

**Formative Evaluation of the
Social Capital Project
in the
Department of Health of the
Provincial Government of Western Cape
April 2005 – March 2006**

**Evaluation Report
August 2006**

Produced by:

**Dr. Ruth Stern, Dr. Brian van Wyk,
Ms Nikki Schaay and Professor David Sanders
of the
School of Public Health, University of Western Cape
and
Mr Paul Tyler
CMDS Consulting**



AN IMPORTANT NOTE TO READERS OF THIS REPORT:

The report of the evaluation of the Social Capital Project is a lengthy one. The rationale for this is that the evaluation team felt that a more *detailed*, as opposed to a *précis*, account of the results of the 44 interviews conducted was important given that:

- the Social Capital Project was a new and innovative pilot initiative and as such had not been previously documented in a comprehensive manner;
- the Social Capital Project has involved a range of diverse stakeholders, many of whom had not had access to information about aspects of the Project that they had not immediately been involved in. This report was seen as one of the ways in which the different experiences of the Project could be shared; and
- considering the evaluation was *formative* in nature, it was considered important to demonstrate the evidence base from which recommendations for the future of the Project were made.

Having outlined the above, the team is aware that many readers will only be able to read some aspects of the report. For this reason the first 8 chapters of the report have been written in a discrete way: each containing a conclusion at the end of the chapter so as enable readers to be able to focus on those aspects of the Social Capital Project that they have a particular interest in.

TABLE OF CONTENTS	
Acknowledgements	6
EXECUTIVE SUMMARY	7
Acronyms	16
Terminology	17
Categorisation of the respondents	18
Chapter 1: Introduction, aim & methodology of the evaluation 1.1 Introduction 1.2 Aim of the research 1.3 Methodology 1.4 Overview of the report	19
Chapter 2: Literature review: social capital formation in health 2.1 Background 2.2 Defining social capital 2.3 Social capital and health 2.4 Examples of social capital building for health 2.5 Conclusion	23
Chapter 3: Documentary review 3.1 Introduction 3.2 Western Cape SCFS, Social Capital Cluster, PGWC 3.3 The Social Capital Project Operational Plan (April 2005 – March 2006) 3.4 The MDHS Social Capital Operational (or Implementation) Plan (July 2005 - July 2006). 3.5 Delivery review and improvement pilot study: discussion document 3.6 Conclusion	39
Chapter 4: Findings: understanding & interpretation of the concept of social capital 4.1 Introduction 4.2 Understanding the theoretical concept 4.3 The interpretation of the theory into practice 4.4 Conclusion	45
Chapter 5: Findings: the establishment of Health's social capital initiative 5.1 Introduction 5.2 The establishment of the PGWC social capital initiative 5.3. The development of the social capital formation strategy: the role	53

<p>and impact of the social cluster</p> <p>5.4 The opinions, activities and experiences of other departments within the social cluster in relation to the SCFS</p> <p>5.4.1 The Department of Social Services & Poverty Alleviation</p> <p>5.4.2 The Departments of Education & Community Safety</p> <p>5.5 Immediate opportunities for collaboration between the Department of Health and other departments in the Social Cluster.</p> <p>5.6 Conclusion</p>	
<p>Chapter 6: Findings: establishing the Social Capital Project and its placement</p> <p>6.1 Introduction</p> <p>6.2 The development of the social capital formation strategy: the PGWC DOH response at the head office level</p> <p>6.3 Support of community participation structures</p> <p>6.4. Confusion with other strategies</p> <p>6.5 Establishing the project within MDHS</p> <p>6.6 How the project was experienced in practice</p> <p>6.7 Conclusion</p>	67
<p>Chapter 7: Findings: implementation of the Social Capital Project activity plans</p> <p>7.1 Introduction</p> <p>7.2 The development of the project within the two pilot sites</p> <p>7.3 General view of the social capital project in the sub-districts</p> <p>7.4 Community IMCI</p> <p>7.5 Non-communicable diseases (NCD)</p> <p>7.6 Health promoting schools (HPS)</p> <p>7.7 Community based eye-care project</p> <p>7.8 Strengthening the community structures</p> <p>7.8.1 The 'Face the People' project</p> <p>7.8.2 Community Health Committee Forum</p> <p>7.9 Conclusion</p>	87
<p>Chapter 8: Findings: support services for the project</p> <p>8.1 Introduction</p> <p>8.2 Financial support</p> <p>8.2.1 Introduction</p> <p>8.2.2 Achievements</p> <p>8.2.3 Problems and challenges</p> <p>8.3 Human resource management (HR)</p> <p>8.3.1 Introduction</p> <p>8.3.2 Achievements</p> <p>8.3.3 Problems and challenges</p> <p>8.3.4 Lessons learnt</p> <p>8.3.5 Training support</p>	119

