Université de Montréal

# Understanding the Intersectoral Collaboration of Rural Community Health Workers and Teachers: The Example of Addressing Violence against Women and Girls in Vulindlela, South Africa

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# Understanding the Intersectoral Collaboration of Rural Community Health Workers and Teachers: The Example of Addressing Violence against Women and Girls in Vulindlela, South Africa

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# RÉSUMÉ

**Objectifs:** Cette étude a documenté la collaboration intersectorielle entre les agents de santé communautaires (ASC) et les enseignants visant à combattre la violence à l'égard des femmes et des filles à Vulindlela, une communauté rurale Sud-Africaine. La collaboration entre ces acteurs, les facteurs qui influencent leur collaboration et les avenues possibles pour une amélioration de cette collaboration ont été explorés.

**Méthodes:** Six ASC et cinq enseignants ont pris part à cette recherche participative qui a inclut l'utilisation du dessin comme méthodologie visuelle. La collecte de données a été réalisée en quatre phases, avec un total de huit entretiens de groupes. La stratégie d'analyse principale a inclus une approche dirigée du contenu narratif et une approche de comparaison constante.

**Résultats:** Le système de collaboration entre les enseignants et les ASC manque de définition et ces acteurs ne peuvent donc en faire l'utilisation. Par conséquent la collaboration actuelle entre ces acteurs a été jugée peu développé, impromptue et informelle. De nombreuses contraintes à la collaboration ont été identifiées, y compris le manque de motivation de la part des enseignants, la nature des relations entre les acteurs, et la capacité individuelle limitée des ASC.

**Conclusion:** Compte tenu des nombreuses contraintes à la collaboration entre ces ASC et les enseignants, il n'est pas évident que cette collaboration conduira aux résultats espérés. Dans l'absence de motivation suffisante et d'une prise de conscience réaliste des défis par les acteurs eux-mêmes, les initiatives externes pour améliorer la collaboration sont peu susceptibles de succès.

**Mots Clés:** ASC, enseignants, violence à l'égard des femmes et des filles, collaboration intersectorielle

# ABSTRACT

**Objectives:** This study had for objective to document intersectoral collaboration (ISC) between community health workers (CHWs) and teachers aimed at addressing violence against women and girls (VAW/G) in Vulindlela, a rural South African community. The current collaborative paths bringing CHWs and teachers together, the factors that influence their collaboration and potential avenues for future improvement of this collaborative were explored.

**Methods:** A total of six CHWs and five teachers took part in this participatory research which included the use of drawing as a visual methodology. Data collection was divided into four phases and included a total of eight group interviews. The analysis of group interviews utilized a directed approach to narrative data analysis, and a constant comparative approach was used in the analysis of the participants` drawings.

**Results:** There are no well-defined collaborative systems that CHWs and teachers are able to make use of. Consequently teacher-CHW collaboration was found to be poorly developed, unplanned and informal. Numerous barriers were identified as impeding collaboration including the teachers' lack of motivation to collaborate, the nature of the relationships between these groups of actors and the CHWs' overall lack of individual capacity.

**Conclusion:** Given the numerous challenges facing collaboration between these CHWs and teacher, it is not clear that such collaboration would necessarily lead to effective outcomes. In the absence of sufficient motivation and a realistic awareness of the challenges from the actors themselves, external initiatives to foster collaboration are unlikely to be successful.

**Key Words:** CHW, teachers, violence against women and girls, intersectoral collaboration

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# LIST OF ABBREVIATIONS AND ACRONYMS

AIDS: Acquired immune deficiency syndrome

ANC: Antenatal care

ASC: Agent de santé communautaire

CAPRISA: Centre for the AIDS program of research in South Africa

CHWs: Community health workers

CVMSC: Centre of visual methodology for social change

DOTS: Directly observed treatment, short-course

EVC: Every voice counts

F: Female

GBV: Gender based violence

HIV: Human immunodeficiency virus

IPV: Intimate partner violence

KZN: KwaZulu-Natal

M: Male

NGO: Non-governmental organization

PHC: Primary Health Care

PMTCT: Preventing Mother-to-Child Transmission

R: South African Rand

SSA: Sub-Saharan Africa

STI: Sexually Transmitted Infection

TB: Tuberculosis

UKZN: University of KwaZulu-Natal

UNAIDS: United Nations Joint Program on HIV/AIDS

USD: United States Dollars

VAW/G: Violence Against Women and Girls

VCT: Voluntary Counseling and Testing

WHO: World Health Organisation

# DEDICATION

*For my sister.*
*Thank you for being a calming voice*
*in my often chaotic life and for being my*
*most precious source of strength.*

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# CHAPTER 1: INTRODUCTION

## 1.1 INTRODUCTION

This study examined the collaborative efforts of teachers and community health workers (CHWs) to address the issue of violence against women and girls (VAW/G) in Vulindlela, a rural community in KwaZulu-Natal (KZN), South Africa. Through this study, I aimed to understand the nature of this collaborative relationship and to explore how the relationship could be improved to address VAW/G more effectively. I set out to achieve this aim primarily by exploring the research participants' perceptions of their collaborative efforts using a participatory research approach. The rationale for this study stemmed from my personal interest and the desire to build upon previous research projects in the area, requests from the community for such research, and gaps in the literature regarding this subject. This introduction provides a brief overview of VAW/G, intersectoral collaboration, and the research context from which this study emerged, before outlining the specific aims and rationale of the study. The introductory chapter then concludes with an overview of the rest of the manuscript.

## 1.2 VIOLENCE AGAINST WOMEN AND GIRLS

Approximately one in every five women worldwide will be a victim of violence in her lifetime (WHO, 2005a, p.3). For some, this violence will occur once; for others, it will be repeated throughout their life. While some cases will go unnoticed by outsiders, others will result in death. Regardless of frequency or outcome, VAW/G is a global health and human rights concern (Grown et al., 2005). According to the World Health Organization (WHO), VAW/G is defined as:

> any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring in public or in private life. (UN General Assembly, 1993, Article 1)

As this definition illustrates, VAW/G is a broad term that covers many different types of violence. VAW/G can be classified by type of violence (physical, sexual, emotional), who the perpetrator is (self-directed, interpersonal, or collective), or who the victim is (child, young adolescent, or woman of reproductive age) (Krantz and Garcia-Moreno, 2005)[1]. Interpersonal violence can further be differentiated according to whether the perpetrator is a family member or partner, or whether the perpetrator is a stranger. Although these categories are presented in discrete terms for conceptual purposes, there is considerable overlap between them in practice, and one type of violence may be closely associated with another (Krantz and Garcia-Moreno, 2005). For example, forms of sexual violence, such as rape, may be associated with the use of physical force (Krantz and Garcia-Moreno, 2005); while psychological abuse has been found to preceded physical abuse in certain contexts (O'Leary, 1999). VAW/G has numerous negative effects at the individual, family and community levels, and the WHO has identified this form of violence as a major public health problem that is entirely preventable (WHO, 2005b). It is said to transcend socioeconomic class, religious and ethnic lines (Heise et al., 1994) and to have an adverse effect on a victim's contribution to community and household life. The presence of violence therefore limits the potential for development and is thus also a major obstacle in attempts to reach development targets (WHO, 2005a).

While VAW/G is a global issue, South Africa in particular is plagued with an alarmingly high presence of such violence. For example, the country has been noted as having the highest prevalence of rape in the world (US Department of State, 2011). According to the South African Police Service (2010, p.11), approximately 55 thousand cases of rape were reported in the country between 2009-04-01 and 2010-03-31. Though this figure is high, it is most likely an underestimate of the true prevalence of rape in the country, with the report suggesting that an estimated 450 thousand cases went unreported that same year

[1] See Krantz and Garcia-Moreno (2005) for more details regarding how these different forms of violence are defined.

(Lindow, 2009). Furthermore, a study by Mathews et al. (2004) found that 8.8 of every 100,000 women in South Africa aged 14 years and older was killed by an intimate partner in 1999. This was the highest such rate that had ever been published at the time of publication in 2004.

As is typically the case throughout the world, women in South Africa experience physical or sexual violence most commonly at the hands of an intimate partner and generally experience multiple acts of violence over time (Heise et al., 1999). The direct consequences of intimate partner violence (IPV) and sexual violence on the victims include 'physical injuries, depression, post-traumatic stress disorder, suicide attempts, substance abuse, unwanted pregnancy, gynaecological disorders, STIs...and others' (Harvey et al., 2007, p.3). Contemporary studies have shown an association between VAW/G and HIV transmission, whereby victims of violence face a considerably higher risk of contracting the virus (Harvey et al., 2007, p.3). This association between VAW/G and HIV has led to a dual epidemic in many sub-Saharan countries (SSA), most notably in South Africa (Kim et al., 2003).

A wide range of risk factors for VAW/G have been mentioned in the literature, such as poverty, lack of education, and alcohol abuse (Abeya et al., 2011; Abramsky et al., 2011; Jewkes, 2002), and VAW/G has been said to be primarily rooted in gender inequalities and the normative use of violence in conflict (Jewkes, 2002). When not rooted in conflict, but rather in the social construct of gender inequalities, VAW/G has been said to require both grassroots-level prevention and response. Additionally, given this broad range of factors, it has been argued that interventions involving the health sector alone are too narrow to effectively address VAW/G. Thus, various authors have concluded that a comprehensive response calling on the collaboration between multiple sectors is required to address this issue (Abeya et al., 2011; Abramsky et al., 2011; Chandran et al., 2011; De Lange et al., 2011; Jewkes, 2002; Kaur and Garg, 2010).

## 1.3 UNDERSTANDING INTERSECTORAL COLLABORATION

Interventions involving multiple sectors working together to address a common goal have been referred to as either multisectoral collaboration (MSC) or intersectoral collaboration (ISC). Health-related ISC has been defined as:

> a recognized relationship between part or parts of the health sector and part or parts of another sector that has been formed to take action on an issue or achieve health outcomes, (or intermediate health outcomes) in a way that is more effective, efficient or sustainable than could be achieved by the health sector working alone. (National Centre for Health Promotion, 1995 in WHO, 1997, p.3)

On the other hand, MSC has been defined as:

> …multisectoral partnerships, partners work independently towards a common purpose…When many sectors work independently, it becomes a multisectoral partnership (MacIntosh and McCormack, 2001).

The distinction between ISC and MSC is an important one. While both types of collaboration involve different sectors working to address a common health-related issue, MSC entails different sectors working in parallel to achieve their common goals. In contrast, ISC implies the conscious and active formation of collaborative partnerships such that multiple sectors are working together interdependently to address a common health-related issue (MacIntosh and McCormack, 2001). Thus, the involvement of multiple sectors is a necessary but not sufficient condition for ISC. In reality, many interventions lie somewhere between these poles of multisectoral independence and intersectoral interdependence. Although literature pertaining to a wide range of collaborative activities was consulted, I primarily focused on ISC when reading and synthesizing this literature given the objectives of this manuscript.

## 1.4 THE EVERY VOICE COUNTS UMBRELLA

I initiated this study under the umbrella of the Every Voice Counts (EVC) project, which is funded by the National Research Foundation of South Africa (2007-2012). The project is headed by Professor Naydene De Lange and involves a team of researchers attached to the Centre of Visual Methodologies for Social Change (CVMSC) at the University of KwaZulu-Natal (UKZN) Faculty of Education, with affiliates at the McGill University Faculty of Education, and in conjunction with the Centre for the AIDS Program of Research in South Africa
(CAPRISA)[2] in South Africa.

In an effort to facilitate the development of rural communities in the context of HIV and AIDS, the project links the areas of social services, education, health and community based research. Schools are the focal point of the project because of the belief that schools, more than any other institution in resource limited settings, can play a pivotal role in promoting whole community partnerships to bring about social change. The project also draws extensively on participatory methodologies (these methods are further discussed in the methodology chapter of this manuscript) (De Lange et al., 2010).

The aim of EVC is to document the lives and experiences of teachers, learners and communities in the Vulindlela sub district of KwaZulu-Natal as they work together to promote the well-being of children and adolescents in the context of HIV and AIDS. To meet this aim, they investigate the five following study areas: 1) reflexive methodologies in studying teachers' lives; 2) school leadership and management; 3) voices of young people; 4) teachers and communities addressing gender based violence; 5) partnerships and pedagogy in preparing new teachers.

[2]CAPRISA is a United Nations Joint Programme on HIV/AIDS (UNAIDS) collaborating center linked to the UKZN Nelson Mandela Medical School, which has conducted studies on HIV and AIDS related issues in the region for many years.

My study was derived from the fourth area mentioned above. This study area poses the following question: how can schools work more directly with communities as a whole to address the high incidence of gender violence in rural areas? To answer this question, EVC focuses on collaboration between secondary school teachers, community health workers (CHWs), youth and parents as a means of addressing gender based violence. This study area builds directly on a previous research project -- Learning Together (2003-2006) – which involved the EVC research team and laid the ground work for collaboration amongst these stakeholders. As an extension to the health sector, CHWs have the potential for playing an important role in intersectoral initiatives aimed at addressing health-related issues, such as VAW/G. Their position as brokers between the formal health sector and the communities allows them the flexibility and contextual knowledge necessary to play an important role within community based ISC (Doherty and Coetzee, 2005; Kahssay, 1998; Negin et al., 2010)

## 1.5 STUDY AIM

Through this study, I aimed to explore the existing ISC between teachers and CHWs in Vulindlela whilst enhancing their understanding of their collaborative relationships with one another. The purpose of this study was primarily to inform and improve future collaborative initiatives between these actors by engaging them in a participatory research process.

Two main objectives were derived from this overarching aim: 1) for the participating teachers and CHWs to document the current state of their collaboration with one another; and 2) for the participants to identify ways in which their collaboration could be improved. To meet these objectives through a participatory research approach, I acted as a facilitator of knowledge construction during the research process rather than positioning myself as an expert on the subject matter (Cornwall and Jewkes, 1995).

The objectives outlined above were shaped by a number of considerations. First, I had a personal interest in conducting a study that would answer various questions I had about the factors required to make ISC function at the community level and how ISC could be used to address VAW/G. In particular, I wanted to know if ISC could be implemented in a resource limited setting and whether CHWs and teachers could be an appropriate combination of actors to implement ISC at the community level. Second, given that this study was initiated under the umbrella of the EVC project which followed the Learning Together project, I sought to build on this body of work. In particular, this study responded to an expressed need from participants from the Learning Together project who requested further assistance in fostering collaborative networks in the community. The participants also requested support in the development of research-lead innovation to better address pertinent issues in the community such as VAW/G. Third, this study is relevant as it explored a number of gaps in the current literature. Despite the interest in addressing VAW/G through ISC, a relatively limited number of studies have been conducted on this topic. There is also a lack of research specifically relating to ISC between teachers and CHWs. I consider this to be an important gap because teachers and CHWs have both been cited as being key actors at the community level, and ISC has been cited as holding important potential as a method of tackling issues related to community health. It was my hope that this study would make a small contribution to both the needs of the participants in the Vulindlela community and to the research gaps mentioned above.

## 1.6 STRUCTURE OF THE MANUSCRIPT

Prior to delving into the study's objectives and methods, it is of primary importance to first understand the context in which the Learning Together project, the subsequent EVC project, and the teachers and CHWs within this study are based. Therefore, the overview of this context will be provided throughout the following chapter.

Following the description of the study site context, I will then discuss the current state of knowledge around the main components of this study, and the objectives and the theoretical framework that were utilized in this study. I will then go on to describe the methods and analysis procedure used, in addition to exposing and discussing the findings before concluding the manuscript by discussing the contributions provided by this study.

# CHAPTER 2:
# STUDY SITE CONTEXT

# 2.1 FIELD CONTEXT

## 2.1.1 KWAZULU-NATAL

The province of KZN is located on the East coast of South Africa along the Indian Ocean. At the time of the 2010 mid-year population estimates, 21.3 percent of the country's population was living in the province, making it the second most populous province in South Africa (StatsSA, 2010, p.4). Black Africans, most of whom are Zulu-speaking, represented 76 percent of the province's population (Rutenberg et al., 2001, p.5). Traditionally, Zulu culture has attributed great importance to gender defined norms, and many of these traditions remain. Given the patriarchal nature of traditional Zulu culture, males hold considerably higher social status than their female counterparts (Magwaza, 2001). The effects of this gender-based hierarchy are pervasive, transcend generations and influence all aspects of social life. For example, the practice of *lobola* – 'an economic exchange joining two families, as well as the transfer of rights over the labor and potential childbearing capacity of the woman' (Kaufman et al., 2001, p.153) – traditionally establishes the woman as her husband's possession. Roles are also defined along gender lines, with men being portrayed as breadwinners, while women are primarily tasked with domestic responsibilities.

