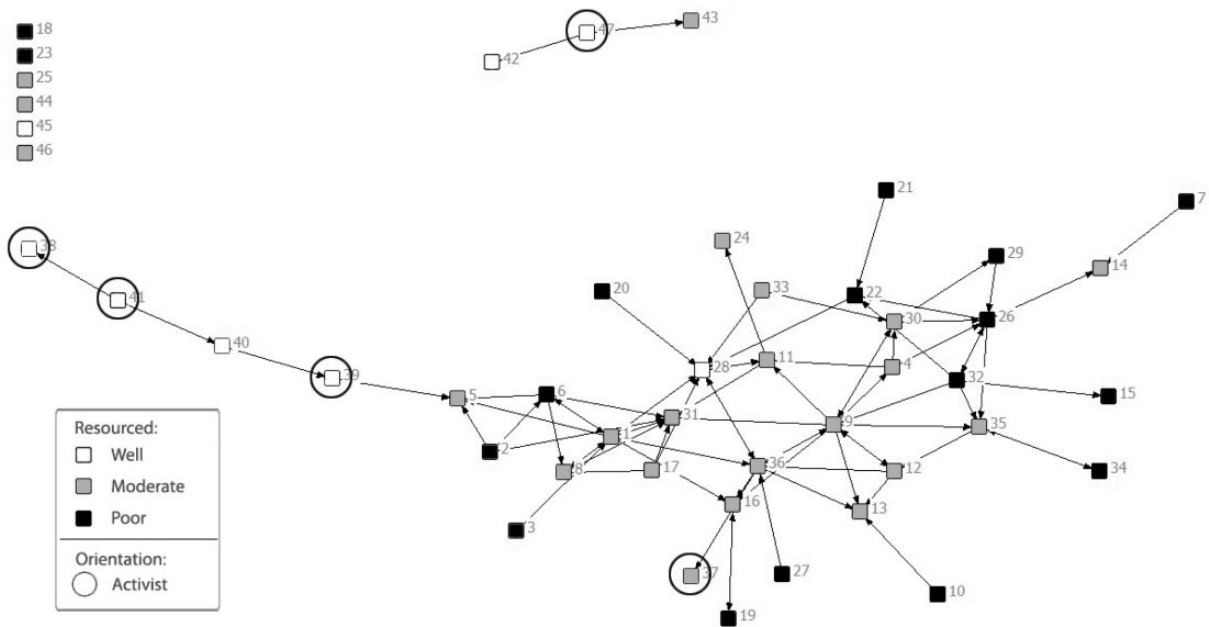


Figure 4 Partnership networks among NPOs in Bushbuckridge ($n = 47$)

different picture emerged in a semi-rural setting, where local CBOs maintained strong connections with one another as well as with better resourced organizations. This was not the case in a deep rural setting, where well-resourced organizations tended to connect only with one another and poorly resourced organizations were marginalized.

The findings that moderately resourced organizations made up almost half of the health-related NPO sector, and that both moderately and well-resourced organizations had a strong

direct service orientation, suggest that these organizations could contribute a pool of fairly skilled care workers to the ward-based PHC outreach teams. These are also the organizations that combined orientations most successfully and were particularly likely to combine direct service with a developmental orientation. This makes them strong candidates for contributing managerial experience and developmental expertise to the overall process of re-engineering PHC. However, many moderately resourced NPOs may find it hard to survive the

changes or may struggle to reposition themselves in communities if there is radical rearrangement of NPO structures and resources in relation to the PHC outreach teams. This may in turn jeopardize some of the developmental activities not included in the scope of work defined for outreach teams. For instance, many of these organizations currently develop capacity in communities to generate income or food security, which assists households made vulnerable through illness or disability. It would be important to support the continuation of such activities by NPOs playing a broader developmental role through relevant ministries such as Social Development, Education and Agriculture.