8.4 Information management 8.4.1 Intentions 8.4.2 Achievements 8.4.3 Challenges 8.4.4 Lessons learnt	
Chapter 9: Discussion 9.1 Introduction 9.2 Input 9.2.1 Strategic and financial support for social capital formation 9.3 Processes and systems 9.3.1 Inadequate planning 9.3.2 Human resource and organisational issues 9.4 Outputs 9.4.1 Achievements 9.4.2 Challenges and problems 9.5 The way forward	139
Chapter 10: Conclusion and Recommendations	155
References	163
Appendix I: List of respondents	167
Appendix II: Project outputs	170

ACKNOWLEDGEMENTS

The evaluation of the Social Capital Project drew on the support and assistance of many people. The evaluation team would like to acknowledge the support of the all those who made it possible. First, our thanks to Dr Lawrence Bitalo, the Director of Health, MDHS for his support for the evaluation. Our special thanks to the Social Capital Project manager Ms Rita Edwards and the Special Project manager, Dr Cynthia le Grange for their assistance in providing us with the background information, contact details of respondents, documentation required for the evaluation, and for always being there to answer our many questions. Thanks also to our colleagues Professor Uta Lehmann, Ms Hazel Bradley and Ms Suraya Mohamed for their assistance with conceptualising the evaluation and for their help with interviews, and to Ms Carolin Gomulia, the Social Capital Researcher at UWC for the information and support that she provided. Above all, our thanks go to all the respondents who willingly gave up their time to be interviewed for the evaluation. The richness of their contributions have made this an interesting and rewarding study.

EXECUTIVE SUMMARY

BACKGROUND TO THE EVALUATION

The Social Capital Formation Strategy has been introduced in the Western Cape as one of the lead strategies of the Provincial Government's *iKapa Elihlumayo*. The Provincial Government of the Western Cape (PGWC) Department of Health (DOH)'s Social Capital Programme began with the development of the Social Capital Concept Document in October 2004, and the draft position statement on Social Capital Formation in Health by Professor Craig Househam in November 2004. The decision was made to develop a Social Capital Project through the Metropole District Health Services (MDHS), under the direction of the Regional Director, Dr Lawrence Bitalo. An Operational Plan (April 2005 – March 2006) was drafted by PGWC DOH to support this process.

The MDHS Social Capital Project is being developed as a pilot initiative in two of the sub-districts in Cape Town – Khayelitsha and Mitchell's Plain. There is also a community based intervention that spans all the sub-districts. The planning of the Social Capital Project and the implementation in these sites form the main focus of the evaluation.

AIM OF THE EVALUATION

The overall aim of the evaluation is to provide PGWC DOH, MDHS and other relevant stakeholders with an in-depth analysis of what the Social Capital Project has achieved to date, what the key challenges and difficulties have been in the process of implementation and to make recommendations for future planning.

OBJECTIVES

The objectives are:

1. To review International & National literature in respect of social capital formation in health and draw out lessons for the PGWC DOH
2. To review and document the history, original intention and concept of the Social Capital Project and compare this to how it has been interpreted by various stakeholders.
3. To review the process & implementation of the Social Capital Project across the following core project activities of the Social Capital Project:
 - internal capacity building,
 - the Integrated Management of Childhood Illnesses (IMCI),
 - the expansion of community based chronic disease management,
 - the Health Promoting Schools (HPS) interventions, and
 - the strengthening of community participation structures.
4. To review the Social Capital Project against the organisational context within the DOH.
5. To make recommendations regarding the strategic direction, process of implementation and material and management support required to implement the Social Capital Project in the future.

METHODOLOGY

Evaluation Framework

The evaluation has drawn on the open systems framework, described by Roberts (1994). This is a framework that looks at the inputs in relation to demands, support and resources, and the way that these inputs are influenced by the system and processes that are designed to convert the inputs to outputs.

Methods

The evaluation included indepth interviews, focus group discussions and documentary analyses. In addition, opportunistic observations were undertaken of meetings and events and a feedback meeting was held with all MDHS respondents that included a useful discussion on the issues raised by the evaluation. A purposive sample of respondents was used, based on initial consultation with key respondents. The levels of respondents included senior and middle level managers in the Provincial Health, Social Services, Education, Community Safety Departments as well as City of Cape Town Health Department. Implementers and support staff from MDHS were also interviewed. In total the evaluation team conducted 41 interviews and 3 focus group discussions and attended 5 Project meetings and events.

RESULTS

Establishing the PGWC DOH Social Capital Initiative (Internal Aspects)

The Social Cluster Social Capital Formation Strategy was led by the Department of Social Services and Poverty Alleviation. Other departments in the Cluster are Health, Education, Safety and Security and Cultural Affairs and Sport. A significant advantage of having a cluster driven approach was so that it could be developed as an integrated approach across departments. The priority focus area for the integrated approach was identified as youth, and it was anticipated by the Premier's Office, the Treasury and initially the Social Cluster that all departments would adopt a youth focus. It was envisaged that the Cluster would be a forum for providing guidance and support to individual departments.