KZN is one of the poorest provinces in the country and slightly less than fifty percent of the population lives in rural communities, a proportion well above the national average (Day et al., 2009;Pauw, 2005, p.4). These high levels of poverty have been partly explained by the fact that most of the province's districts were previously part of the KwaZulu homeland (Pauw, 2005, p.19; Rutenberg et al., 2001, p.5). Though the creation of exclusively Black African reserves began with the Natives Land Act of 1913, the homeland system only reached its apex during the Apartheid era (Eidelberg, 1997). During the nineteen fifties, quasi-independent homeland states began to be established under the authority of the local chiefs and the apartheid government. The homelands were generally

segregated by ethnicity, with the KwaZulu homeland predominantly being inhabited by the Zulu population. Freedom of movement and the right to own land were highly restricted for non-whites in areas outside of the homelands, particularly in urban centers (Roberts, 1994). Due to a lack of economic opportunities, there has long been widespread poverty in the former homeland areas (King and McCusker, 2007). In 1994, after South Africa's first democratic elections, the KwaZulu homeland was merged with the Natal province (formerly part of white South Africa) to form the province of KwaZulu-Natal.

### 2.1.2 THE VULINDLELA SUB-DISTRICT

The uMgungundlovu District is centrally situated in the KZN Midlands, covering an area of approximately 9, 190 square kilometers (UDM, 2008b, p.8). There is a diverse range of settlements in the area, which include major urban centers, peri-urban centers, and semi-rural and rural areas (UDM, 2008a). The district is further divided into seven local municipalities; the Vulindlela sub-district community (also referred to as the Vulindlela township) is located in the Msunduzi municipality. Vulindlela is a large rural community situated in a poor and isolated area. This area is home to around 400,000 people, many of whom live in poverty (Kharsany et al., 2004). Despite the scenic beauty of the lush rolling hills, the clusters of homes – primarily mud and block houses – scattered throughout Vulindlela are immediate evidence of the poverty that is present in the area.

### 2.1.3 HEALTH OVERVIEW OF THE POPULATION

The health issues present in the uMgungundlovu district municipality are similar to those found throughout KZN and rural South Africa. The disease burden in KZN is particularly high, partly due to the notable prevalence of HIV and AIDS, the incidence of sexually transmitted infections (STIs), and diarrhea (Day et al., 2009). In addition to South Africa being an epicenter of the HIV and

AIDS pandemic[3], KZN is the province most affected by HIV and AIDS (in both relative and absolute terms) in the nation (StatsSA, 2010). According to the South African National HIV Survey 2008, between 13.4 and 18.6 percent of the provincial population aged two years and older was HIV positive at that time (Shisana et al., 2009, p. 32). Among the populations in South Africa most at risk of infection are Black African females between the ages of 20 and 34 (Shisana et al., 2009, p.36). In addition to the HIV and AIDS epidemic, KZN has a high incidence of STI infections. Despite falling from 9.4 percent in 2005-2006 to 6.9 percent in 2007-2008, the incidence of STIs in the uMgungundlovu district are still amongst the highest in the country (Day et al., 2009, p.168). Furthermore, the lack of access to clean water contributes to the presence of diarrhea and the transmission of other water borne diseases in numerous rural communities of KZN (Hemson and Dube, 2004). These overall statistics paint a stark image of the status of community health in the area and this reality is further reflected by the long queues at community healthcare facilities and the high rates of absenteeism among local high school students. In response to these issues, KZN relatively recently adopted a comprehensive program targeting HIV and AIDS, tuberculosis (TB), and STIs (Day et al., 2009, p.159).

As a result of this greater emphasis on infectious diseases, less attention has been paid by the formal health system to other health related issues, such as the noteworthy presence of VAW/G. As mentioned in the introduction, VAW/G is a major issue throughout South Africa, and the Vulindlela community is no exception. The community has encountered considerable difficulty in attempting to address VAW/G, and the devastating effects of such violence have been further compounded by the acute presence of HIV and AIDS.

3 At the time when this study was conducted, in 2009, there were 5,4 – 5,9 million people living with HIV in South Africa, and the prevalence of HIV among adults between the ages of 15 and 49 was 17.2– 18.3 percent (UNAIDS, 2009).

### 2.1.4 THE PRIMARY HEALTHCARE SYSTEM

Given the high levels of poverty, most of the rural population of the uMgungundlovu municipality is unable to afford private healthcare and only has access to the public primary health care (PHC) system. As of 2009, there were forty-eight fixed clinics, twelve mobile clinics, four community health centers and nine hospitals funded and managed by the South African Department of Health in the uMgungundlovu district (KZN DoH, 2009). Due to the size of the uMgungundlovu District municipality, both in terms of area and population, and with the majority of the larger facilities (such as fully staffed clinics) situated in peri-urban or urban areas, access to healthcare is especially limited for rural populations.

Efforts to address the region's high disease burden through the PHC system have been constrained by a shortage of doctors and nurses (Pang et al., 2002). The shortage of professional health workers has led to elevated numbers of lay health workers being incorporated into the public PHC system (Chopra et al., 2008; Schneider et al., 2008). This shift towards lay workers was not unprecedented in the history of the country. Lay health worker programs were implemented in the nineteen seventies and eighties in response to both the *Alma Ata Declaration* and the inadequate state of the Apartheid-era PHC system (Clarke et al., 2008; WHO, 1978). Contrary to popular expectations, the new South African government was reluctant to maintain and develop the lay worker programs in the country. Instead, the role of doctors and nurses in the public PHC system was emphasized by the post-Apartheid government. As a result, many of the pre-existing lay worker initiatives were dissolved (Clarke et al., 2008).

One program initiated in the KwaZulu homeland did, however, survive the transition to democracy, and later contributed to the development of the national CHW Policy Framework initiated in 2004 (Schneider et al., 2008). This framework defined CHWs in South Africa as all community/lay workers in the health sector. In addition, the framework recognized the need for CHW training

and remuneration (NDoH, 2004a). When this policy was adopted, there were an estimated forty thousand CHWs in the country, a figure that was almost equal to the number of professional nurses in the public sector (NDoH, 2004b).

The management of CHW activities is highly fragmented. Community health facilities are responsible for CHW training; Non-governmental organizations (NGOs) are responsible for the general supervision of their post-training work; while issues relating specifically to time sheets are monitored by a community-based supervisor (KZN DoH, 2001). Provincial health departments, such as the KZN DoH, are now expected to identify NGOs that can implement CHW programs, with the National government partially funding these programs (Chabikuli et al., 2005). CHWs receive a monthly stipend ranging from one thousand to a little over two thousand South African Rand (R) (equivalent to roughly 119.00 to a little over 237.00 United States Dollars (USD))[4] (KZN DoH, 2001). CHWs from the former KwaZulu homeland have been said to receive the highest stipends in the province (KZN DoH, 2001).

Candidates wishing to become CHWs must reside in their area of service and be selected by the local community. In addition to these requirements for non-contract workers, contracted CHWs are also required to have at least a grade ten level of education (KZN DoH, 2001). CHWs undergo twelve months of training. During this period, modules on situational analysis, environmental healthcare, acute and chronic diseases and their management at home, TB and Directly Observed Treatment Short-Course (DOTS), HIV and AIDS (including counseling and support), health education and promotion, maternal and child health (including Preventing Mother-to-Child Transmission of HIV (PMTCT)), infectious diseases, and community development, amongst other topics, are covered (KZN DoH, 2001). In addition, monthly in-service training is provided to CHWs following their initial training. It is during this in-service training that

4 These figures are based on the exchange rate on 2012-06-08 of approximately USD 0.118 to R 1.00.

topics such as nutrition, VAW/G (domestic violence) and drug abuse are discussed in specialist-lead sessions (KZN DoH, 2001). Because CHWs in KZN typically serve a large number of households and provide a wide variety of services, they have been said to hold the potential for improving the coverage of the PHC system (Clarke et al., 2008; KZN DoH, 2001). There have been, however, debates as to whether they are actually fulfilling this role, and these debates are highlighted in the literature review.

### 2.1.5 THE EDUCATION SYSTEM

Education in Vulindlela is hindered by a number of district wide constraints. Although up-to-date district-level data regarding the education system is limited, data specifically around the education system's constraints at the district level have been collected. The uMgungundlovu district municipality integrated development plan identified the issue of congested classrooms as a major constraint to education within the district (UDM, date unknown). A further constraint is the concentration of public libraries and study centers in the major urban areas of the district, which limits access for the large numbers of rural students. Both the explicit costs of education, such as tuition fees, and the implicit costs, such as forgone labor, also limit access to education in the district (UDM, 2007), despite the right to basic education (grades 0 to 9) being enshrined in the constitution. In addition to these general constraints, female access to education and health is especially limited due to cultural norms emphasizing the value of investing in males (Soetan, 2001). As a result of these challenges, only 75 percent of the uMgungundlovu district population was functionally literate as of the 2008-2009 uMgungundlovu District Municipality Integrated Development Plan (UDM, date unknown).

## 2.2 STUDY SITES

There were two main research sites chosen for this study: a local high school (Gobindlovu Senior Secondary School) and a PHC facility (Songonzima clinic).

Gobindlovu Senior Secondary School was specifically chosen as a research site because of the commitment shown by the school's teachers to providing their learners with positive academic and school-based social experiences. As part of this commitment, some of the school's teachers had participated in previous EVC and Learning Together research activities relating to health issues such as gender based violence, VAW/G, and HIV and AIDS. Consequently, some of the teachers were familiar with both the issues being discussed and the research approach used by my study.

The Songonzima clinic was then chosen as the PHC center site for the study primarily due to its proximity to the Gobindlovu School. I took this proximity to be an advantage as I believed that close proximity would facilitate sustained collaboration between teachers and CHWs. Thus, the clinic was selected with the hope that my study would lay a foundation upon which the community could build in the future. Songonzima clinic was also selected because the clinic served the school's students and their families and the clinic's CHWs frequently visited the homes of these families.

### 2.2.1 GOBINDLOVU SENIOR SECONDARY SCHOOL

Gobindlovu Senior Secondary School is situated in the heart of Vulindlela and is six kilometers from any major road. It was founded by the community in 1996 and caters to students from grade eight through twelve. Despite being founded as a community-based school, Gobindlovu was incorporated into the public school system and now follows the provincial education curriculum.

Like most schools in the region, the school consists of four main buildings - three of which are used as classrooms, with the fourth housing the principal's office and staff room. The classrooms all face a central yard where students socialize between periods and during breaks. The school includes male and female course level teachers and one female head teacher. Some teachers are from the community while others commute from the larger urban centers.

A female deputy principal and a male principal head the school. The principal has held his position since the school's opening and is an active member of the school's community, working closely on community projects with the sub-ward's traditional leader.

In an interview conducted at the start of the study, the school's principal acknowledged both the presence of VAW/G among students and the fact that such acts of violence are under-reported. He also mentioned a list of factors he believed contribute to this abuse in and around Gobindlovu and rural South Africa more generally. First, student-teacher ratios are high, making it difficult for teachers to provide their students with individual attention. This lack of attention means that teachers are less likely to witness acts of VAW/G that occur in and around the school premises, and that they are also less likely to counsel the youth to prevent or respond to such acts of violence. Second, there is a lack of constructive extra-curricular activities, resulting in increased opportunities for students to engage in risky, unsupervised activities before and after classes. Third, very few parents are involved in the learners' school-based endeavors, making communication between teachers and parents difficult and resulting in an increased likelihood that VAW/G will go unaddressed. Fourth, the principal stressed the lack of special resources for students with learning disabilities, which results in some students falling behind academically. As a result, a situation is created where there are considerable differences in age and sexual maturity between students within a class. These differences can lead to inequalities in power and ultimately coercive sexual practices may take place. Fifth, many pupils have to travel long distances to reach the school. These long commutes not only affect the pupils academically, but also leave them vulnerable to acts of violence while in transit. Finally, the presence of VAW/G at times takes place with the teachers taking on the role of the perpetrators. The principal noted that though he could not confirm whether this type of violence has taken place within

Gobindlovu, he suspected that similarly to the school-based context across the province, teachers may be at times the cause of such violence. The principal also mentioned that known situations of violence within the school are dealt with according to the school's code of conduct. This code was developed cooperatively by the teachers, but has not proven to be adequate in addressing and preventing acts of VAW/G.

### 2.2.2 SONGONZIMA CLINIC

The Songonzima clinic is situated at the top of a hill along a major road that leads to the heart of Vulindlela. The clinic consists of three small buildings secured by a metal fence and watched over by two male guards. The two main buildings are used as offices and medical examination rooms, with the third serving as an HIV voluntary counseling and testing (VCT) center. Families line the narrow hallways of each building while waiting to be seen by one of the nurses on duty. Despite the overcrowding of the facility, the nurses work in an organized fashion, ensuring, to the best of their ability, that accurate patient records are kept. The clinic is supervised by members of the KZN Department of Health and offers basic PHC services including vaccinations, family medicine, and Antenatal Care (ANC). Emergency cases are also brought in and an examination room is quickly cleared in these instances. Given the clinic's long history of collaboration with CAPRISA, a number of nurses and CHWs from the Songonzima clinic have been exposed to the research process through participation in studies conducted by the CAPRISA research group.

In all, 25 CHWs report to the Songonzima clinic on a weekly basis. In addition to conducting routine household visits, CHWs are called by Songonzima nurses to visit patients for follow-up care. The CHWs meet on a monthly basis with their supervisor, who is based in the provincial health department's office in Pietermaritzburg. CHWs also work closely with social workers in the community, whose offices are situated less than half a kilometer away from the clinic.

# CHAPTER 3: LITERATURE REVIEW

# 3.1 OVERVIEW

Given that the primary aims of this study were to document the collaborative efforts of teachers and CHWs to address VAW/G, I have structured the literature review in the following manner. The chapter begins with a section on VAW/G, which is concluded by establishing the need to address VAW/G using an intersectoral approach. I then provide a general overview of ISC to lay the foundation for understanding the collaborative dynamics between CHWs and teachers working together in Vulindlela. Since the functioning of collaboration is closely linked to the actors involved, I go on to examine the literature on CHWs and teachers as social actors in their individual and collaborative capacities. In general, I have focused on ISC and the actors involved more than the health-related issue which they are addressing. This focus arises because the primary aim of the study is not to understand VAW/G itself but rather how to address it through collaboration at the community level. A different emphasis is involved when studying an issue as opposed to studying means to address such an issue, and for this reason, the VAW/G section mainly serves to contextualize the subsequent sections.

This review was compiled through a standard systematic review of Ovid MEDLINE, PubMED, PsychINFO and Google Scholar databases and included various combinations of the search terms displayed in the table below.

**Table I - Search terms included in the literature review of this study**

| | |
|---|---|
| **VAW/G** | violence against women and girls, gender based violence, intimate partner violence(IPV) , domestic abuse, abuse (mental abuse, psychological abuse, emotional abuse, verbal abuse, sexual abuse / rape, masculinity, South Africa |
| **Intersectoral collaboration** | intersectoral collaboration, collaboration, intrasectoral collaboration, multisectoral collaboration, networks, partnership, coalition, integration, conceptual framework, theoretical framework, health, education, South Africa |

| | |
|---|---|
| **Community Health Workers** | community health workers, CHW/ CHW as social actors, health workers, rural health workers/rural CHW, village health workers, lay workers/ lay health workers, capacity, role, collaboration / intersectoral collaboration / intrasectoral collaboration / multisectoral collaboration, VAW/G, CHW in South Africa |
| **Teachers** | teacher, teachers as social actors, school / secondary school / rural school, health / community, capacity, role, collaboration / intersectoral collaboration / intrasectoral collaboration / multisectoral collaboration, VAW/G, teachers in South Africa |

## 3.2 VAW/G

### 3.2.1 FACTORS LEADING TO VAW/G

As mentioned briefly in the introduction chapter of this manuscript, the determinants of VAW/G are multidimensional, and operate at both the individual and community level. These determinants interact dynamically with each other and may mediate each other's influence and can at times be a risk factor in one setting and be protective against VAW/G in another (Antai, 2011; Koenig et al., 2003).

Despite this complexity, Jewkes et al. (2002b) presented a general model identifying the channels through which IPV is caused. According to this model, two factors are necessary for IPV to occur: 'the unequal position of women in a particular relationship (and in society) and the normative use of violence in conflict' (Jewkes, 2002, p.1426). Given these, a complex web of complementary factors then comes together to produce IPV (Jewkes et al., 2002b). Although this model was designed to describe IPV, gender inequalities and the normative use of violence have also been cited as the key drivers of VAW/G more generally (Campbell, 1992; Jewkes et al., 2001; Moffett, 2006; Wood and Jewkes, 2001).