The finding that few health-related NPOs had an activist orientation, and that these organizations were mainly found in urban and well-resourced environments, is cause for concern given the emphasis placed in current policy and research on the role of community participation and mobilization in responding to health needs in low- and middle-income countries (Birdsall and Kelly 2005; Campbell and Cornish 2010; Wilson *et al.* 2012). For example, the 'targeted strategic investment approach' towards combating HIV/AIDS advocated by the UNAIDS and WHO (Schwartzländer *et al.* 2011; UNAIDS and WHO 2011) regards community mobilization as a 'Priority Work Area' and highlights the importance of building community-based structures to contribute to the demand, planning, delivery and evaluation of services and to advocate for rights-based approaches to service delivery. However, if well- and moderately resourced organizations with developmental or activist orientations were to be drawn into the state's process of implementing policy guidelines on revitalizing PHC, these organizations may not retain enough autonomy to mobilize communities independently. In this respect Habib (2005) cautions that too close a relationship between NPOs and the state may limit their ability to respond critically to the interests of the poor and marginalized. An important question for both government and NPOs to consider is how a stronger association with the state might influence the orientations of some of the most experienced health-related NPOs in the country. The question is made more pertinent given the important relational role that NPOs with an activist orientation played in the partnership networks of two of the sites in this study.

The finding that the majority of poorly resourced NPOs had a single orientation towards service delivery has similar implications. These NPOs focus mainly on services like home-based care (of seriously ill, frail, disabled or mentally ill clients), psychosocial support and alleviating poverty by facilitating access to basic material resources, for instance, by running soup kitchens. Some of these services may likewise fall outside the scope of work described for the ward-based outreach teams. It is possible that workers from poorly resourced NPOs, offering a flexible combination of care and welfare services, would not be integrated into the outreach teams. At the same time, they risk losing funding for the services they provide and may find it particularly hard to survive in a new dispensation.

The question remains, then, what the prospects are for poorly resourced community-based organizations: whether they risk becoming further marginalized, or whether the state could find a way of harnessing the work they perform in communities, and of building on their potential to form strong partnership networks with one another. Hanneman and Riddle (2005)

explains that the density of networks may indicate social capital. Similarly, Campbell and Cornish (2010) highlight the importance of 'relational contexts', showing that organizations lacking the advantages of favourable 'material contexts' could still manage to operate in a 'relational context' that enable them to build up constructive networks within communities as well as with external constituencies like government departments and policy-makers. Wilson *et al.* (2012) similarly present networks of community-based organizations as influential actors in policy decision-making, in that they offer opportunities for public engagement and collective action. Given the importance attached to community participation and mobilization in responding to health needs and service delivery, especially in marginalized communities, the importance of maintaining and strengthening such partnership networks should not be overlooked.

Limitations

Our study fills a serious gap in the literature by providing insight into the health-related NPO sector and its partnership networks in South Africa, and more generally into the roles of community-based organizations involved in health-related activities in low- and middle-income countries. The study faced challenges inherent in its study design and methods of gathering data. Firstly, transferability of the study may be limited as the sites selected purposively are not representative of the country as a whole. The selection of an urban, a semi-rural and a deep rural environment in three different provinces goes some way towards addressing this limitation. Secondly, the list of NPOs constructed for each of the study sites may not be comprehensive. Organizations were asked to self-identify whether they had a health focus and to identify other organizations. Organizations may have been incorrectly omitted or included. To address this limitation, we cross-checked the list of NPOs using different data sources and inclusion criteria.

Conclusion

Overall, our research aims to inform both government and civil society, and points to a need for further research on how to harness existing strengths in communities and community-based organizations, and how to pre-empt unintended consequences of policy changes. In particular, our research indicates that many moderate to well-resourced organizations in South Africa have the capacity and infrastructure to contribute staff and developmental expertise to the process of deploying ward-based outreach teams and strengthening PHC in communities. In this respect, the research points to the importance of maintaining strong partnerships between government departments and the NPO sector. Our research further highlights the potential wealth of social capital locked up in organizational networks operating in otherwise impoverished environments with a high burden of disease. The conditions under which constructive networks come into being and their potential to mobilize communities to participate in policy-making and implementation deserve further attention. Our research also cautions against potential pitfalls in implementing new policy guidelines on re-engineering PHC in South Africa. An important risk identified is that funding could be channelled away

from the NPO sector in order to strengthen national health programmes (as happened post-1994). Lacking resources or experienced staff, NPOs may find it difficult to survive. Activities not taken over by the outreach teams may fall away, depriving communities of important resources and social networks. Finally, our research suggests that a uniform approach to policy implementation may not adequately accommodate regional differences and variations in the NPO sector. Considerations for adaptation may be necessary in light of the observed differences between urban and rural settings.

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Conflict of interest

None declared.

Endnote

¹ The term 'community care worker' is used in this paper to signal inclusion of a broad range of biomedical and psychosocial forms of care provided. Policy documents of the Department of Health mostly use the term 'community health worker'. This paper only uses 'community health worker' when the term has been drawn specifically from Department of Health documentation.

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