However, apart from initial and occasional inter-departmental interaction, a coordinated approach did not occur. Instead, the departments have developed their initiatives independently, each having their own budget and full autonomy to develop their initiative within that budget. The establishment of separate initiatives reinforced the development of vertical programmes, with minimal collaboration across departments.

The development of the PGWC DOH Social Capital Formation Strategy began with discussions at a policy level. The involvement of the Head of Department and other senior departmental heads was indicative of the importance given to the initiative. A task team was established to write the DOH Social Capital Formation Strategy Concept Document in October 2004, and to draw up the framework and strategic approach that led to the development of the Social Capital priorities in the Western Cape Department of Health Five Year Strategic and Performance Plan 2005-2006.

The PGWC DOH was applauded by the Social Cluster members for its concept document at the beginning of the process, as it was seen as one of the most developed. It was subsequently criticised for failing to contribute to the Departmental

Social Capital Formation Initiatives document. However, this opinion has now shifted. Because of the development of the MDHS Social Capital Project, PGWC DOH is currently being seen as taking a lead in developing an integrated initiative, albeit at a local level.

MDHS establishing the Project and its Placement

Developing operational plans

PGWC DOH was the only one of the Social Cluster departments to develop a separate project - the other departments integrated social capital into their existing programmes. PGWC DOH's rationale was that as a project it would have its own identity that they could manage, monitor, and finance in a clearly identifiable way. It was also stated that creating a separate project enabled creativity of thinking by those involved, whereas with an integrated approach, staff would have just continued with the usual way of working. Finally and importantly, it would provide an opportunity for lessons to be learnt that could later be integrated into the mainstream PGWC DOH.

However, there was considerable confusion as to who was responsible for developing the social capital proposals. Initially there were two different proposals written, one by the PGWC DOH, and one by MDHS. These were requested by the relevant managers without adequate guidance and within a very short timeframe. These proposals were both rejected and a third and final document was drafted by PGWC DOH, the Operational Plan (April 2005 – March 2006). This forms the foundation for the MDHS Social Capital Project, and the R7m funding was allocated for its delivery. It also includes a section on strengthening community structures, for which R4m was allocated. This final plan adopted existing Programme priorities of PGWC DOH. The reason for this choice was that it would build on what was already being developed, but with the additional opportunities to develop and build on linkages within the community, and between communities and the services. This would be strengthened by the additional funds, which would enable employment of additional staff.

Choice of pilot sites

The Operational Plan (April 2005 – March 2006) identified Khayelitsha and Mitchell's Plain as pilot sites. The advantage of having only two sites was that it would enable a concentration of resources in these areas. This would provide an enabling environment in which to test the benefits of adopting a social capital approach. Working in small areas was also seen as enhancing the opportunity to develop networks and partnerships in these areas, between both communities and professionals. Furthermore, as Khayelitsha and Mitchell's Plain are both Urban Renewal sites, the potential for collaboration was significant.

Choosing health priorities

The Programme priorities for the Social Capital Project, selected from within the Provincial DOH overall 8 divisional priorities, were child health through the IMCI programme, focusing on diarrhoea and immunisation; and non-communicable diseases, focusing on hypertension and diabetes. The project was also to build on, and importantly, strengthen the existing Health Promoting Schools (HPS) initiatives in the two sub-districts. In doing so, they would be building on significant experience and networks that had already been established, and would also be contributing

considerable resources to develop them further and more collaboratively. However, there was a contrary view from the architects of the original MHDS plan, suggesting that this was not the most useful way to proceed. For them, the Programmes were too limited in their disease-based approach, which they felt worked against their interpretation of the concept of Social Capital. This difference in interpretation created a tension in the DOH that had detrimental implications for the placement and running of the Project

Establishing the Project

It was the responsibility of the Director, MDHS to locate the Project and appoint staff to manage it. The Project was boosted tremendously with the appointment of key staff members to set up a Social Capital Project office at Woodstock regional office, as well as two offices in the pilot sites.

The decision made was to run the Social Capital Project as one of the MDHS Special Projects, and the manager of Special Projects became its overall manager. This meant that social capital was technically an independent project, even though most of its activities were located within community-based components of existing health Programmes directorate. This decision, however, became a major source of contention within the Project as a majority of arguments were made by respondents argued in favour of the Deputy Director of Programmes managing the project. The main argument was that she has the overall responsibility for those Programme areas, which had been designated as the main priorities for the Social Capital Project. Placing the Project under Special Projects Unit of MDHS was seen as creating a dual management system that left both managers with confused roles, and left some staff under them feeling resentful. It also meant that the Project had limited support in terms of financing, employment issues and relationships with NPOs, which were competencies that the Programmes sub-directorate had to then provide.