Explanations of VAW/G rooted in gender inequalities and the normative use of violence in conflict are particularly relevant to South Africa. Gender inequality is a major issue nationwide, and the dynamic and contested nature of gender

relations and identities has been closely linked to VAW/G in this setting (Campbell 1992; Moffett, 2006; Morrell et al., 2012; Petersen et al., 2005; Wood and Jewkes, 2001). On the one hand, it has been argued that the socioeconomic system of accumulation and racial domination in South Africa that reached its apex under Apartheid has 'limited the power of working-class men in the wider community' (Campbell, 1992, p.618; Wolpe, 1972), which led to a crisis of masculine identity (Morrell et al., 2012). In the face of such a crisis, one of the ways in which men have sought to reassert their masculinity has been through violence (Campbell, 1992). Given existing gender inequalities, women have often, though not exclusively, been the target of such violence (Campbell, 1992; Wilson and Ramphele, 1989). On the other hand, VAW/G has also been said to be a reactionary response by men to challenges from women to the existing gender-based hierarchy (Moffett, 2006; Petersen et al., 2005; Wood and Jewkes, 2001). Thus, while representing an exercise of power, VAW/G is often, among other reasons, a response from men to real or perceived undermining of their power (Morrell et al., 2012).

In addition to experiencing such deeply rooted gender inequality, South Africa also suffers from high levels of violence more generally. The country has had a history of state violence and community insurrection in which violence was used both as a tool of repression and resistance (Jewkes, 2002). It has been argued that this history of racial oppression, particularly during the Apartheid period, 'legitimated violence by the dominant group against the disempowered' (Moffett, 2006, p.129). Consequently, although state-sanctioned violence has ended, violence is still regularly used to settle disputes in a wide range of settings and violence is now widely accepted as a social norm (Jewkes, 2002).

While gender inequalities and the normative use of violence have been given prominence in explaining why VAW/G occurs, a variety of complementary factors are also examined. Of these factors, poverty and education are cited as two of the most important (Abeya et al., 2011; Abramsky et al., 2011; Antai,

2011; Chandran et al., 2011; Jewkes, 2002; Laisser et al., 2011). Other complementary risk factors for VAW/G that are mentioned in the literature have included whether a woman or man has witnessed or experienced abuse as a child (Abeya et al., 2011; Abramsky et al., 2011; Jewkes, 2002; Tufts et al., 2010; Wei and Brackley, 2010); alcohol abuse (Abeya et al., 2011; Abramsky et al., 2011; Jewkes, 2002; Kaur and Garg, 2010); and the HIV status of a woman (Tufts et al., 2010).

### 3.2.2 EFFECTS OF VAW/G

VAW/G has serious impacts on the women who are directly involved as victims, their families, and the wider communities in which they live. At the individual level, the effects of VAW/G are numerous and have been said to include multiple forms of physical harm; increased risk of HIV transmission; mental health issues; alcohol and drug abuse; and feelings of shame, guilt, and low self-esteem (Boyle et al., 2009; Chandran et al., 2011; Fontana and Santos, 2001 in da Fonseca et al., 2009; Jewkes et al., 2002a; Laisser et al., 2011). Moreover, victims of VAW/G often become part of a larger cycle of abuse in which they are more likely to suffer from VAW/G and other forms of violence in the future (Chandran et al., 2011; Jewkes et al., 2010a). This cycle is particularly notable in the case of violence against girls. Violence against girls often leads to the victims dropping out of school, thereby reducing the girl's future social and economics options. Girls who are raped are also more likely to engage in a range of other 'unsafe sexual practices during later years, including having multiple partners, participation in sex work, and increase in risk of rape in adulthood' (Jewkes et al., 2002a, p.320). Consequently, these girls are placed at a much greater risk of suffering from violence and health problems in the future (Jewkes et al., 2002a). It has further been shown that VAW/G has a negative impact on the physical and mental health of the families of women who are affected and renders these family members more susceptible to other forms of violence in the future (Chandran et al., 2011; Casique and Furegato, 2006 in da Fonseca et al., 2009). Children of women who are victims of IPV are particularly affected and

suffer from a range of more immediate effects such as aggressive behavior and problems in school (Durand et al., 2011).

At the community level, the presence of VAW/G increases the likelihood that other forms of violence will occur (Chandran et al., 2011). In addition, by lowering a woman's productivity and stunting her career development, VAW/G inhibits the process of economic development and increases a victim's risk of contracting HIV (ICRW, 2005; Jewkes et al., 2002a; Schraiber et al., 2002 in da Fonseca et al., 2009).

### 3.2.3 ADDRESSING VAW/G

Although there is progressive legislation to address VAW/G in South Africa, there continues to be a large gap between legislation and practice (Britton, 2006). This gap reflects the fact that strategies which focus primarily on the apprehension and prosecution of perpetrators are unlikely to succeed and that far more needs to be done to address VAW/G (Jewkes et al., 2009).

It has been suggested that VAW/G be tackled at multiple levels. In the long term, the fundamental drivers of VAW/G – social norms that condone the use of violence, and gender inequalities – must be addressed (Abramsky et al., 2011; Britton, 2006; Jewkes et al., 2002a; Laisser et al., 2011). Successfully addressing these issues is extremely challenging and requires interventions that target women, men and children, given that gender inequality is relational and reproduced intergenerationally (Jewkes et al., 2009; Jewkes et al., 2010b).

While tackling the fundamental drivers of VAW/G is necessary, it has also been recognized that addressing proximal factors can have an important impact on VAW/G. A variety of measures have been suggested: for example, providing individual support, such as counseling, psychotherapy and social-casework for female victims (Antai, 2011; Jewkes et al., 2002b); interventions to address alcohol consumption (Jewkes et al., 2002b); and tougher legislation and law

enforcement (Abrahams et al., 2010; Antai, 2011). Also, as is the case of education, some measures which empower women may initially increase the risk of violence as women become more likely to challenge oppressive gender-based norms. It is only at a certain threshold of empowerment that the protective effects begin to dominate and that the risk of VAW/G decreases (Jewkes et al., 2002b). While this finding was certainly not a case against women's empowerment, it does highlight the need to be aware of the challenges of addressing VAW/G and the context in which interventions are implemented.

To effectively address VAW/G, a number of authors have recognized the need to execute these initiatives through multisectoral and intersectoral action, with the education sector being seen as a key partner to the health sector in the fight against VAW/G (Abeya et al., 2011; Abramsky et al., 2011; Chandran et al., 2011; De Lange et al., 2011; Jewkes, 2002; Kaur and Garg, 2010). This academic recognition has also been coupled with a shift in practice with many organizations addressing VAW/G in South Africa attempting to adopt a multisectoral or intersectoral approach to their work (Britton, 2006).

## 3.3. INTERSECTORAL COLLABORATION

As implied by the definition given in the introduction, ISC is a broad concept that can cover a wide range of organizations engaging in a diverse range of collaborative activities, so long as they are united by some form of common purpose (Adeleye, 2010; El Ansari and Phillips, 2001; Harris et al., 1995).

Widespread interest in ISC was initially sparked by the *Alma Ata Declaration* (WHO, 1978) of 1978, which noted the centrality of ISC to PHC. This emphasis on ISC for health was further reinforced by subsequent WHO publications. Of particular importance was the *Ottawa Charter for Health Promotion* (WHO, 1986), which formally recognized that the factors influencing population health are determined by a wide range of sectors (O'Neill et al., 1997; Roe et al., 1999;

WHO, 1986). The rationale behind ISC for health is based on the idea that single purpose approaches to health care, and PHC in particular, are too narrow to address the social determinants of health (Adeleye, 2010; Campbell and Cornish, 2010; Negin et al., 2010; Walley et al., 2008).

### 3.3.1 BENEFITS OF ISC

One of the primary benefits of ISC is that it allows for resources to be used more efficiently as the duplication of services can be avoided (Holveck et al., 2009). Many health issues share common risk factors and this increased efficiency is of great value in situations where healthcare budgets are already stretched. In addition to being a cost-saving mechanism, ISC can also improve the quality of prevention and response services as collaborative synergies emerge (Pearson, 1992). One of the by-products of such synergies, for example, is that innovative ideas may be stimulated through the involvement of a variety of participants with diverse ideas and expertise (Costongs and Springett, 1997; Holveck et al., 2007; Lasker et al., 2001).

A broader benefit of ISC is that it can contribute to the building of 'bridging social capital' (Campbell and Cornish, 2010). Whilst Campbell et al. (2007, p.352) mentioned that community actors can form "'bridging' relationships with networks and agencies outside the community who have the political or economic power to facilitate effective local community responses to AIDS" by engaging in ISC, this argument applies equally well to other health-related issues (Fear and Barnett, 2003). Related to the issue of building relationships is that of building awareness: ISC also has the potential to draw attention to issues that would otherwise fall outside the purview of the health sector but that play a key role in community health and development (Holveck et al., 2007).

### 3.3.2 DRAWBACKS OF ISC

Despite the many benefits associated with ISC, there are also potential drawbacks to collaborative activity. One of the most serious drawbacks is that

ISC has been said to be costly and time consuming to implement effectively and requires a wide range of institutional support (Dormady, 2012; Gazley and Brudney, 2007; Harris et al., 1995; Lasker et al., 2001). While such costs may be justified on the grounds that the benefits provided by ISC are greater than the costs, evidence suggests that the benefits associated with ISC can be uncertain (Fear and Barnett, 2003; Geneau et al., 2009; Harris et al., 1995; O'Neill et al., 1997). The experience of collaborative partnerships in South Africa gives credence to such concerns regarding the high costs and uncertain benefits of collaboration (Ashman, 2001; El Ansari and Phillips, 2001b; Nair and Campbell, 2008). The potential for diverting scarce resources towards ineffective ISC initiatives is a major drawback in settings such as rural KZN where there is already an acute lack of resources and institutional capacity.

Another drawback of ISC is that the parties involved must forego some autonomy over key issues such as decision-making and resource allocation for ISC to be effective (Harris et al., 1995). This loss of autonomy can be particularly problematic in the context of the unequal power relations that are often present in collaborative activity (Lasker et al., 2001). Evidence from ISC involving civil society and business in South Africa, Brazil and India has shown that the business partners tend to dominate decision-making within these collaborations, undermining the agency of their collaborative partners and also the overall effectiveness of the partnership (Ashman, 2001). Other drawbacks of collaboration include mission drift, loss of accountability, cooptation of actors, greater financial instability, and greater difficulty in evaluating results (Gazley and Brudney, 2007: 392).

### 3.3.3 EFFECTIVENESS OF ISC

Writing in 1997, O'Neill et al. (1997, p.80) found that 'this type of work [ISC] fails more often than it succeeds', a view which has been supported by other authors (El Ansari and Phillips, 2001; Fear and Barnett, 2003; Lasker et al., 2001; Mitchell and Shortell, 2000). More recently, Holveck et al. (2007) have

provided a more positive outlook on the outcome of ISC initiatives, highlighting a number of success stories in Latin America. A potential source of ambiguity in such evaluations is the fact that it has proven to be difficult to demonstrate the added-value of ISC in addressing health-related issues, particularly with regards to primary outcomes (Geneau et al., 2009). While it is often the case that secondary outcomes (for example, increased capacity to work intersectorally and collaboratively) can clearly be shown to have improved, measuring primary outcomes (for example, improvements in under five mortality rates as a result of increased collaboration) has proven to be much trickier (Geneau et al., 2009). Although a case could be made for the fact that improvements in such process variables are valuable in their own right, it is highly debatable whether such changes alone could justify the high cost of ISC in resource poor settings.

## 3.4 COMMUNITY HEALTH WORKERS

### 3.4.1 THE ROLE OF CHWs

CHWs hold a semi-formal position in the healthcare system that was created as a means of scaling-up PHC services. Despite the WHO's internationally recognized definition of the CHW position, there is still a lack of consensus within the literature regarding the precise definition of their role. This ambiguity may be due to the fact that the CHW's role has been shown to differ considerably in relation to these actors' working environment (Celletti et al., 2010). There has been, however, agreement on the fact that CHWs generally hold a decentralized role, serving to connect members of the community to formal health services (Gilson et al., 1989; Suri et al., 2007). It is in this decentralized role that the true value of CHWs is said to emerge. That is, CHWs are seen as key community-level actors for ISC for health in resource-poor settings and specifically within SSA for two reasons. First, given the critical shortage of other health workers in SSA, CHWs have been seen as playing an essential role in expanding health care services at the community level by providing an effective and relevant first level contact within the PHC system (Berman, 1984; Clarke et al., 2008; Gilson

et al., 1989; Kelly et al., 2001; Lehmann et al., 2004; Lehmann and Sanders, 2007; Leinberger-Jabari, 2005; Swider, 2002). Second, it has been argued that CHWs' position as community 'insiders' allows them to bridge the gap between formal health services and communities (Lehmann et al., 2004; Lehmann and Sanders, 2007).

Furthermore, Standing et al. (2008) noted that there have been two agendas driving the PHC movement and the promotion of CHWs. First is a cost-cutting and task-shifting agenda, which seeks to address the health worker shortage in a pragmatic manner. Second is a much broader transformative agenda in which

> community based health agents are seen as also being political agents whose role is partly to create awareness of the social context of community health and work with communities to tackle this through broader political means (Standing et al., 2008, p.2097).

Given that it is the cost-cutting agenda that has been the primary driving force behind most CHW initiatives, and because CHWs have often not been empowered to fulfill a more transformative role (Standing et al., 2008), there are debates as to whether CHWs are actually capable of fulfilling the abovementioned expectations.

The essence of this debate is captured by Werner's (1981) dichotomized distinction of CHWs as either *lackeys* or *liberators*. A liberator is described as an agent of change in the community who is able to engage in preventative care by mobilizing the community around a broad base of social and economic issues and who serves in a complementary rather than subordinate role to medical doctors. According to Werner (1981), it is both feasible and desirable for CHWs to act as liberators. At the time, however, Werner (1981) argued that CHWs have normally served as lackeys who are unable to affect real change, largely due to the ideological biases of program planners, consultants and instructors. This distinction was later studied by Walt (1990) who further examined whether the CHW position involves a broad transformative role or simply a source of

inexpensive assistance that serves as a lower level of the formal health system. In particular, it has been argued that when CHW programs are quickly scaled-up and make use of a top-down approach; these actors are likely to become an undervalued extension of the health system. In support of Werner's earlier findings, Walt (1990) claimed that CHWs tended to be used as just another pair of hands.

Rifkin (1996) built on this debate by arguing that the gap between outcomes and expectations regarding CHW programs was due to the rigid, dichotomized paradigm being used to analyze these programs. Both the empowerment frame of reference, which promotes the transformative role of CHWs, and the target-oriented frame of reference, which promotes narrower programs with a clinical focus, have been said to have engendered unrealistic expectations and have not provided an appropriate framework for understanding the complexity of the systems within which CHWs operate. Rifkin (1996) advocated for a more inclusive paradigm, in which both these perspectives are considered, leading to a deeper understanding and more realistic expectations of CHW programs. Central to this more inclusive paradigm is the understanding that while community participation and perspectives are especially important, they are not a magic bullet for issues relating to community health.

### 3.4.2 EVIDENCE REGARDING CHW EFFECTIVENESS

As aforementioned debates suggest, 'the literature on the implementation of CHW programs and the experience of CHWs presents at best a mixed picture' (Christopher et al., 2011; Standing et al., 2008, p.2098). On the one hand, there has been a wide range of evidence from a variety of settings suggesting that CHWs have achieved some measure of success (Brenner et al., 2011; Celletti, 2010; Jerome and Ivers, 2010;Wadler et al., 2011;Yeboah-Antwi et al., 2010). These programs range from large-scale interventions, such as health systems strengthening in Haiti (Jerome and Ivers, 2010) and successful national CHW programs in Bangladesh and Brazil (Macinko et al., 2006; Standing et al., 2008),

to more specific interventions, such as a low-cost child health promotion model using volunteer community health workers in Southwestern Uganda (Brenner et al., 2011).