Implementation of activities

Sub-district offices

The sub-district offices were each run by a project coordinator, a community liaison officer and an administrative assistant. School health nurses were seconded from the school health services to be project coordinators. The project coordinators were required to establish task teams in their sub-districts, as well as monitor the work of community-based workers in the Health Programmes.

Community IMCI programme

The Diarrhoea Campaign in both Khayelitsha and Mitchells Plain, were noted for their success due to the good relationships that were being developed between schools, the City of Cape Town Health Department and the Department of Water Affairs and Forestry. In some NPOs the community based workers were already active in the communities, and training in the IMCI protocol enabled them to provide an extended service to households. This saved time and increased coverage of services, while providing the community-based workers with an additional income.

Management of chronic diseases

The Social Capital Project funding was used to pay for training, as well as for equipment and to pay the NPOs who were managing the community-based workers. This helped to formalise the support groups, which were being run as loose social organisations and, through the social capital approach, it enabled the support groups to be a bridge between MDHS and the community.

Health Promoting Schools

Community-based workers played a major role in reviving health promotion activities in schools, as they assisted school health nurses in a range of activities, as an 'extra pair of hands'. In addition, partnerships have been formed with community groups and other government departments, and they have laid the foundation for plans to develop schools as hubs for social capital formation in the communities

Eye-care programme

Another achievement of the Social Capital Project was the partnership with the League of Friends of the Blind to provide eye-care services in the community. This partnership was not part of the initial objectives for the Social Capital Project, and came about through an initiative between the Project office and the NPO.

Face the People Project

Although not included in the Social Capital Operational Plan (April 2005 – March 2006) it became clear to the evaluation team that the Department of Health's *Face the People Project* was considered by the MDHS to be one of the most successful projects. This was achieved by popularising the concept of social capital by honouring and profiling diverse members of the Metro community who work in a voluntary or semi-voluntary capacity to promote the health and wellness of their communities at a grassroots level.

Some concerns about choice of priority programmes

However, the need to spend funds quickly led to decisions being made about priorities without undergoing proper situational analyses, and without involvement of the communities in determining the priorities. The choice of interventions were according to 'top down' priorities, which are demonstrably important, but not necessarily the priorities of the communities, or the implementers.

Inadequate communication

There were many complaints about the inadequate communication at all levels. The lack of awareness about decisions and recommendations from the Premier's Office, the Social Cluster and the Provincial DOH was seen as an obstacle for those attempting to deliver social capital programmes on the ground. Concerns centred around the limited support, lack of clarity about what is expected, insufficient feedback on what was being implemented on the ground, and also a lack of awareness about how to access funds. This limitation in communication was seen as part of an ongoing institutional problem, but one that was particularly important given the newness of the initiative and the poor understanding of the concept.

Limited collaboration

The collaboration between the Social Cluster Departments was limited. There was also limited collaboration with the City of Cape Town. The collaboration at the sub-district level between the Social Capital Project and the City of Cape Town Health Department was good, but there was not the same co-operation between those involved in the community-based components of the Project and health facility staff working in the identified programme areas. This was despite the considerable efforts by the coordinators to bring different stakeholders together.

Support for social capital

Financial systems support

The main achievement of the Social Capital team in terms of financial management was the implementation of spreadsheet reports that captured expenditure commitments to date. This allowed for greater control over expenditures by the Project's financial administrator, albeit in the absence of support from the finance division.

However, the delay in producing the Operational Plan, particularly as the money was already available, led to confusion, as the details of the programme activities still had to be determined, while those budgeting for it had to have it complete.

There also were considerable delays in spending, which led to subsequent pressure to spend. This was caused by general 'bungling' by MDHS, which meant that it took months for documents to be signed, along with a lack of induction for Social Capital Project team members into financial procedures of the organization.

Human Resource (HR) management

Critical vacancies in the human resources office led to a limited capacity to perform HR functions such as recruiting for vacancies in the services. This led to the Project manager being tasked with recruiting staff without adequate support structures in place. It also meant that she had to perform a task that amounted to under-utilisation of her skills.

The lack of establishment for posts made available through Social Capital Project funds created staff payment delays and meant that some posts were recorded with incorrect descriptions in the human resource systems.

Newly appointed project staff had no orientation or induction to the organization. Had this been done, it would have helped to familiarise them with the systems and procedures within the organisation, and in doing so facilitate the process of setting up the project.

Information management systems

The importance of a computerised information management system for monitoring health programmes and outcomes was already recognized within MDHS, and the Social Capital Project was seen as a means to add impetus to that initiative, as there was the need to monitor and evaluate initiatives that came within the Social Capital Project. Social capital funding contributed to the appointment of staff for setting up an information management system.

Training

Two workshops were arranged to raise awareness of the concepts of social capital and potential for implementation of the MDHS Social Capital Project. The first workshop, which was a one day workshop, targeted managers, with a view to assisting them to relate social capital to their existing priorities, and to provide support for their staff involved in social capital initiatives. The second workshop involved a five-day training intended for those who would be tasked to be implementers of Social Capital in one form or another.

A computer training facility and an internet resource centre were established at headquarters for internal human capital development within MDHS.

DISCUSSION

One key themes that emerged from the analysis was the inadequate planning, which led to a lack of clarity about the concept of social capital. Although the importance of intersectoral collaboration was highlighted from the outset, this necessary integration did not occur.

Strategic decisions about the placement of the project within MDHS meant that the implementation of activities in the pilot sites was confused by the dual management arrangements, and this led to considerable tension amongst the managers. The focus of activities was also a limiting factor. Because the Project was aiming to strengthen existing programmes, it was predominantly health service based, thereby lacking in intersectoral collaboration. By implication, this meant that the Project was not giving a focus to approaches that tackle the social determinants of ill health, and consequently health equity.

Organisational issues that work against the Project include the absence of a performance contract for social capital outputs to give formal recognition to the strategy, and, consequently, a lack of commitment from some senior managers to support the process. The organisational culture of mistrust, as well as a lack of management intervention led to failure to address those tensions within the organisation also hindered project implementation and development.

Poor communication, which is endemic to health sector bureaucracies, as well as the myriad of bureaucratic processes, hampered project implementation and internal collaboration in many ways.

Despite many constraints and limitations, particularly those related to insufficient planning and tight time frames for implementation, several notable achievements have been made by the Social Capital Project. These include:

- Setting up a social capital infrastructure within MDHS and in the pilot sites
- Building on, and strengthening existing health programmes, adding strong community components.
- Giving a high profile to the achievement of communities, building bridges between communities and health services.

A major challenge for the project is that of sustainability. The issue of increased or, at least, sustained funding is imperative for the Project.

RECOMMENDATIONS

A number of recommendations have been made. In essence they include the following:

- A consistent working definition of social capital should be developed and communicated throughout PGWC DOH and MDHS, using a range of mechanisms appropriate to the different levels;
- Greater consideration and planning ought to be given to how existing and future initiatives, developed as a result of the Provincial Social Capital Formation Strategy (SCFS), can be planned, budgeted for and implemented collaboratively between the various departments within the Social Cluster;
- A number of specific recommendations are made in relation to the institutional support that is required in relation to social capital formation. These include: incorporating social capital formation in the key performance areas of managers and sub-directorates; clarifying the particular roles and responsibilities that PGWC and MDHS both play in operationalising the SCFS within the Department of Health; providing particular support to managers of new and innovative projects, such as this one. It is also recommended that PGWC learns from and draws on the experience of other countries in relation to their endeavours to integrate social capital into the policy environment and service delivery activities
- Future planning related to the Social Capital Project should be considered in a more methodological manner and be done, at the very least, collaboratively between the PGWC DOH and MDHS, and ideally in consultation with community structures and other sectors;
- A working group session should be convened to critically analyse which of the existing social capital formation activities of the Social Capital Project running across the five focus areas of 2005/06 should be given priority, which should be refined and which should be abandoned;
- Measures for the monitoring and evaluation of the Social Capital Project's activities and outputs need to be extended to move beyond numerical output measures to include qualitative process and relationship measures;
- The current location of the Social Capital Project under Special Projects should be reviewed, and the final decision regarding its future location and management be considered both *strategically* in relation to new and emerging programmes, and in relation to the tensions and challenges of the past year – many of which have been highlighted in this evaluation report.
- Greater attention should be paid by PGWC DOH and MDHS to the way in which the channels of communication are structured so as to facilitate greater dialogue between the Project implementers, managers and the policy makers – both within Health and between other departments;
- A comprehensive training programme should be designed to re-orientate managers and implementers to adopt a 'social capital lens' in their work;
- A working partnership should be established between the Project and Human Resources to as to address the issue of organisational mistrust in particular and

to strengthen the implementation of the *human* capital component of the SCFS within PGWC DOH and MDHS;

- Greater attention should be given to maintaining a consistency and clarity in relation to the documentation and use of terminology within the Social Capital Project; and
- In relation to finances, it is recommended that clarification regarding the conditions relating to Social Capital funding and unspent funds be sought, and that clear procedures for authorising the use of funds against the budget before any expenditure commitments are made be developed. It is also recommended that the reporting requirements for NPOs be reviewed so as to provide smaller NPOs a greater opportunity to access Social Capital funding.