However, in addition to this body of evidence supporting the effectiveness of CHW programs, there has also been evidence to the contrary. For example, a 2005 Cochrane review found that while targeted CHW interventions have provided benefits, 'generalist' programs have not proven to be effective, possibly reflecting the general inability of modern CHW programs to fulfill a broad transformative role (Lewin et al., 2005). Furthermore, some CHW programs which initially produced positive results have suffered from issues related to sustainability, quality control, and scaling-up (Brenner et al., 2011; Hermann et al., 2009; Walt et al., 1989). Historically, sustaining CHW programs has proven to be especially difficult, with numerous programs established after Alma Ata going 'progressively into decline from the 1980s onwards' (Standing et al., 2008, p.2098). This decline was due to a combination of waning political and financial support for CHW programs and intrinsic institutional factors associated with these programs (Christopher et al., 2011; Standing et al., 2008). Moreover, large-scale programs at the national level have been particularly difficult to manage, suggesting that scaling-up CHW initiatives effectively is an important part of the implementation challenge (Hermann et al., 2009; Lehmann and Sanders, 2007). This experience implies that many of the gains cited in the literature regarding contemporary CHW programs may be fragile, difficult to implement at a wider-scale, and susceptible to changes in the broader political and financial climate. In spite of the debate regarding the actual effectiveness of CHW programs, Hermann et al. (2009) noted that there has been much more of a consensus on the potential of CHWs and there has been widespread recognition of the need for CHW programs even if successful programs have yet to be broadly implemented.

**CHWs in South Africa**

The evidence of CHWs in South Africa is similarly mixed. Introduced as early as the 1920s, CHW programs in South Africa experienced somewhat of a 'golden era' between 1970 and 1990. While CHW programs faced many difficulties during these years, and CHWs were often simply treated as the lowest level of the existing healthcare hierarchy, a number of programs successfully addressed the broader social determinants of health in a truly transformative manner that was closely intertwined to larger political and economic struggles. Underpinned by the struggle against Apartheid, these programs 'were seen as innovative, responsive, comprehensive and empowering for staff and communities' (Van Ginneken et al., 2010, p.1110). In fact, the success of these initiatives has illustrated that CHW programs can be both sustainable and transformative in certain contexts. It needs to be acknowledged, however, that the development of these programs has been attributed to the unique and highly repressive environment of the time (Van Ginneken et al., 2010). While there have been a range of CHW programs in the post-Apartheid era that have shown positive outcomes (Wadler et al., 2011), many of these programs have been criticized for abandoning the broad, transformative focus of their apartheid era predecessors in favor of a technically driven model focused on clinical conditions (Daniels et al., 2012; Van Ginneken et al., 2010). This shift has lent support to the notion that Apartheid created a unique set of conditions that was particularly favorable to the development of broad and transformative CHW programs. In addition to this general criticism, issues such as CHW's lack of job satisfaction, poor relationships between CHWs and nurses, and difficulties regarding sustainability have been cited (Campbell et al., 2008a; Schneider et al., 2008).

### 3.4.3 FACTORS INFLUENCING CHW EFFECTIVENESS

As with the previous section, the evidence pertaining specifically to the factors that influence CHWs' ability to collaborate is limited; thus, this section discusses the factors that have been found to influence CHW effectiveness more generally but that are relevant to the collaborative context.

Similarly to ISC, there has been a consensus that community ownership plays an important role in successful CHW programs (Lehmann and Sanders, 2007). Such ownership and participation is important not only in ensuring that these programs are responsive to local needs but also because it allows CHWs to tap into pre-existing social networks. The better developed these community networks are, the more successful a program is likely to be; because, while CHWs can be effective in already mobilized communities, they tend to struggle when tasked with initiating such mobilization (Lehmann and Sanders, 2007; Lewin et al., 2005).

The recognition of the CHW position by health professionals, the community, and the organizations and government institutions that employ them has also been identified as one of the most important factors influencing CHW capacity (Bhattacharyya et al., 2001; Doherty and Coetzee, 2005; Schneider et al., 2008). Previous research has illustrated that a lack of recognition has a substantially negative impact on the quality of services provided by CHWs, as CHWs lose legitimacy in the eyes of both the community and other health professionals making it difficult to fulfill their bridging role between these two groups of actors. This lack of recognition has been a prominent issue hindering many CHW programs worldwide (Bhattacharyya et al., 2001; Doherty and Coetzee, 2005; Lehmann and Sanders, 2007; Schneider et al., 2008).

Because CHWs are meant to serve as a link between formal health care services and the community, it is also imperative that CHWs form positive relations with the formal health care sector (Lehmann and Sanders, 2007; Ofosu-Amaah, 1983; Walt, 1990). Positive relationships tend to emerge in the absence of paternalistic and hierarchical relationships between CHWs and health professionals, and as noted above, a lack of recognition of CHWs by other health professionals is a major hindrance to developing such relationships (Haines et al., 2007; Lehman et al., 2004). Evidence from South Africa has shown that relationships between CHWs and nurses are often strained, with nurses having

difficulty recognizing the role of CHWs and often simply treating them as nursing subordinates (Doherty and Coetzee, 2005; Van Ginneken et al., 2010).

Closely related to the issue of recognition and relationships is that of role definition. Proper role definition can both limit conflict between CHWs and health professionals who may feel threatened by the CHW position, and also enhance the community and health professional's understanding of their role thereby increasing recognition and status (Bhattacharyya et al., 2001; Clarke et al., 2008; Gilson et al., 1989). What constitutes an appropriate role for CHWs has been, however, highly contested and reflects the nature of the debates already mentioned regarding the purpose of CHW programs. According to Rosenthal et al. (2011, p.257), 'if the CHW role is defined narrowly as increasing access to existing services, then the historic role of CHWs as change agents who work for social justice could be lost'. As this statement illustrates, the way in which a CHW's role is defined is closely related to the expectations of what a CHW should achieve. Realistic expectations from their supervisors lead to an enhanced sense of self-efficacy which facilitates capacity building (Bhattacharyya et al., 2001); on the other hand, unrealistic expectations have the opposite effect and may also lead to CHWs being overloaded with work (Berman et al., 1987; Bhattacharyya et al., 2001; Lehmann and Sanders, 2007; Walley et al., 2008; Walt, 1990).

Furthermore, it is essential that proper selection (Brenner et al., 2011; Celletti, 2010; Lehmann and Sanders, 2007), training (Brenner et al., 2011; Hermann et al. 2009; Perez et al., 2009) and supervision (Berman et al., 1987; Bhattacharyya et al., 2001; Lehmann et al., 2004; Lehmann and Sanders, 2007; Walt, 1990) are provided to CHWs for them to function effectively. From the perspective of the individual CHWs' job satisfaction and motivation, it is important that CHWs are adequately remunerated (Celletti, 2010; Perez et al., 2009; Standing et al., 2008), and have opportunities for personal growth and career development (Berman et al., 1987; Schneider et al., 2008; Walt, 1990).

There is a tension here, however, in that while it has been learned that 'CHWs cannot be retained in the long term if they do not receive adequate remuneration', this funding model raises concerns about the financial sustainability of CHW programs (Hermann et al., 2009, p.9). Given the elevated rates of attrition in most voluntary CHW programs (Bhattacharyya et al., 2001; Olang'o et al., 2010), the evidence has suggested that it is necessary for CHW programs to incur this cost if they are to be successful.

This trade-off between cost and quality highlights a more general point: that although the main driving force behind CHW expansion is cost-saving, running an effective CHW program can actually be very costly (Hermann et al., 2009; Lehmann and Sanders, 2007; Rifkin, 1996). This is not to say that CHWs cannot be cost-effective; rather, the point is that a considerable investment of time, money and human resources is required to establish an effective CHW program and that only through such an investment can potential cost-saving benefits be realized. Unfortunately, because of the emphasis on cost-effectiveness, this aspect of CHW programs has often been neglected leading to too few resources being allocated to CHW programs (Berman et al., 1987; Lehmann and Sanders, 2007).

## 3.5 TEACHERS

### 3.5.1 THE ROLE OF TEACHERS

Given the interest in addressing VAW/G in South Africa through intersectoral action, it is necessary for CHWs and other health care workers to collaborate with actors from other sectors. The education sector is ideally suited as a partner in this regard because schools have a key role to play in addressing VAW/G. First, schools are seen as key nodes for community development, particularly in 'network-poor' settings (Campbell et al., 2008b; Campbell et al., 2010; De Lange et al., 2011). Second, there are alarmingly high rates of VAW/G in South African schools (HRW, 2001; Prinsloo, 2006). It is argued that the unequal gender

relations that underlie VAW/G "are tolerated and 'normalized' by everyday school structures and processes" (Leach and Humphreys, 2007, p.51). In some cases, teachers are perpetrators of such violence within schools. There are numerous cases of teachers physically, sexually and emotionally abusing learners, or using their authority as teachers to pressure girls into performing sexual favors in exchange for better grades (HRW, 2001). Thus, 'the importance of the school as a site for integrating services is of prime concern because it is both part of the solution and often a central part of the problem' (De Lange et al., 2011: p.179). The sentiment regarding the importance of schools in community health has been reflected more generally in the WHO's Global School Health Initiative which aims to increase the number of Health-Promoting Schools (HPS) globally. Launched in 1995, this initiative is based on the principles of the Ottawa Charter for Health Promotion (WHO, 1986) and 'involves all groups in the school community, including students, families, school staff and the wider community, working together to promote the health and well-being of the whole school community' (Rowe et al., 2007, p.525).

Given the potential to address VAW/G through schools, it follows that teachers should play a central role in such initiatives. Although there may be structural factors that limit their ability to act (Smit and Fritz, 2008; Sultana, 1992; Wotherspoon, 2006), teachers have the potential to be key social actors both within schools and the wider community (Sives et al., 2005; Smit and Fritz, 2008; Wotherspoon, 2006). This potential has been largely linked to the fact that teachers are at the frontline of the education sector (much as CHWs are at the frontline of the health sector in resource-poor settings) and 'may have the closest and most direct relationship with young people in the community' (Mitchell et al., 2005, p.2). The latter statement is certainly relevant to a country like South Africa, which had a net primary school enrolment ratio of ninety percent between 2007 and 2009 (UNICEF, date unknown). Evidence from studies assessing health-education ISC has supported these claims: it has been noted that teachers

play a key role in successful interventions involving the health and education sectors (Mukoma and Flisher, 2004).

### 3.5.2 EVIDENCE REGARDING TEACHER EFFECTIVENESS RELATED TO ISC

Through this literature review, I have found few studies that directly address collaborative initiatives involving teachers and the health sector. Most evaluations of ISC partnerships between the health and education sectors have been of programs inspired by the HPS initiative; even within this body of evidence, there have been few studies pertaining specifically to Africa (Mukoma and Flisher, 2004).

Similarly to ISC in general, the evidence from HPS initiatives has been mixed (Keshavarz, 2010; Mukoma and Flisher, 2004; Potvin, 2010; Tang et al., 2008). Although a number of HPS initiatives have shown short-term positive outcomes, sustaining these outcomes and scaling-up and broadening the scope of initiatives has proven to be challenging (Keshavarz, 2010; Tang et al., 2008).

### 3.5.3 FACTORS INFLUENCING TEACHER EFFECTIVENESS

Given that health-education ISC is a subset of ISC in general, all of the factors mentioned as affecting ISC within the theoretical framework outlined in the next chapter are relevant to this discussion. The purpose of this section is to examine those factors that are specific to health-education ISC.

As stated before, teachers have played a central role in determining the effectiveness of health-education ISC. Given that these initiatives often require teachers to develop some knowledge of health-related issues while also being advocates for social change, relatively skilled teaching staff is needed for effective implementation (St Ledger, 2001). In addition to demanding such skills, ISC has also proven to be very time consuming for teachers (St Ledger, 2001). In resource-poor settings, many teachers lack these skills and have insufficient time to fulfill their currently defined roles as a teacher, let alone the expanded role

necessitated by ISC (Bennell and Akyeampong, 2007). A lack of teacher time and capacity can, therefore, be a major barrier to effective ISC.

Community involvement, particularly from the parents of learners, has also been cited as an important factor influencing the success of such initiatives (Keshavarz, 2010). In addition to forming relationships with parents and the wider community, it is also necessary for schools to form relationships with the health sector. As with other forms of ISC, a lack of such relationships has been said to represent another barrier to the effective formation of HPS collaborations (Keshavarz, 2010).

Just as schools need to engage in more collaborative relationships with the community and health care workers, they need to create a collaborative environment within schools too. That is, a shift from a 'teacher-dominated hierarchy to a more collaborative community' is necessary such that schools become more student-centered and responsive to their needs (St Ledger, 2011, p.203). In South Africa, many schools continue to have hierarchical and teacher dominated environments that are not suited to ISC.

## 3.6 SUMMARY

Though ISC has received considerable attention within health-related literature and interventions, a general lack of comprehensive frameworks with regard to this concept persists (Potvin, 2012). A further gap in the current state of knowledge relates to the limited understanding of how ISC can be used to address VAW/G. Similarly, the literature pertaining to ISC involving the education sector is quite thin. While there is a fair amount of literature specifically relating to HPS, many of these studies and initiatives tend to be somewhat narrow in that they often focus on health education within schools rather than broader primary health care initiatives.

Of particular relevance to this study is the lack of research relating to ISC involving teachers and CHWs. The key innovation of this study is the contribution it aimed to make to this knowledge gap. In this regard, the present study, which is embedded in the EVC initiative, builds on the findings from the Learning Together project. As discussed in earlier chapters, the Learning Together project sought to investigate the perceptions that CHWs and teachers in Vulindlela had of each other through the use of drawings. This project aimed in part to address the gap regarding teacher-CHW collaboration and to lay the groundwork for future ISC between these two groups of actors to address HIV and AIDS. Although the teachers' and CHWs' reflections of each other were initially rather uncritical, their drawings, comments and interactions soon began to point to a less than harmonious relationship. While CHWs viewed teachers as powerful social actors who sometimes play a positive role, they did not necessarily see teachers as the best custodians of this power and were critical of their leadership style. The CHWs also vocalized concerns that teachers were not effectively educating the students about sexuality, because they lacked the time and expertise in this area to do so. The CHWs went further by mentioning that teachers often committed acts of violence and sexual abuse against their pupils making them part of the problem. Teachers, while generally positive, also expressed their mistrust of CHWs, which seemed to be related to doubts regarding the professionalism of CHWs. For example, one major concern for teachers was that CHWs might not keep sensitive issues, such as a person's HIV status, confidential. In general, De Lange et al. (2011) found that major challenges had to be overcome if these two groups of actors were to collaborate successfully. In particular, the authors highlight the unequal power relations between these actors. During the research process, the voices of the male teachers tended to dominate while the female CHWs took a far more peripheral role and found it difficult to make their voices heard. As mentioned in the ISC section of the lit review, managing power dynamics is critical to the success of ISC and De Lange et al.'s (2011) findings suggest that these power relations could be a critical barrier to ISC between teachers and CHWs in Vulindlela.

In light of these findings, the purpose of this study was to partly pick-up where Learning Together left off by attempting to better understand the collaborative dynamics of teachers and CHWs in Vulindlela while focusing on their efforts to address VAW/G. More specifically, as presented in the following chapter, the present study aimed to respond to the requests of teachers and CHWs in the Vulindlela community, and to contribute to the existing body of knowledge on ISC involving CHWs and teachers as it relates to efforts to address VAW/G in a rural community setting.

# CHAPTER 4: OBJECTIVES AND THEORETICAL FRAMEWORK

# 4.1 OBJECTIVES

To better inform future attempts at addressing VAW/G through ISC between CHWs and teachers in Vulindlela, I aimed to document the existing ISC between these actors. Through participatory research methods, I encouraged research participants to critically explore the nature of their current collaboration. I had hoped that this process of critical engagement would not only inform future collaboration initiatives between these actors, but that it would also improve their understanding of the context in which they collaborate. This general aim was further broken down into two main objectives, both in relation to the actors' efforts to address VAWG in the community they serve.

The first objective was to document the current state of CHW-teacher collaboration with the help from the actors themselves. In meeting this objective, I aimed to understand current collaborative efforts whilst also facilitating the participant-led exploration of their collaborative relationships. That is, participants were encouraged to consider their perceptions of their present collaboration, their roles and responsibilities within this collaboration, and the manner in which this collaboration was actually taking place. To meet this first objective, the following questions were addressed:

**Question 1.** How do CHWs and teachers currently perceive their collaborative relationship with one another?

**Question 2.** How do CHWs and teachers perceive their roles and responsibilities within this collaboration?

**Question 3.** In practice, how do these actors collaborate when addressing VAW/G in the community?

**Question 4:** According to the CHWs and teachers, what factors currently influence ISC between these actors?

The second objective was to identify ways in which CHW-teacher collaboration could be improved. This objective led to the following question:

> **Question 5:** According to the CHWs and teachers, what actions are needed to improve this collaboration in the future?