Finally, it is recommended that:

- the findings, discussions and recommendations contained within this evaluation be presented to key stakeholders that have been an integral part of the Project over the past year. In so doing the content of the evaluation can be used as a basis for reviewing the Project's progress, reflecting on lessons learnt and then planning in a more robust manner for the Project's future.

ACRONYMS

CBOs	Community based organisations
CBS	Community Based Services
CHCs	Community Health Clubs
CDM	Chronic Disease Management
CoCT	City of Cape Town
DOH	Department of Health
DOSS	Department of Social Services
DWAF	Department of Water Affairs and Forestry
HC2010	HealthCare 2010
HPS	Health Promoting Schools
HR	Human Resource
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
MDHS	Metropole District Health Services
MSATS	Multi-Sectoral Action Teams
NCD	Non-communicable diseases
NGOs	Non-government organisations
NPOs	Non-profit organisations
PHC	Primary Health Care
PGWC	Provincial Government of the Western Cape
PFMA	Public Finance Management Act
PNs	Professional Nurses
SCFS	Social Capital Formation Strategy
SOPH	School of Public Health
WC	Western CapeCategorisation of the respondents

TERMINOLOGY

Many different terms were used by respondents in their interviews. This was because there are many terms that are used interchangeably. At times it was because of a lack of clarity in the use of terms. For consistency, the report will be using the following terms in the following way:

social capital

(In lower case) refers to the theoretical concept of social capital, and as such is used in a general sense.

The Social Capital Project (or the Project)

(In capitals) refers to the Social Capital Project located within and implemented by the MDHS.

The PGWC Social Capital Formation Strategy (SCFS)

This refers to the strategy introduced by the Office of the Premier (Western Cape) as one of the lead strategies and pillars of the Premier's provincial growth and development strategy (*iKapa Elihlumayo*).

The Social Cluster

This refers to the cluster of departments within the PGWC, namely: the Department of Cultural Affairs and Sport; the Department of Community Safety; the Department of Education; the Department of Health, and the Department of Social Services and Poverty Alleviation, that are all responsible for the delivery of social services. The Department of Social Services and Poverty Alleviation is the lead facilitator or co-ordinator of the Social Cluster.

PGWC DOH

The Provincial Government Department of Health, sometimes referred to by respondents as 'Head Office' or 'Health.'

Programme

The MDHS Programme areas of child health, non-communicable diseases, health promoting schools, women's health, and so on.

Community based workers

Refers to a range of people working at a community level and includes such people commonly referred to as volunteers, or members of the community who are employed part time or paid a stipend by various provincial government departments (such as home based carers and IMCI workers for the DOH, or community facilitators for the Expanded Public Works Programme, or safety officers at schools), and NPO field workers and community health workers.

CATEGORISATION OF THE RESPONDENTS

In order to ensure issues of confidentiality, the report has divided respondents into four categories:

- **Senior level respondents:**
Respondents responsible for strategic decisions within the Office of the Premier, departments within the Social Cluster, PGWC DOH, MDHS, and the City of Cape Town.
- **Middle level respondents:**
Respondents responsible for developing and managing the implementation of a broad range of programmes within the Social Cluster, PGWC DOH, MDHS, and the City of Cape Town.
- **Implementers**
Respondents involved in the direct implementation of social capital activities within communities and primary level facilities.
- **Support workers**
Respondents providing administration, finance, and human resource support.

A list of the respondents interviewed as part of the evaluation process, and that have been categorised into the above four categories can be found in Appendix 1.

REFERENCES

- Ahern, M. M. & Hendryx, M. S. (2003). Social capital and trust in providers. *Social Science and Medicine*, 57, 1195-1203.
- Altschuler, A., Somkin, C. P., & Adler, N. E. (2004). Local services and amenities, neighbourhood social capital, and health. *Social Science and Medicine*, 59, 1219-1229.
- Baum, F. (1998). *The new public health: An Australian perspective*. Melbourne: Oxford University Press.
- Baum, F. & Palmer, C. (2002). 'Opportunity structures': urban landscape, social capital and health promotion in Australia. *Health Promotion International*, 17, 351-361.
- Baum, F. & Ziersch, A. (2003) Social Capital Glossary, *Journal of Epidemiology & Community Health*, May, 57, 5, 320-323
- Boneham, M. A. & Sixsmith, J. A. (2006). The voices of older women in a disadvantaged community - issues of health and social capital. *Social Science and Medicine*, 62, 269-279.
- Bourdieu, P. (1986). The forms of capital. In J.G.Richardson (Ed.), *The handbook of theory and research for the sociology of education* (New York: Greenwood Press.
- Boutilier, M., Mason, R., & Rootman, I. (1997). Community action and reflective practice in health promotion research. *Health Promotion International*, 12, 69-78.
- Campbell, A. (2006). Why in-house collaboration is so difficult. *Financial Times*, 13 February, 8.
- Carpiano, R. M. (2006). Toward a neighbourhood resource-based theory of social capital for health - can Bourdieu and sociology help. *Social Science and Medicine*, 62, 165-175.
- Cattell, V. (2001). Poor people, poor places, and poor health - the mediating role of social networks and social capital. *Social Science and Medicine*, 52, 1501-1516.
- DeFilippis, J. (2001). The myth of social capital in community development. *Housing Policy Debate*, 12, 781-806.
- Emmet, T. (2003). Social disorganisation, social capital and violence prevention in South Africa. *African Safety Promotion*, 1, 4-18.
- Farquhar, S. A., Michael, Y. L., & Wiggins, N. (2005). Building on leadership and social capital to create change in two urban communities. *American Journal of Public Health*, 95, 596-601.
- Gilson, L. (2003). Trust and the development of health care as a social institution. *Social Science and Medicine*, 56, 1453-1468.
- Grant, E. (2002). Social capital and youth violence in Cali, Columbia: Work in progress. *Urban Health & Development Bulletin*, 5, 32-41.