## 4.2 THEORETICAL FRAMEWORK

### 4.2.1 OVERVIEW OF THE STUDY FRAMEWORK

With regards to ISC, theoretical developments have lagged far behind ideological and practical considerations (Costongs and Sprignett, 1997; Mitchell and Shortell, 2000; O'Neill et al. 1997). Though this theoretical gap has been partly addressed over the last decade or so, I was unable to find a widely accepted theoretical framework pertaining specifically to ISC. Furthermore, of the frameworks I found, there was no single one that I felt sufficiently addressed the needs of this study. As a result, I have formed a hybrid framework of ISC, which draws on the strengths of a number of different frameworks presented in the literature.

Harris et al.'s (1995) framework of ISC provides the overall structure for the framework used in this study. Harris et al. (1995) defined six conditions necessary for effective ISC: necessity, opportunity, capacity, relationships, planned action, and sustained outcomes. I found this framework to be particularly relevant to my study for a number of reasons. First, the categorization of the factors is neat, comprehensive and logical, providing a good overarching structure for conceptualizing ISC. Second, by considering necessity and opportunity, the framework allows for an analysis of both the initiation and implementation stages of ISC, whereas most work examining collaboration has tended to focus exclusively on the implementation stage (Gazley and Brudney, 2007). This emphasis on understanding how collaborative partnerships are formed is especially relevant to my study given that ISC between teachers and

CHWs in Vulindlela is still in its formative stages. Third, the work of Harris et al. (1995) is well suited to an analysis of ISC at the individual level given that the factors examined relate to both individual and organizational dynamics. Finally, this framework was adopted because it has been successfully applied in previous studies of ISC (see Bindon 2002; Dick, 2002; Miller and Pollard, 2007; Rose and Harris, 2004; Webb et al., 2001)

I did, however, make some relatively minor modifications to Harris et al.'s (1995) six original factors. I changed the name of necessity to motivation as I believed this name more accurately captured the essence of the factor as defined by Harris et al. (1995) themselves. I also dropped the sustained outcomes factor and included an external environment factor instead. The sustained outcomes factor was omitted because I viewed sustainable outcomes as a goal of ISC rather than a factor that influences it. This view is supported by the literature, which takes sustainability to be a function of the other factors originally cited by Harris et al. (1995) (Harris and Powell-Davies, 2000; Miller and Pollard, 2007; Rose and Harris, 2004; Roussos and Fawcett, 2000; Von Schirnding, 1997). An external environment factor was included instead because I felt that such a factor was relevant to my study, as illustrated in the subsequent sections, and because this factor has been included in a previous framework of collaboration (Lasker et al., 2001).

The six factors that I was left with – motivation, opportunity, relationships, capacity, planning, and external environment – were treated as meta-factors that provided an overarching structure for the framework. I then augmented these meta-factors using other frameworks and literature pertaining to collaborative activity as described in the following sections.

### 4.2.2 MOTIVATION

'Motivation' refers to an actor's motivation to engage in ISC. It is generally assumed that actors are willing and able to engage in ISC, with the challenge then being to optimize an already existing collaboration (Gazley and Brudney, 2007).

Unfortunately, this assumption is not always true. In a world where actors have strategic interests and the benefits of ISC are uncertain, a fundamental starting point for any individual-level analysis of ISC must be the actors' motivation to collaborate (Geneau et al., 2009; O'Neill et al., 1997).

After synthesizing the range of factors that have been said to influence an actor's motivation to engage in ISC, I found that motivation can be conceptualized as a three stage process[5]: motivation to address a particular issue; motivation to engage in ISC; and motivation to collaborate with a specific actor. These stages can be considered to be sequential in that motivation at each of the first two stages is necessary but not sufficient for the actor to be motivated to engage in a specific collaborative initiative, while motivation at the third stage is sufficient. Given the nature of collaboration, it is also essential that all of the key parties in a collaborative venture are sufficiently motivated to collaborate.

This three stage conceptualization of motivation can be illustrated with the example of a CHW's motivation to collaborate with teachers to address VAW/G. First, the CHW must decide if VAW/G is an issue that they are interested in addressing. From a professional perspective, this means the CHW must decide whether addressing VAW/G is part of their 'core business' (Harris et al., 1995; Miller and Pollard, 2007). Beyond professional concerns, individuals are likely to have a range of other motivations, both selfish and altruistic, for wishing to address a particular issue. Assuming there is interest at this level, the CHW must then decide if ISC is a relatively more effective means of addressing VAW/G than working alone or in another type of collaborative arrangement (Harris et al., 1995; Webb et al., 2001). Finally, if the CHW is interested in addressing VAW/G and engaging in ISC, they must consider whether they are sufficiently motivated to collaborate with teachers specifically (Harris et al., 1995). The motivation to collaborate with specific actors has itself been analyzed by two distinct

[5]I do not believe that actors necessarily make decisions in discrete steps in the manner that is presented in this framework, as certain steps are unlikely to be considered in isolation. However, I still believe that this step-by-step presentation of the decision-making process captures the essential elements of such a process and is valuable for conceptual purposes.

theoretical traditions (Gazley, 2010). The economic strand focuses on resources: it is said that actors will be motivated to collaborate when the resources available to one partner are perceived to be scarce and complementary for the other (Delaney, 1994; Harris et al., 1995). Such resources can be attractive both as an end in themselves and because they indicate that a partner has the capacity to contribute to the effective implementation of ISC. On the other hand, the sociological strand focuses on human factors such as ideology, personality, and previous relationships (Gazley, 2010). Gamson (1961) refers to these factors as non-utilitarian preferences and defines them as all factors that influence an actors' decision to collaborate with another actor that are not motivated by the resources actors have at their disposal. Delaney (1994) argues that both of these perspectives are important when analyzing actors' incentives to collaborate.

It is important to point out that it is perceptions, rather than reality, that motivate actors (Rose and Harris, 2004). Regardless of how effective an ISC initiative is in furthering an actor's own interests, if this actor is not aware of the benefits of such an initiative, they will not be motivated to engage in it; conversely, an actor can also be highly motivated to engage in a collaborative initiative that provides them with few benefits if they falsely believe that such an initiative is an effective means of achieving their goals.

### 4.2.3 OPPORTUNITY

'Opportunity' refers to an actor's opportunity to engage in ISC. Because collaboration is associated with considerable costs, even if we have established that actors are willing to engage in ISC, we cannot simply assume that they have the opportunity to do so. The main constraints limiting opportunities to initiate collaboration are a lack of time or financial resources (Dormady, 2012; Gazley and Brudney, 2007; Lasker et al. 2001). In addition to time and resources, existing relationships can also play an important role in creating opportunities to collaborate. Although the time, resources, and relationships that each individual actor has available to them are expected to vary from person to person, there are

also structural factors that determine the opportunities actors have to collaborate (Harris et al., 1995). These factors include time of year, particularly relevant in the case of activities involving schools; location; the social and cultural environment; the political environment, which is partly reflected in policies, reports, and legislation; the economic environment, which has a major impact on the allocation of resources; and the organizational context (Harris et al., 1995). As with motivation, it is crucial that all the essential actors involved in ISC have sufficient opportunities to collaborate; enabling just a few of these essential actors to collaborate is unlikely to lead to sustainable outcomes (Harris et al., 1995).

### 4.2.4 RELATIONSHIPS

'Relationships' refer to the nature of relationships between actors engaging in ISC. Aside from playing a role in providing opportunities for ISC, relationships are important in their own right in determining the effectiveness of ISC. More specifically, positive relationships play a crucial role in the sustainable development of networking and joint working, both of which have been identified as cornerstones of ISC (Constongs and Sprignett, 1997).

Because of the strategic interests that motivate collaborative activity, ISC has been said to be "a 'political matter of bargaining and negotiation'" (Delaney, 1994, p.221). Relationships can take on both cooperative and competitive elements, and power dynamics become particularly important given that actors can have divergent interests (Delaney, 1994; O'Neill et al., 1997). According to El Ansari and Phillips (2001, p.235) 'central to the notion of collaboration is the concept of shared power…and the struggle for participation is one of the democratization of decision making'. It has been noted in the relevant literature that where power is unequally distributed and formal mechanisms for mediating such inequalities do not exist, it is the stronger voices that are likely to dominate the collaborative process (Ashman, 2001; Harris et al., 1995). Collaborative initiatives that are dominated by a few powerful voices are expected to be less sustainable and successful than those with more participatory dynamics as

participation promotes both satisfaction and the diversity from which collaborative synergies emerge (Ashman, 2001; D'Amour et al., 2005; Dormady, 2012; Harris et al., 1995; Lasker et al., 2001; Roussos and Fawcett, 2000)

In such a context, trust lies at the heart of positive relationships (Gadja, 2004;Gazley, 2010). There is the potential for positive feedbacks to occur here, as collaborative experiences may breed further familiarity and trust (Gazley and Brudney, 2007). The diversity of the actors involved – measured by factors such as personality, ideology, beliefs, interests, and constructs of professional identity – also has an important influence on relationships. Paradoxically, diversity amongst participants has the potential to be both the greatest strength and greatest weakness of collaboration (Harris et al., 1995). On the one hand, it is diversity that can make ISC more effective than intrasectoral collaboration and individual action (Dormady, 2012); however, heterogeneity can lead to tension and conflict between participants (El Ansari and Phillips, 2001b; Lasker et al., 2001). Thus, managing diversity is an essential part of ISC.

### 4.2.5 CAPACITY

'Capacity' refers to an individual's capacity to engage in ISC. At the individual level, it is the resources that an actor is able to draw upon that are the most important factor influencing collaborative capacity (Harris et al., 1995). Lasker et al. (2001) identified a range of resources that influence collaborative capacity. For the sake of clarity, I have chosen to disaggregate these resources into sub-categories of resources that are more consistent with the manner in which the terms tend to be used in the literature. These categories are as follows: financial resources; physical resources (space, equipment, goods); human resources (skills, expertise, information); and social resources (connections to people, organizations, groups; power) (Lasker et al., 2001).

Resources are important because they create capacity within and between groups of actors (Harris et al., 1995). Capacity within a group of actors refers to the capacity of a group of actors to fulfill their core responsibilities within a

collaborative (Foster-Fishman et al., 2001). For example, CHWs would be expected to have some health-related expertise if they were to be effective partners in ISC to address VAW/G. In addition to working effectively as individuals, actors also need capacity relating specifically to the ability to collaborate (Alter and Hage, 1993; Gray, 1985). Elements of an individual's capacity to collaborate include the ability to work in groups, such as negotiation and conflict resolutions skills; the ability to engage with individuals from different professions and sectors; and a clear understanding of the capacities and roles the other actors have in the collaboration in relation to themselves (Harris et al., 1995). The more capable actors are of collaborating, the more interdependent we expect collaborative activity to be and the more we expect the synergies associated with ISC to emerge (Lasker et al., 2001; MacIntosh and McCormack, 2001). While a certain degree of capacity is required for collaboration to be successfully initiated and sustained, Harris et al. (1995) also stated that capacity is likely to be further built through engaging in collaboration.

### 4.2.6 PLANNING

'Planning' refers to the planning process associated with collaboration. Planning is an important element of effective ISC for a number of reasons. Amongst other benefits, planning can alleviate the tensions associated with conflicts of interest; promote inclusiveness; provide clarity and predictability; and create systems that are not overly reliant on individuals for their sustainability (Deschesnes et al., 2003; Fear and Barnett, 2003; Harris et al., 1995; Miller and Pollard, 2007).

Elements of planning include agreeing upon the aims, objectives and vision of ISC; defining roles and responsibilities; and establishing decision-making mechanisms, conflict resolution mechanisms, evaluation procedures, means of allocating recognition and rewards, and clear exit points (El Ansari and Phillips, 2001; Roussos and Fawcett, 2000; Harris et al., 1995).

Both the process and the outcomes of planning are important, and the planning of ISC can be evaluated according to a number of dimensions. In terms of the planning process, the main dimension that must be considered is whether this process was participatory and democratic (Deschesnes et al., 2003). In terms of planning outcomes, the formality, rigor and coverage of the plans are all important (Foster-Fishman et al., 2001; Harris et al., 1995). Although increasingly formal collaborative relationships do provide a number of benefits, formality can also be associated with costs; therefore, the appropriate level of formality depends on the context in which a collaborative initiative is implemented (Harris et al., 1995; Nathan et al., 2002). It is also important that the planning outcomes facilitate participatory and democratic relationships during ISC (Deschesnes et al., 2003). As stated in the 'relationships' section, participatory processes and outcomes are important because they breed synergies, satisfaction and ownership.

### 4.2.7 EXTERNAL ENVIRONMENT

External Environment' refers to those factors that influence a collaborative partnership but that are 'beyond the ability of a partnership to control' (Lasker et al., 2001, p.196). Lasker et al. (2001) disaggregated the 'External Environment' into community characteristics, and public and organizational policies. Given the grassroots focus of my study, I am particularly interested in community-level factors.

# CHAPTER 5:
# METHODOLOGY

## 5.1 SITUATING THE RESEARCHER

The purpose of this section is to provide a critical account of the channels by which my personal history influenced my engagement as the researcher in this study. Specifically, I aim to demonstrate the experiences, knowledge, and expectations that shaped my impressions and interaction with the research topic, site, participants and methods.

As noted in earlier chapters, the fieldwork for this research took place in rural South Africa, which meant that I spent close to five months living and working in a rural part of KwaZulu-Natal. Much of this time was spent in the Vulindlela sub-district. While this was my first trip to South Africa, it was not my first experience working in a resource limited context. Having interned in Tanzania twice prior to my time in South Africa, I possessed some understanding of the realities of health related action in resource limited settings. Of course, this understanding also came with certain skewed expectations. These expectations shaped my interactions on the field and subsequent analysis of the data that were gathered. Most notably, having witnessed and documented a number of barriers relating to rural health care during my time in Tanzania, I had a negative perception of rural health care provision. When I first travelled to this study's rural research site, I was surprised to observe well-functioning health facilities such as the Songonzima clinic, and to witness the enthusiasm from CHWs and teachers when approached to take part in this study. Though the physical infrastructure of the Gobindlovu Secondary school did meet my expectations of a rural school, the teachers defied my expectations. Their university education and high levels of professionalism and commitment were unexpected, and as a result, I had to adjust the manner in which I approached them.

Furthermore, the subject of VAW/G was of particular interest to me as an individual who has experienced this specific type of violence and as a community health student who has witnessed such violence. My previous exposure to this

type of violence undoubtedly influenced my perceptions and understanding of VAW/G. During the early stages of this study, it was particularly difficult to put aside my preconceptions regarding the causes of VAW/G and how this issue should be dealt with. However, following my initial exposure to the accounts of VAW/G provided by the research participants during the data collection phase, I quickly realized that my experience with VAW/G was incredibly limited and that the CHWs and teachers' understanding of this issue was far more complex and context appropriate than mine. It was at this point that I began relinquishing my initial perceptions to let the participants' accounts, feelings and perceptions relating to VAW/G become the dominant ones within the data collected.

A further influence that shaped my perception as a researcher was my academic background. I completed an undergraduate degree in education prior to reorienting myself towards global health by enrolling in an MSc in community health. This background influenced my motivation to conduct this study, as I wanted to better understand how collaboration between the education and health sectors could be fostered to promote community based development. In my opinion, my interdisciplinary background also proved to be an asset during the research process. On the one hand, I strongly believe that my background as a teacher helped me establish a somewhat peer-based relationship with the participating teachers; similarly, I believe that my grassroots level experience with community health helped me establish a positive relationship with the CHWs. During the data collection phase of this study, I had the impression that the nature of these relationships helped position me on a more equal footing with the participants as opposed to an expert attempting to investigate them.

My engagement with the participants was also influenced by my expectations of them as social actors working in a rural setting, particularly with regard to their language skills. Based on a limited knowledge of their training, I expected to encounter major language barriers between myself (a bilingual French and English speaker) and the isiZulu speaking participants. I was not only caught off

guard by the teachers' level of education and professionalism, as mentioned earlier, but also by the teachers' and CHWs' command of English. Being able to converse with the participants in English immediately altered my perception of their capacities.

I also entered the study site with an expectation of how I would be perceived as an outsider. As a Caucasian female from Canada, I expected to be treated as an outsider attempting to understand a foreign reality. I initially thought the participants would meet me with hostility and a lack of enthusiasm. Much to my surprise and relief, this was not what I experienced as I developed a friendly relationship with the participants through the research process. It is true that I have no way of fully confirming their initial perceptions of me as an outsider seeking a way in. However, their enthusiasm to take part in the study even after having met me, their unwavering commitment to engaging in the knowledge construction process, and their efforts to make sure that information or accounts they provided were always contextualized for the benefit of my understanding led me to believe that with time they were able to move past the fact that I was an outsider. For some participants this building of relationships even meant sharing personal accounts of experienced violence with me outside of the study specific activities. Nonetheless, the demands of fostering and upholding positive and authentic relationships with participants throughout the data collection phase did involve constant negotiation and proved to be time consuming.

Finally, as a newcomer to the field of research, the groundwork laid by the Learning Together and EVC projects helped me narrow the focus of my study and enabled me to build on the participatory research methods that had been used by these projects. The use of these methods was of particular importance to me as they were aligned with my firm belief that research should be an interactive process that directly benefits the participants. Although I had no experience with the use of visual methodologies specifically, I soon came to appreciate these methods as valuable tools for data collection.

Just as the data collection was influenced by my personal history, so were the findings which emerged from my analysis of the data. In the data analysis section of this chapter, I attempt to provide a detailed account of the analysis I conducted to demonstrate that while the findings may be influenced by the inherent subjectivity of qualitative research, the analysis was conducted in a rigorous manner.

## 5.2 STUDY DESIGN

### 5.2.1 PARTICIPATORY METHODS

For the purposes of this study I chose to draw on participatory research methods, as they lent themselves well to the general aim and specific objectives of the study. Participatory research calls on research participants to play an active role in the research process (Cornwall and Jewkes, 1995). Therefore, throughout the research process, participants were acknowledged as research colleagues in a mutual learning process, with me acting as a facilitator of the knowledge production. As a result, the participants developed a sense of ownership over the research process.

One of the strengths of participatory research lies in its potential to produce context-bound knowledge, which can be used to inform theory that is accessible and relevant to communities at working the grassroots level (Macaulay et al., 1998). Participatory research also provides a platform to link

> theory with intervention, work with groups outside of their institution, analyze with them the problems faced by their community, help them to perceive these problems more clearly and to take charge of the sectors that influence their collective life (Alery et al., 1990 in Macaulay et al., 1998).

The use of participatory methods in this study provided an opportunity for participants to construct their own understanding of the context in which they operate. It was my hope that the participants would use this knowledge to

improve their ISC with one another when attempting to address VAW/G in their community in the future.

It is important to note that while participatory research does call on the active involvement of participants in the research process, its primary focus within this study was not to yield actions or immediate decisions, but rather to inform future decision making processes. It goes without saying, however, that action is generally thought to follow independently of the research process soon after the knowledge is acquired from the research findings. In contrast, action research and participatory action research focus on improving practice rather than the production of knowledge (Elliott, 1991). Again, however, this is not to say that these two approaches to research cannot yield the construction of knowledge, but rather that it is not their primary aim. In this study I therefore did not identify taking action as an objective, but rather aimed to produce the knowledge and understanding necessary to better contextualize future actions.

### 5.2.2 VISUAL METHODS

Within the framework of participatory research, the area of participatory visual methods – photo voice, participatory video and drawing – have been particularly important in the work of the various researchers working in the Every Voice Counts Project (De Lange et al., 2007; Mitchell, 2011; Theron et al., 2011). Drawing seemed appropriate to me for the purpose of this study as an entry point for discussion with participants about their perceived collaborative role in addressing VAW/G. It was a simple method to use that did not require participants to have any previous experience, and thus was easier to implement successfully than other visual methods might have been. A number of authors have highlighted the benefits of using drawing with adult research participants, most notably when this method is implemented in a non-competitive manner (Weber and Mitchell, 1995; Weber and Mitchell, 1996; Theron et al., 2011). For instance, Barthes (1981) argued that this type of symbolic imagery promotes the thorough discussion of experiences.

This method was used to promote self-conscious awareness of the topic amongst the research participants by allowing them to scrutinize their own perceptions. Drawing was also used because of its successful application in previous studies conducted with teachers and CHWs in Vulindlela by researchers from the CVMSC (De Lange et al., 2011). In these earlier studies, drawing served to 'evoke discussion and, at the same time, offered a window into key issues to be addressed in multisectoral work' (De Lange et al., 2011).

## 5.3 SETTING-UP THE STUDY ENVIRONMENT

### 5.3.1 ETHICAL CONSIDERATIONS

The following measures were taken to ensure that research participants' rights were respected throughout the entire research process. During the recruitment phase, all potential respondents were informed that participation was voluntary and that they could withdraw from the study at any point in time without penalty or judgment. Each participant was asked to individually sign a consent form (see appendix 1) prior to the commencement of the study. This form was made available to all participants in both English and isiZulu. Additionally, particular care was taken to ensure that the identities of the participants remained anonymous in this manuscript by referring to them by their age, gender and profession only.

Clearance from the KZN Department of Heatlh was provided for this specific study to take place in Vulindlela, in addition to the approval from the KZN Department of Education that had already been granted for research to be conducted in Gobindlovu Senior Secondary School under the umbrella of the EVC project. Permission to conduct research activities at the Songonzima clinic was granted by the clinic manager to allow for the recruitment of the clinic's CHWs. Permission to conduct research activities at Gobindlovu Senior Secondary School was granted by the school's principal prior to the recruitment of participating teachers.

Ethical approval for this study was granted by the Université de Montréal Medical Research Ethics Committee. This study was also covered by the approval provided by the UKZN Ethical Committee for Research with Humans for the EVC umbrella project, as the original approval encompassed the themes, participants and methods included in this particular study.

### 5.3.2 COMMUNITY ENTRY

Despite initial concerns regarding how I would gain entrance to the community and access to the field of study, the CAPRISA leadership team and members of the EVC team provided considerable insight into this challenge. To complement the information I accumulated prior to my arrival on the field, I first met with the director of CAPRISA to gain a better understanding of the practical CHW reporting system used in KZN. Knowledge of this type regarding the education system had previously been outlined to me by the EVC project's principal investigators. The director of CAPRISA at the time was the first to mention that the Songonzima Clinic would be the best point of entry to access CHWs given its proximity to the specific school identified in my initial research proposal. This fact was later corroborated by the Gobindlovu Senior Secondary School's principal. Additionally, the Songonzima Clinic was identified as a particularly good point of entry given CAPRISA's previous experience conducting research with this clinic. This previous engagement meant that the clinic's leadership would have a good understanding of the logistical implications of conducting research, and that the clinic's health providers were more likely to be familiar with the process of research as well.

Following the recommendation of CAPRISA's director, I set out to meet with the Songonzima Clinic manager, an isiZulu speaking nurse, to discuss my study's aims and methods, and the possible recruitment of the clinic's CHWs. Due to the clinic manager's working knowledge of English, communicating with her and soliciting her help for the recruitment of CHWs was not hindered by any language barriers. Her enthusiasm regarding the study was apparent as she

provided a brief overview of the CHWs' role and importance within the area and their link to the clinic. She then assured me that CHWs would be keen to participate in the research process.

Because of the earlier research activities conducted at the Gobindlovu Senior Secondary School under the EVC umbrella, my arrival at the school was well received. I first met with the principal to explain the study's aims, methods and its links to the earlier initiatives carried out within and around the school by the EVC team. The principal was visibly enthused by the study's topic and objectives as he cleared his afternoon schedule to volunteer information about the school and his perception of the community based issues relating to the presence of VAW/G.

After receiving approval from both the clinic's manager and the school's principal to recruit participants and conduct research in the area, I began the recruitment process.

### 5.3.3 PARTICIPANTS AND RECRUITMENT

Two weeks prior to the commencement of data collection activities I began the recruitment of the CHWs. The Songonzima clinic manager offered the opportunity of joining the study to all 25 CHWs who usually report to the clinic. With the use of the study's recruitment letter, ten CHWs were recruited who expressed an interest in participating in the study. A total of six CHWs were present for the first session. All participants were female members of the community between the ages of 32 to 57 years of age. Participating CHWs were isiZulu speakers but all spoke some English. Their experience working as CHWs ranged from ten to twenty years. The CHWs that were present during the first session participated in all subsequent data collection phases. When I asked them about their motivation to take part in this study during the first meeting, CHWs expressed the following as reasons for participating: their interest in better understanding their environment and their collaborative relationships; a

commitment to improving their current collaboration with teachers to provide higher quality services; and specifically, to better address VAW/G in the community they serve. Despite lacking prior research experience, the CHWs' enthusiasm for the research process and its potential outcomes provided a solid foundation for their participation in this study.

The recruitment of teachers was conducted in a similar fashion to the CHWs' recruitment; however, this recruitment was led by the school's head teacher. The head teacher presented the study's objectives and recruitment letter to twenty teachers during school hours. Ten teachers then agreed to participate in the study. Of these ten, only five teachers were present at the start of the first session. The five teachers' ages ranged between 35 and 49, two were male, and all of them had roughly ten years of teaching experience. Despite being isiZulu speakers, all the teachers had a working knowledge of English. During the first session, when I questioned them about their motivation to take part in this study, the teachers all expressed similar views to the CHWs. In particular, they expressed a keen interest in exploring their environment and their collaborative relationships with the Songonzima based CHWs. The teachers added that they were hoping to further develop their research and synthesis skills in addition to a better understanding of the health and social implications of VAWG in the community where they teach. Though four of the five teachers hadn't been formally involved with research prior to this study, they all had a basic grasp of the research processes and were excited about the potential impact of their participation. In the case of the participating teacher who had previously taken part in research-based activities, her experience was primarily linked to the EVC project which had sparked her interest in research as a means of better understanding her environment and her role within it.

### 5.3.4 BUILDING A POSITIVE RESEARCH ENVIRONMENT

From the start of the research process, I made a conscious effort to establish an open, peer-based relationship with the participants. Positioning the CHWs and teachers as active participants within the study from the start was of great importance for the participatory nature of the research process. This positioning was done from the commencement of the first group discussion, in which I established myself as a facilitator and acknowledged the participants as capable, important and experienced community-based collaborators. It was my hope that the somewhat egalitarian nature of the relationship that I attempted to establish between myself and the participants would reduce self-imposed participant censurship and would foster trust between everyone involved in the study. This effort also led to partial levelling of unequal power dynamics amongst participants themselves and produced what participants described as a productive and accepting research environment.

In addition, an effort was made to incorporate the terms used by CHWs and teachers to ensure that the participants' voices were reflected throughout the research process. For example, at the start of data collection, CHWs and teachers used terms such as *intimate partner violence*, *domestic violence* and *gender violence* interchangeably to refer to any form of gender based violence (GBV) they encountered in the community. To illustrate the connection between these terms and VAW/G, I provided the WHO definition of VAW/G[6] to participants. Despite being given this distinct definition, the terms *GBV* and *gender violence* continued to be used by participants throughout the study when referring to VAW/G. For the sake of consistency and to reflect the participant's conceptualization of VAW/G, I therefore took the terms *GBV* and *gender violence* to be synonymous with VAW/G when interacting with the study participants.

[6]See the introduction chapter of this manuscript for the full WHO definition (UN General Assembly, 1993, Article 1).

## 5.4 DATA COLLECTION

Data were collected through four different data collection phases encompassing a total of eight group interviews (see appendix 2 for a breakdown of group interview questions). The group interviews were all documented using video and audio recording equipment, and through the notes I took in my research journal. In light of the participants' active involvement in the co-production of knowledge, I didn't feel that the hiring of a research assistant for the purposes of this study was necessary.

Despite the unnatural social context of the group interview, this method of data collection did allow for the documentation of interactions between multiple actors in a social context (Greenbaum, 1988). Therefore, participants were situated in a dynamic environment that permitted the discussion of their relational experiences. The data produced by these interactions and noted in my research journal were a rich source of information for analysis. During the group interview phase, I met with the teachers and CHWs three times in separate, profession-specific groups and once all together. Throughout the study, I gave participants the option of holding the discussion in English or isiZulu. This provided participants who were not completely comfortable expressing themselves in English with the opportunity to share their thoughts in their mother tongue. To facilitate the discussions in both languages, an IsiZulu speaking translator was invited to translate for the participants during the first data collection phase. However, having had the opportunity to see how a translator would facilitate the discussions in both languages and in the spirit of the participatory approach, I chose to have translations during subsequent data collection phases provided on a voluntary basis by the research participants themselves. The minimization of the number of external facilitators allowed for further participant involvement and resulted in a more comfortable setting for teachers and CHWs to express themselves.

### 5.4.1 AUDIT TRAIL

A primary source of data encompassed my audit trail, which I recorded during and following all data collection activities. The audit trail was documented in my research journal and included both process and field notes. Following the recommendations of Glaser and Strauss (1967), the process notes incorporated both my methodological and theoretical records of the study's evolution, and the field notes included both my personal and observational notes (Glaser and Strauss, 1967). To ensure that my thoughts regarding the data collection phase were accurately documented, I made use of low-inference descriptors throughout my research journal (Seale, 1999).

### 5.4.2 PHASE 1: VISUAL METHODS

During the first data collection phase, participants met in groups divided according to profession for a two hour session. Two sessions were therefore held in this first phase, with teachers meeting together for a group discussion and CHWs meeting together on a different day for a separate group discussion. I first asked participants to introduce themselves to each member of the group, stating how long they had been working as a CHW/teacher, and providing the reasons for pursuing their chosen vocation. A short discussion regarding the study's objectives and methods followed and included the participants' reason for participating in the study. This was conducted in isiZulu to ensure that the study objectives were fully understood by all participants. I then asked participants to discuss their perceptions of the presence of VAW/G (according to the WHO definition) in the community. Following this discussion, I asked participants to produce two drawings in response to the following prompts: 1) 'draw what VAW/G in the community is according to you as a CHW/teacher', and 2) 'draw your role as a CHW/teacher in addressing VAW/G in the community'. I then provided each participant with two A4 sheets of paper and color markers of their choice and allowed them fifteen minutes to produce their drawings.

The drawings were displayed on the wall once they were completed to provide an overview of the issues portrayed by the participants. Finally, a discussion followed where participants shared their thoughts on the images produced by the group. At this point I asked participants to identify the similarities and differences they could see between the images they produced before asking them to analyses the meaning of these differences and similarities. The combination of the images and the discussion that followed allowed for the extraction of the participants' values, attitudes, perceptions, actions, opinions and feelings regarding their role in addressing VAW/G (Cohen et al., 2000; Harrisson, 2002). During this phase I recorded key points that emerged on poster size chart-paper and considered them when developing subsequent data collection activities.

Discussion relating to the collaboration between CHWs and teachers was not introduced during this first phase as it was important to me to first gather the participants' perspectives of VAW/G and of their individual roles prior to discussing collaborative avenues to address this issue. It was my belief that first discussing VAW/G gave the participants an opportunity to exercise critical analysis of an issue that was familiar to them and that they had clear opinions about, instead of attempting to immediately reflect on a more abstract concept such as the nature of their collaborative ties.

### 5.4.3 PHASE 2:GROUP INTERVIEW INVOLVING ALL PARTICIPANTS

In the second data collection phase I brought together all participating CHWs and teachers for a single three hour group interview regarding the challenges of CHW-teacher collaboration aimed at addressing VAW/G. Though their individual efforts were discussed, the majority of the discussion that took place was on their collaborative relationships.

I began the session by recalling the data recorded in the first data collection phase by reviewing the poster size chart paper on which notes were taken during

the previous session. Additionally we then looked at and discussed the participants' drawings, all of which were posted on the walls of the room. This provided an opportunity for response validation to be carried out where I asked participants to agree, disagree or add to what was previously recorded on the chart paper. In this process I included a revision of the key ideas and general preliminary findings that had emerged from the participants' initial discussions and provided an opportunity for CHWs and teachers to view each other's drawings and briefly discuss them as a group. Returning to participants with these rough data allowed the data to be refined which further engaged the participants in critical analysis (Reason and Rowan, 1981). In addition, comments made by participants during this discussion were added to what was initially recorded. This new information was considered in the final analysis of the data. This same process of response validation was repeated at the start of each subsequent group interview.

Following this validation process, a discussion of the participants' efforts to address VAW/G was prompted by the viewing of a 17 minute-long video entitled *Seeing for Ourselves* (CVMSC, 2006). This short video was produced by researchers working as part of the CVMSC and included data from local students, teachers, CHWs and parents who were asked, by the researchers, to explore an issue that affected their lives and to create and film a scenario that represented the issue. Most of the scenarios chosen by video producers documented issues of gender based violence and rape. Three of these scenarios were presented in the video that the study participants viewed during this session, these were entitled 'Rape,' 'Protect the Children,' and 'Stop Abuse.'

Following this viewing, I conducted a short debrief regarding how participants felt after watching the video and how this video influenced the way they perceived VAW/G. I then invited participants to discuss their collaborative efforts to address VAW/G, the nature of their relationships with one another

within this collaboration, as well as the challenges and enabling factors that influence the quality of this collaboration and their response to VAW/G.