Hancock, T. (1999). People, partnerships and human progress - building community capital. *Health Promotion International*, 16, 275-280.

Harpham, T., Burton, S., & Blue, I. (2001). Healthy City Projects in developing countries: the first evaluation. *Health Promotion International*, 16, 111-125.

Hawe, P. & Shiell, A. (2000). Social capital and health promotion: a review. *Social Science and Medicine*, 51, 871-885.

Industrial Health Research Group (IHRG) & South African Municipal Workers Union (Samwu) (2005). *Who cares for health care workers? The state of Occupational Health and Safety in Municipal Health Clinics in South Africa*. Municipal Services Project: Cape Town.

Islam, M. K., Merlo, J., Kawachi, I., Lindstrom, M., & Gerdtham, U. (2006). Social capital and health: Does egalitarianism matter? A literature review. *International Journal for Equity in Health*, 5.

Kawachi, I. & Kennedy, B. P. (1997). Health and social cohesion: why care about income inequality? *British Medical Journal*, 314, 1037-1040.

Kawachi, I., Kennedy, B. P., & Glass, R. (1999). Social capital and self-rated health: a contextual analysis. *American Journal of Public Health*, 89, 1187-1193.

Leyden, K. M. (2003). Social capital and the built environment: The importance of walkable neighbourhoods. *American Journal of Public Health*, 93, 1546-1551.

Lindstrom, M. & The Malmo Shoulder-Neck Study Group (2006). Psychosocial work conditions, social participation and social capital - a causal pathway investigated in a longitudinal study study. *Social Science and Medicine*, 62, 280-291.

Looman, W. S. & Lindeke, L. L. (2005). Health and social context - social capital's utility as a construct for nursing and health promotion. *Journal of Pediatric health care*, 19, 90-94.

Lundborg, P. (2005). Social capital and substance use among Swedish adolescents - an explorative study. *Social Science and Medicine*, 61, 1151-1158.

Lynch, J., Due, P., Muntaner, C., & Smith, G. D. (2000). Social capital - Is it good investment strategy for public health? *Journal of Epidemiology and Community Health*, 54, 404-408.

Macinko, J. & Starfield, B. (2001). The utility of social capital in research on health determinants. *The Milbank Quarterly*, 79, 387-427.

Miller, S., Murray, C., & Palmer, C. (1999). *Social capital in action: health promotion and community groups*. Adelaide: Flinders University.

Morrissey, M., McGinn, P., & McDonnell, B. (2002). *Report on research into evaluating community-based and voluntary activity in Northern Ireland* Community Evaluation Northern Ireland.

Mosavel, M., Simon, C., van Stade, D., & Buchbinder, M. (2005). Community-based participatory research in South Africa: Engaging multiple constituents to shape the research question. *Social Science and Medicine*, 61, 2577-2587.

Muntaner, C. & Lynch, J. (2002). Social capital, class gender and race conflict, and population health: an essay review of Bowling Alone's implications for social epidemiology. *International Journal of Epidemiology*, 31, 261-267.

Narayan, D. (1999). *Bonds and bridges: Social capital and poverty* (Rep. No. 2167). World Bank.

Niiranen, V. (2003). Leadership and knowledge in social service organisations -The mechanism of social capital in the development of the activities of an organisation. Unknown
Ref Type: Unpublished Work

Pan, R. J., Littlefield, D., Valladolid, S. G., Tapping, P. J., & West, D. C. (2005). Building healthier communities for children and families - applying asset-based community development to community pediatrics. *Pediatrics*, 115, 1185-1187.

Pearce, N. & Smith, G. D. (2003). Is social capital the key to inequalities in health? *American Journal of Public Health*, 93, 122-129.