The social dynamics that were present during these interactions were recorded in my observation notes. An important observation pertained to the fact that the teachers' voices dominated the discussions while the CHWs shied away from participating. This observation led me to decide to have the CHWs and teachers meet in separate groups for the subsequent data collection phases to ensure authentic and uncensored participation from all participants. Meaningful passages from my observation notes relating to the social dynamics present between CHWs and teachers during this session were also included as data in the analysis process.

### 5.4.4 PHASE 3: DRAFTING OF A RECOMMENDATIONS GUIDE

The third data collection phase served as an opportunity to examine the collaboration between CHWs and teachers in greater detail. For this session I decided to separate the CHWs into two groups according to their age. The three youngest CHWs formed the first group, while the three older CHWs met together at a later time. Separating the CHWs according to age was done following a review of my observation notes which pointed out that the older CHWs' voices were slightly more prominent within discussions than those of their younger colleagues. It was my hope that this decision would allow younger CHWs to voice their opinions more freely in the absence of judgment from their senior colleagues. The teachers, on the other hand, continued to meet in a single group as I did not detect this same issue among teachers. That is, I had found that all teachers were participating to an equal extent in the discussions and respect for their fellow teachers' opinions was expressed throughout the group interviews.

As with the previous data collection phase, I opened the session by recalling data from earlier discussions using the chart paper on which I had written notes during the previous session. CHWs and teachers were again provided with an

opportunity to add comments and details to the key concepts identified during the previous session.

To further engage participants in the research process and to initiate the dissemination of ideas, I asked participants to engage in the drafting of a recommendations guide. This guide, entitled by participants *Stop Abuse: Together We Can End Violence Against Women and Girls in Our Community* (see appendix 3), was produced through the joint efforts of teachers and CHWs participating in the study. The guide was created to summarize the key concepts identified by the research participants during the group discussions. Additionally, the exercise of drafting the guide was designed to serve as a discussion tool to engage participants in a more detailed exchange about their collaborative efforts to address VAW/G in the community. Before starting, I also suggested to participants that the guide be used as a learning tool for future teachers and CHWs. At the start of the drafting session, I provided participants with fifteen minutes to think about the key elements they felt were relevant to the guide before sharing their thoughts with the group. A discussion highlighting each element brought up by the participants was then conducted.

The participants were also informed that a compilation of the ideas drafted by both groups of actors (CHWs and teachers) would be provided during the subsequent meeting and that they would be given the opportunity to make any changes to the guide that they felt were necessary.

### 5.4.5 PHASE 4: FINAL GROUP INTERVIEWS

The fourth phase was the final group interview with CHWs meeting together and teachers meeting in a separate session. As a continuation of previous proceedings, I initiated this final phase of data collection by another round of data recall and response validation, this time using the recommendation guide draft as a recall tool rather than the chart paper. This discussion served to verify whether

any new content should be discussed regarding the CHWs and teachers' collaboration or ways in which this collaboration could be improved.

Following this discussion, I asked participants to look over the recommendations guide that I had cleaned up from the drafts provided by the participants during the previous sessions. Opinions regarding the guide were shared and participant requested changes were made to the final version. Consent to publish the guide was also acquired from each participant (see appendix 4). This recommendations guide was later printed in English and isiZulu and copies were handed out to the Songonzima clinic manager, to the Gobindlovu School principal, to CAPRISA leadership, and a number of additional copies were given to each research participant in order for them to use it in their future work and to share it with their colleagues. This allowed for an initial dissemination of the knowledge constructed through the research process at the community level to be conducted. Sector leadership, including the KZN Departments of Health and Education were also provided electronic copies of the guide in the hope that this would inform sector specific leadership. Following this dissemination, I was unable to document any further use of the guide within the study context due to logistical constraints.

Finally, to conclude the data collection process, I asked participants to share their thoughts and feelings about their participation in the study. In accordance with the participatory methods used, my questions focused on the participants' feelings regarding the research process to which they actively contributed. The participants were also asked to share what they had learned through their participation in the study regarding the issue of VAW/G, their role in addressing this issue and their ISC partnerships. To keep track of what had been said during the session, all comments were once more noted on the chart paper that was hung on the walls while I took notes in my research journal. These final comments reflected the participants' perceptions of the outcomes of the research process and

of their involvement in it. These benefits are discussed in the final chapter of this manuscript.

## 5.5 DATA ANALYSIS

In this section, I aim to provide an account of the data analysis process that explains the choices I made and how these choices led to the findings and interpretations presented in the following chapters. Included is an account of the data sources analyzed and the analysis process itself. Both the data sources and data analysis process were subject to some limitations. These limitations will be presented in the final chapter of this manuscript.

### 5.5.1 DATA SOURCES

Analysis of the narrative data collected during the group interviews was conducted following the completion of the data collection phase. Three sources of data were analyzed: transcripts from the eight group discussions; my research journal, which included notes taken during group discussions; and the drawings produced by the participants during their first group discussion. The group interview transcripts were translated in two stages. First, the transcripts were translated into English by an isiZulu speaker; second, the translation was then back-translated by a second isiZulu speaking translator to compare the isiZulu and English versions of the transcripts. In total, ten hours of audio recording from the group sessions were transcribed which produced 213 typed A4 pages of text. In addition, 74 typed A4 pages taken from my research journal and 22 drawings were also included in the analysis.

### 5.5.2 ANALYSIS OF THE GROUP DISCUSSION TRANSCRIPTS

The group discussion transcripts were analyzed to provide an understanding of CHWs' and teachers' perceptions of their current collaborative activities to address VAW/G. The analysis of these transcripts was conducted using a directed approach to narrative data analysis which called on a four-step process (Hsieh

and Shannon, 2005).The four steps encompassed becoming familiar with the data and focusing the analysis; reducing and categorizing the data; identifying patterns and connections among the categories of data; and interpreting the data. In this section, I discuss the three first steps; the final step of interpreting the data, which includes listing the important findings and attaching meaning to them, is presented in the following chapters.

**Becoming Familiar with the Data and Focusing the Analysis**

To gain an overall sense of the transcribed data, I started by reading all of the transcribed text, a process which I repeated multiple times (Graneheim and Lundman, 2004). During my first reading, I read the discussion transcripts in chronological order. I then went through the transcripts a second time by reading all of the teachers' sessions first, the CHWs' sessions second, and then reading the session that included both groups of actors. Additionally, this first step allowed me to verify that the data was complete and that there were no unclear passages.

My initial impression of the data following multiple readings of the transcripts was that the comments made by participants sometimes lacked consistency as CHWs and teachers seemed to contradict themselves from one discussion to the next. I also had the impression that their responses to my questions became more candid over the course of our sessions. Where answers seemed to be calculated during the first session, participants' responses during later sessions were more emotional and less guarded.

To focus the analysis prior to coding the data, I began by reviewing the study objectives and research questions. I made final preparations to the data by moving the transcribed text into an excel file. I also changed the font of teachers' comments to blue to distinguish them from the CHWs' comments in black and highlighted the text from each session in a different color. These changes were made so that I could move around the passages without losing the context of the

session in which the discussion occurred. I was then ready to start analyzing the discussion transcripts based on themes related to the research questions. These themes are summarized in Table II (p.73) (Hsieh and Shannon, 2005).

**Reducing and Categorizing the Data**

The process of reducing and categorizing the data began with the identification of meaningful units to code. Meaningful units, such as the example presented in the box below, were any passages within the transcribed text which contained information pertaining to the pre-established themes derived from the initial research questions. A total of 1421 meaningful units were identified and condensed so that they could be coded.

Example of a meaningful unit:

-So, it's the matter of the information that we don't have. If they [the departments] were to help, because I think if the issue of money could be solved, then, then the local government can come in and can give the money or the fare to the health workers so that they can go to visit the homes of the victims that we see. I think the local government must come because there are departments who deal specifically with such issues. *(Teacher B, 35 yr. old, M.)*

Example of transcribed text not included among meaningful units analyzed:

-You ask us to make another drawing?
- No, not to show or to draw, I am saying to bear in mind when you use the paper vertical or horizontal to draw , yes, yes
- Just to say
- Ya, ya
- Ok. *(Three CHWs discuss how to place the paper for their drawings)*

Abbreviated codes representing specific ideas, concepts, behaviors and interactions were then placed at the end of each meaningful unit of data to help organize the data into categories. During this coding process, each code was assigned a descriptive name and rules were established for applying each code to ensure that the codes were applied uniformly throughout the transcripts. For example, the code *CHAN* represented the *improvement of community channels*. This code was attached to all units which included content relating to the development of community-based channels to respond to VAW/G. As I coded the data, abbreviations representing sub-categories were also added to the end of

each meaningful unit when necessary. The process of building new categories continued until new mutually exclusive codes were exhausted. Thus, the coding process continued until no new codes could be identified and all meaningful units were coded. A total of 33 categories and 17 sub-categories were identified through this process. All codes and sub-codes were then displayed in the following table to facilitate the identification of patterns and connections within the data.

**Table II - Themes and codes from transcripts**

| Related Themes | Category Codes | Sub-Category Codes |
|---|---|---|
| Perception of relationships between CHWs and teachers | 1. Perception of a shared goal between the actors **(SG)** | |
| | 2. Perception of each other's attitudes **(ATT)** | Presence of trust **(tr)**<br>Presence of distrust **(distr)** |
| | 3. Actors' perception of the status attributed to their own role **(STAT)** | |
| | 4. Actors' perception of the nature of their relationship with each other **(REL)** | Positive **(pos)**<br>Negative **(neg)** |
| Perception of CHWs and teachers' roles and responsibilities | 5. Community's perception of the CHWs and teachers' roles, influence and capacity **(COMM)** | Role (**rol)**<br>Influence (**inf)**<br>Capacity (**cap)** |
| | 6. Perception of their own individual **(IR)** | |
| | 7. Perception of each other's roles **(EOR)** | |
| | 8. Perception of each other's capacity to intervene as social actors **(EOC)** | |
| | 9. Perception of their own capacity to intervene as social actors independently from the support from other actors **(IC)** | |
| | 10. Perception of their own influence within the community and the sectors in which they work **(INF)** | |
| Practical manifestation of collaboration taking place with teachers and CHWs to address VAW/G | 11. Collaboration with actors with social actors who typically work outside of the health and education sectors **(CC)** | Collaboration with social workers **(sw)**<br>Collaboration with police officers **(pol)**<br>Collaboration with traditional leaders**(tl)**<br>Collaboration with government or legal authorities **(gov)**<br>Collaboration with faith based leaders **(fb)**<br>Collaboration with traditional healers **(th)** |
| | 12. Referral of cases from CHWs to teachers **(cREF)** | |
| | 13. Referral of cases from teachers to CHWs **(tREF)** | |
| Practical manifestation of collaboration taking place with | 14. Actors conducting an intervention within each other's sector without collaborating with each other. (e.g. CHWs going to intervene in a school without working directly with teachers) **(CSI)** | |

| | | |
|---|---|---|
| teachers and CHWs to address VAW/G (continued) | 15. Actors collaborating with actors within their respective sectors (e.g. CHWs collaborating within the health sector with nurses) **(INTRA)** | |
| | 16. Using other social actors as brokers to intervene in each other's' sectors (e.g. a CHW using a social worker as a broker to intervene in a school) **(CCISC)** | |
| Factors influencing collaboration | 17. Mention of situations and reasons for which VAW/G is not reported **(REP)** | Reason for not reporting **(sit)** Situation where not reporting occurs **(reas)** |
| | 18. The actors' perception of their own knowledge pertaining to collaborating **(IK)** | |
| | 19. Financial resources necessary for CHWs and teachers to collaborate effectively with each other **(FIN)** | |
| | 20. Time necessary for CHWs and teachers to collaborate effectively with each other **(TIME)** | |
| | 21. Actors' possession of information about how to collaborate with one another (including how to refer to each other) **(INFO)** | |
| | 22. Difference between the CHWs' and teachers' status that influences their collaboration with each other **(STATD)** | |
| | 23. Communication as a factor that influences collaboration between CHWs and teacher **(C)** | |
| | 24. Community's capacity to effectively address VAW/G **(COMCAP)** | Community's capacity to ensure the reporting of VAW/G (**rep)** Community's capacity to enforce consequences on perpetrators **(perp)** |
| Ways to improve collaboration between CHWs and teachers | 25. Supporting the development of community based channels to respond to VAW/G **(CHAN)** | |
| | 26. Formalization of collaboration activities between CHWs and teachers **(FOR)** | |
| | 27. Improving the referral system between CHWs and teachers **(IREF)** | |
| | 28. Improving the collaboration with social actors other than CHWs and teachers **(ICC)** | |
| | 29. Improve information acquisition about how to collaborate with each other **(IINFO)** | |
| | 30. Improved support and recognition of the collaboration between CHWs and teachers **(ISUP)** | |
| | 31. Encouraging actors to work within the social construct of their roles instead of challenging the status quo **(WWSC)** | |
| | 32. Improving communication between sectors **(ICOMMU)** | |
| | 33. Improving the interpersonal relationships between CHWs and teachers **(IREL)** | |

**Identifying Patterns and Connections within the Data**

With the codes displayed in a table, I proceeded to identify potential patterns and connections between the categories. To establish relationships between the categories, I first grouped the data by category before examining the key ideas within each category and recording any similarities or differences between these key ideas. Following this process, I combined several categories based on their similarities to create more aggregated themes, which are presented in the findings chapter. This aggregation was done so that I could gain a better understanding of how each category related to the whole of the data collected. I also considered whether two or more categories or concepts were consistently mentioned together to examine relationships within the data.

I then assessed the relative importance of each of the categories identified during the coding of meaningful units. To complete this ranking, I used a simple enumeration approach by counting the number of times a code was repeated among the coded units. Particular attention was paid to the frequency with which a code was associated to either teachers or CHWs in the hope that this would provide a rough estimate of the relative importance of a category to these actors (Leech and Onwuegbuzie, 2008).

### 5.5.3 ANALYSIS OF THE RESEARCH JOURNAL

I conducted the analysis of the structured entries provided by the logs kept in my research journal using the same process as described above. Prior to coding the journal, I first separated the entries according to their type. Methodological and theoretical notes were set aside and only personal and observational notes were included as meaningful units in the analysis process. A total of 19 pages of notes were then coded. Most of the meaningful units identified addressed the underlying interpersonal dynamics present both within and between the participating groups of teachers and CHWs. Final categories and sub-categories that emerged from this narrative analysis process were added to the group discussion transcript table above.

### 5.5.4 ANALYSIS OF THE DRAWINGS

Finally, the drawings were analyzed using constant comparative analysis. This approach allowed for a systematic analysis of similarities and differences across drawings. Following the suggestions of de Lange et al. (2011), little emphasis was placed on extracting meaning from a single drawing; instead, close attention was paid to the overall differences and similarities between the drawings.

A preliminary participant-led analysis of the drawings was conducted during the first group discussion. After participants had completed their drawings, the illustrations were mounted on the walls and participants were asked to discuss their own drawings, similarities and differences between the drawings, and what might have caused these similarities and differences. By examining the complete set of drawings produced during the group interviews, the participants were able to comment on their perceptions of the themes and key concepts that emerged. This discussion served two purposes. First, it provided a first level of analysis of the drawings. Second, the discussion itself served as an additional source of data that was analyzed using the four step approach described earlier.

The use of constant comparison to analyze the drawings then allowed me to take into account the differences and similarities within and between the teachers' drawings and the CHWs' drawings. To conduct such an analysis, I first considered the codes that had emerged from the drawing-related transcripts and then coded the teachers' and CHWs' drawings. Following this first coding of the data, I explored the codes of a few drawings and grouped the recurrent codes together to begin creating overarching themes. I then moved back and forth between the meaningful units and the emerging themes to produce refined thematic categories that would be representative of the overall content present in the drawings (Graneheim and Lundman 2004). Final themes and codes that emerged from the drawings were displayed in the table below.