Petersen, I. (2000). *From policy to praxis: Rethinking comprehensive integrated primary health care*. Unpublished doctoral dissertation. University of Cape Town.

PGWC: Western Cape Department of Health Five Year Strategic and Performance Plan 2005-2006

PGWC (October 2005) The Provincial Social Capital Formation Strategy with an emphasis on Youth

Poortinga, W. (2006). Social capital: An individual or collective resource for health? *Social Science and Medicine*, 62, 292-302.

PRI Project. (2003). Social capital: Building on a network-based approach. Ref Type: Unpublished Work

Putnam, R. D. (1997). *Making democracy work*. Princeton, New Jersey: Princeton University Press.

Ramphela, M. (1991). Social disintegration in the black community- Implications for transformation. *Monitor*, 7-16.

Sanders D.,(1998) "PHC 21 – Everybody's Business", main background paper for the Meeting: PHC 21 – Everybody's Business, An International Meeting to celebrate 20 years after Alma-Ata, Almaty, Kazakhstan, 27-28 November 1998, WHO Report WHO/EIP/OSD/00.7, 2000.

Sanders, D., Dovlo, D., Meeus, W. & Lehmann, U. (2003). Public Health in Africa. In: R. Beaglehole (Ed.), *Global Public Health: A New Era* (pp. 135-155). Oxford University Press.

Schilder, A., Kennedy, C., Goldstone, I.L., Ogden, R.D., Hogg, R.S., & O'Shaughnessy, M.V. (2001). "Being dealt with as a whole person." Care seeking and adherence: the benefits of culturally competent care. *Social Science and Medicine*, 52, 1643-1659.

Short, S. E. D. (2004). Making sense of social capital, health and policy. *Health Policy, 70*, 11-22.

Smith, M (2006): Service Delivery Review and Improvement Pilot Study Discussion Document For the Department of the Premier, Western Cape, Strategy and Tactics, Feb 2006

Stone, W. (2000) *Measuring Social Capital* Working Paper, Australian Institute of Family Studies, Melbourne.

Stern, R (2003) *Partnership working in Healthy Cities initiatives: a case study on the interaction between communities and statutory sector organisations*, Unpublished doctoral thesis, University of London, UK

Stern, R. & Green, J. (2005). Boundary workers and the management of frustration: a case study of two Healthy City partnerships. *Health Promotion International, 20*, 269-275.

Szreter, S. (2002). The state of social capital: Bringing back in power, politics and history. *Theory and Society, 31*.

Szreter, S. & Woolcock, M. (2004). Health by association? Social capital, social theory and the political economy of public health. *International Journal of Epidemiology, 33*, 650-667.

Thomas, L. (2002). Is social capital a useful tool for public health and development at a local level? Insights from social capital theory and a South African case study. *Urban Health & Development Bulletin, 5*, 42-50.

Van der Walt, HM. (1998). *Nurses and their work in tuberculosis control in the Western Cape: Too close for comfort*. Unpublished doctoral dissertation, University of Cape Town.

Van Wyk, B.E. (2005). *Caring for caregivers: developing a psychodynamic understanding of a process of staff support for primary health care workers*. Unpublished doctoral dissertation, University of Stellenbosch.

Wakefield, S. E. L. & Poland, B. (2005). Family, friend or foe - critical reflections on the relevance and role of social capital in health promotion and community development. *Social Science and Medicine, 60*, 2819-2832.

Walker, L. & Gilson, L. (2004). 'We are bitter but we are satisfied': nurses as street-level bureaucrats in South Africa. *Social Science and Medicine, 59*, 1251-1261.

Wilkinson, R. (1996). *Unhealthy societies*. London: Routledge.

Xu LS, Pan BJ, Lin JX, Chen LP, Yu, SH, and Jones J (2000): Creating health-promoting schools in rural China: a programme starting from deworming, *Health Promotion International, Vol 15 no 3*, 197-206, OUP

Ziersch, A. M. (2005). Health implications of access to social capital: findings from an Australian study. *Social Science and Medicine, 61*, 2119-2131.

CONTACT DETAILS

Social Capital Project:

Ms Rita Edwards: Tel: 021-460-9203, email Riedward@pgwc.gov.za or
Dr Cynthia Le Grange: Tel: 021-447-1758, email Clegrang@pgwc.gov.za

School of Public Health, University of Western Cape:

Tel: 021-959-2809

Email: Ruth Stern: rstern@uwc.ac.za
Brian van Wyk: bvanwyk@uwc.ac.za,
Nikki Schaay: schaay@mweb.co.za
David Sanders: lmartin@uwc.ac.za

CDMS Consulting:

Paul Tyler: Tel: 021 797 6245, Email: paultyler@mweb.co.za