**Table III - Themes and codes from the participants' drawings**

| Themes | Category Codes |
|---|---|
| Types of violence | Violence committed by husband on family **(HF)** |
| | Violence between students/youth **(SS)** |
| | Intimate partner violence **(IPV)** |
| | Physical violence with use of a weapon **(WEAP)** |
| Factors leading to violence | Financial reasons **(FIN)** |
| | Gender inequality **(GI)** |
| | Food insecurity**(FOOD)** |
| Context of violence | Home context – violence within a family **(HOME)** |
| | School context **(SCH)** |
| Individual approach to addressing VAW/G | Indirect intervention to end violence - by dealing with situations that lead to violence **(INDIR)** |
| | Direct intervention to end violence **(DIR)** |
| Current collaboration channels | Referral of cases from CHWs to teachers **(cREF)** |
| | Referral of cases from teachers to CHWs **(tREF)** |
| | Cross-sector interventions not involving collaboration **(CSI)** |
| | Use of community based actors other than CHWs/teacher as brokers to conduct cross-sector interventions **(CC ISC)** |
| Factors influencing collaboration | Time to collaborate **(TIME)** |
| | Individual capacity **(IC)** |
| | Status differential between CHWs and teachers **(STATD)** |
| | Community's capacity to address VAW/G **(COMCAP)** |
| | Under reporting of violence in the community **(REP)** |
| | Communication between actors **(COMMU)** |
| Paths to improve collaboration | Working within the social construct of their roles **(WWSC)** |
| | Improve communication **(ICOMMU)** |
| | Improve the personal relationships between CHWs and teachers **(IREL)** |
| | Developing community based channels to respond to VAW/G **(CHAN)** |
| | Formalization of collaboration activities **(FOR)** |
| | Improving the referral system **(IREF)** |
| | Improving the involving social actors other than CHWs and teachers **(ICC)** |
| | Improving the opportunities for full collaboration **(IFULL)** |
| | Improve information acquisition about how to collaborate to address VAW/G **(IINFO)** |

Once all the codes were considered and themes had emerged from the constant comparison of data from each of the drawings, I stepped back from the data to examine the relationships and patterns within and between the themes. I paid particular attention to how the themes related to one another given the context and the presentation of the codes. For example, attention was paid to the differences and similarities between the codes and whether any themes consistently appeared together.

Though the analysis process described in this section utilized a systematic approach, a number of factors may have influenced the interpretation of the data

and the findings that emerged from it. These factors and potential biases are touched upon in the discussion chapter of this manuscript following the presentation of the study's findings.

# CHAPTER 6:
# FINDINGS

The findings presented in this chapter were derived from participating CHWs' and teachers' perceptions of their efforts to address VAW/G, with a particular focus on their collaborative efforts. Though the inclusion of perspectives from other community members, such as victims of violence, social workers, nurses and law enforcement officers, would have allowed for a more comprehensive analysis of the topic, their inclusion was beyond the scope of my study. As noted in the analysis section of the methodology chapter, these findings were based on data collected through the use of visual methodologies, group discussions, and my research journal.

The findings are grouped in three overarching sections: current collaboration involving CHWs and teachers aimed at addressing VAW/G in the community; the factors influencing current collaboration between CHWs and teachers; and the participants' suggestions for improving collaboration between CHWs and teachers.

## 6.1 CURRENT COLLABORATION INVOLVING CHWs AND TEACHERS

Findings from this study pertaining to the collaboration involving CHWs and teachers in Vulindlela have been organized into three distinct paths: multisectoral action between the health and education sectors involving CHWs or/and teachers; intrasectoral collaboration; and multisectoral action involving actors from sectors other than education and health (see table IV, p 81). The table below maps out these three paths and presents in parentheses the codes from which these categories emerged during the data analysis process.

**Table IV - Current Collaborative Paths Involving CHWs and Teachers**

| **Multisectoral action between the health and education sectors involving CHWs or/and teachers** | **Intrasectoral collaboration** | **Multisectoral action involving actors from sectors other than education and health** |
|---|---|---|
| Cross-sector interventions **(CSI)**<br>• Use of other social actors to conduct cross-sector interventions. (**CCISC)** | Teachers working with actors within the education sector, such as other teachers or the school's principal. **(INTRA)** | Teachers working with social actors other than those within the health and education sectors, such as social workers, police officers, religious and local government leaders, and traditional healers. **(CC)** |
| Teachers and CHWs referring to each other for support. **(tREF, cREF)** | CHWs working with actors within the health sector, such as nurses, traditional healers and other health-related actors. **(INTRA)** | CHWs working with social actors other than those within the education and health sectors, such as social workers and police officers. **(CC)** |

### 6.1.1 MULTISECTORAL ACTION BETWEEN THE HEALTH AND EDUCATION SECTORS INVOLVING CHWs AND/OR TEACHERS

#### 6.1.1.1 CROSS SECTOR INTERVENTIONS

Actions that involve either teachers or CHWs intervening in the other actors' sector without these actors actively engaging in collaboration were discussed during all the group discussions with the exception of the one that brought CHWs and teachers together. In their discussions, teachers noted instances when they venture into the community to meet with the learners' parents to address social or health-related issues such as the presence of violence. This includes situations where a student is acting violently in school or is perpetrating some form of VAW/G and the teacher wishes to involve the learner's parents. Teachers also said they address situations of violence occurring in the learners' homes when they are asked by the pupil to intervene or when they feel the home situation is detrimental to the students' learning and well-being.

> It is very difficult for the teachers; because you might find that there are teachers that must go to the families...I drove the learners to their homes, because sometimes we have to sacrifice. We are the teachers, we have the responsibility of this, [and] the learners are a huge responsibility. *(Teacher C, 35 yr. old, M.)*

> When you sit and talk with a learner you find out what is happening at home. You must go to the house and see what is happening. You don't have a choice,

> the learner maybe goes to bed hungry, is abused or there are no parents at home. You must know how this started, what is happening. *(Teacher D, 39 yr. old, F.)*

CHWs described situations where they visit schools to provide health-related education to the youth. According to CHWs, this intervention is typically prompted by the principal and is not initiated by the CHWs themselves. Such health-related education includes teaching learners about GBV, VAW/G and their human rights.

> We visit the learners in schools and at sometimes at home when we can get to them during holiday time. *(CHW A, 45 yr. old, F.)*

> You know, I am near the school, every time, if there's a problem, the principal can phone me to come. He tells me there's a child here and asks me do you know their family? You see, I know the family so I can go and ask the learner what is happening and I will bring the report of what is happening to the principal.*(CHW C, 57 yr. old, F.)*

When discussing these school visits, the CHWs' failure to mention the teachers' involvement was notable. The principal was identified as their sole contact at the school and teachers were never mentioned as actors with whom CHWs work in this context.

**Use of other social actors to conduct cross-sector interventions**

Though CHWs reported occasionally visiting schools, they also emphasized their need to involve another social actor as a broker to negotiate their entry into the school environment. The community's nurses, social workers or NGO-employed counselors were the three types of actors they mentioned when discussing this broker role. In addition to facilitating their entry, the CHWs noted that the broker's presence enabled them to convey their message with more credibility than if they had delivered it alone. The brokers' value in this regard was said to be because they are actors with higher social standing and more influence in the community than the CHWs.

- What I'm going to do…I'm going to organize a facilitator and I will go with the facilitator to the school to speak to the learners. *(CHW E, 40 yr. old, F.)*
- Or sometime we organize the counselors and go with them. *(CHW E, 40 yr. old, F.)*
- Ya, like this we can go to the school with the counselor and speak to the group of learners with a counselor. They will listen to the counselor.*(CHW C, 57 yr. old, F.)*

Data extracted from my research journal notes taken whilst CHWs discussed the use of other social actors as brokers to facilitate their cross-sector interventions point out that CHWs discussed this mechanism with great enthusiasm. According to these notes, as seen in the passage below, CHWs seemed proud of their initiative and ingenuity around their approach to overcoming collaborative barriers to intervene within the education sector.

> CHWs talk about working with social actors such as social workers and NGO-counselors to intervene in schools. When discussing this, they talk with confidence, speaking quickly with assurance and large smiles, nodding their heads in approval of one another – they seem proud of this channel. They talk about it in a way that makes it seem like they are comfortable taking this approach whenever needed. (*Research Journal Entry)*

#### 6.1.1.2 TEACHERS AND CHWs REFERRING TO EACH OTHER FOR SUPPORT

While instances of collaboration between CHWs and teachers were mentioned, they were limited to the referral of cases to one another. Such referrals occur when either teachers or CHWs feel they have reached their intervention limit and believe that the other actor may be more capable of handling the situation.

Referrals were shown to occur most often when stemming from teachers. However, this asymmetry in referrals is not because teachers are especially eager to collaborate with CHWs. Instead, it is because teachers make referrals to other social actors, including CHWs, when they reach their intervention limit, which occurs relatively often. As noted in my research journal, teachers were hesitant to discuss instances where they have called on CHWs for support. They mentioned that such collaboration has produced subpar outcomes in the past. In contrast,

CHWs portrayed their referrals to teachers as a means of adding to the quality of their work and as a valuable source of support.

> Yes, even the time that we have isn't enough so we can't do it on our own. *(Teacher E, 49 yr. old, F.)*

> If the case need be, we need to refer to them, because on a serious note, our power is within the school premises. *(Teacher C, 35 yr. old, M.)*

> So the cases we have will be referred to others and maybe if it's the case it can be attended to by the CHW. So the CHW will take it over maybe and then visit the house of the victim if they can. *((Teacher B, 35 yr. old, M.)*

> If the child is afraid to talk to me, he/she will speak to the teacher, the teacher will then contact me. But the children must understand that we CHWs and the teachers have a close working relationship. If the child talks to a teacher, they must know that the matter will reach a CHW...and the CHW will be able to finish dealing with the case. *(CHW A, 45 yr. old, F.)*

### 6.1.2 INTRASECTORAL COLLABORATION

In addition to engaging in multisectoral action, CHWs and teachers also take part in intrasectoral collaboration to address VAW/G. Though intrasectoral collaboration involves collaboration between actors from the same sector rather than actors from different sectors, such as the education and health sectors, this finding is of interest as it provides a broader picture of the collaborative paths utilized by these actors. For teachers, this type of collaboration involves working within the education sector with other teachers and the school's principal; for CHWs, such collaboration mainly involves working with nurses.

#### 6.1.2.1 TEACHERS WORKING WITH ACTORS WITHIN THE EDUCATION SECTOR

Teachers discussed instances when they collaborate with actors within the education sector. This type of collaboration takes place within the school setting and was perceived in a positive light. When reaching their individual intervening limit due to factors such as time constraints, teachers collaborate with one another to address the issue at hand. This type of collaboration mostly involves referrals of students or groups of students from one teacher to another.

> I tend to refer to other teachers. It's good because they are good with this. Sometimes I refer some learners to them because I identify that there are certain

> problems with learners. So the teachers might speak to him or her make sure that the learner isn't violent in school. *(Teacher C, 35 yr. old, M.)*

Teachers also collaborate with the school's principal to address issues of violence at the school-wide or community level. Once again, this collaboration typically takes place when teachers feel unable to address an issue on an individual level. One of the ways that teachers collaborate with the principal to address VAW/G is by asking the principal to reach out to the students' families in the community. On a number of occasions, the teachers noted that collaborating with the principal can yield positive outcomes due to the influence and social standing he has in the community.

> The principal used to call meetings with parents because they also introduce [VAW/G] to the parents in those meetings. And with [VAW/G], they need to be told what to do. *(Teacher D, 39 yr. old, F.)*

> I think that our principal has influence so we can call on him. Because he's someone who is around the area with the locals in the area. *(Teacher C, 35 yr. old, M.)*

Overall, teachers discussed this avenue for collaboration in a positive manner. Teachers spoke about the principal and the influence he holds within the community with much respect and admiration as displayed in the passage below.

> When talking about working with the principal, all the teachers displayed a positive attitude towards him. The confidence they convey when talking about in his capacity highly contrast with their occasional rolling of the eyes, shaking of heads, ironic laughter or raised hands in a sign of desperation when speaking about their experiences working with other social actors, such as law enforcement officers. (*Research Journal Entry)*

#### 6.1.2.2 CHWS WORKING WITH ACTORS WITHIN THE HEALTH SECTOR

Similarly to teachers, during the third group discussion, participating CHWs discussed this collaborative path as an approach used when reaching their individual intervention limit. However, in contrast to teachers, this path was acknowledged by CHWs in a negative light. Rather than embracing this collaboration as an extension of their role, CHWs engage in intrasectoral collaboration out of necessity due to their limited influence in the community. The referral of cases of VAW/G to nurses was identified as the main form such

collaboration takes. Though CHWs see nurses as actors with considerable influence, they voiced the belief that nurses are out of touch with the domestic reality within the community. According to the entries in my research journal and passages within the discussion transcripts, collaboration with nurses came across as a clear source of frustration for CHWs.

> We refer to the nurses. The nurse is the one who can call the police, and maybe they can take you to doctor, because she will not be able to treat you. But if you refer [a case] to her you know that your case will go further with evidence. *(CHW A, 45 yr. old, F.)*
>
> The police will know for sure that the incident has happened for real if it is reported by the nurse *(CHW C, 57 yr. old, F.)*
>
> Nurses are there in the clinic and in the office. And the CHW they go down to the houses. We go [to] houses and see the problems. Even the Sisters at the clinic they don't know the problems. *(CHW C, 57 yr. old, F.)*

Though both the groups of CHWs and teachers engage in intrasectoral collaboration, it is not among their most common types of collaboration, nor was it identified among the most important types among the results of the enumeration of the meaningful units during the analysis process.

### 6.1.3 MULTISECTORAL ACTION INVOLVING ACTORS FROM SECTORS OTHER THAN EDUCATION AND HEALTH

Collaboration with social actors in the community from sectors other than health and education emerged as another means by which CHWs and teachers address VAW/G. This form of collaboration is mainly limited to the referral of cases and rarely extends to more developed forms of collaboration such as recognized partnerships.

#### 6.1.3.1 TEACHERS WORKING WITH SOCIAL ACTORS OTHER THAN THOSE WITHIN THE HEALTH AND EDUCATION SECTORS

Teachers engage in collaboration with social actors working outside of the health and education sectors by working with social workers, law enforcement officers, community chiefs, religious leaders, and traditional healers. For instance, they accompany learners to the police stations and ask social workers to

visit some of their learners' homes. Notwithstanding these case-by-case interventions, teachers do not partner with these specific actors to address VAW/G or any other health and social-related issue on a community-wide basis. Teachers did, however, briefly mention the possibility of partnering with community or religious leaders to speak during community meetings or at church; however, this is not an avenue they often employ. Though the partnerships between teachers and these other actors do not seem to be especially well developed, they do extend slightly beyond a simple referral system.

> - [I] must take learners to police. When a girl tells me teacher this this is happening at home. I tell her I will tell no one but we must go to police so that she can report it. I take her in my car. I ask the principal if I can take this one and then take her to talk to the police. *(Teacher D, 39 yr. old, F.)*
> -Maybe then social workers go to the girl's house. I will speak to them and make them see that this one, she needs help in her house. This way the [social] worker can speak to the family. *(Teacher A, 35 yr. old, F.)*
> -Then there are churches. We can speak to local churches, [they] can include gender violence in their sermons or teachings. We can do this with them. *(Teacher B, 35 yr. old, M.)*
> -And even the community meetings. We can go there and speak to the community. We don't go, but we can. It is good if we do this so that the whole community will know you can do this violence here. *(Teacher C, 35 yr. old, M.)*

#### 6.1.3.2 CHWS WORKING WITH SOCIAL ACTORS OTHER THAN THOSE WITHIN THE HEALTH AND EDUCATION SECTORS

CHWs were found to collaborate with a more limited number of social actors than teachers, namely social workers, NGO-based counselors, and, on rare occasions, law enforcement officers. Aside from the collaboration route presented earlier where CHWs use other social actors as brokers to intervene within the education sector without the collaboration of teachers; collaboration between CHWs and these other community actors is mainly based on a referral system through which CHWs refer a case to social workers and request that they intervene directly within a household.

> Ya, sometimes we need to refer the person to a social worker or a psychologist, or maybe even the police. The social worker can go to the house if the family doesn't listen to me. They can tell them how to report abuse. *(CHW E, 40 yr. old, F.)*

> Then I say what else we can do? She says she doesn't know because she fears her husband because he always carries a gun with him. I say to her its better she report her case to social workers so they come and talk to your husband and so they know how long he has done this for. She says it's the way they are, he always acts [like] this but problem is now he always carries his gun. Then I advise her to make a decision that's going to be right for her and the safety of her children. She can even go to court but she'll have to start at the social workers to talk about it firstly. *(CHW C, 57 yr. old, F.)*

CHWs also often advise community members experiencing VAW/G in their homes to seek advice from social workers, and they encourage victims to report the violence to the police. CHWs rarely go directly to law enforcement officers to report the occurrence of violence in a home or to ask the law enforcement officers to intervene. According to the data extracted from my research journal, in their discussion of this particular collaboration path, CHWs spoke with confidence about asking social workers to intervene. However, they pointed out that they leave it up to the families or social workers to decide when the police should become involved.

### 6.1.4 SUMMARY OF COLLABORATIVE PATHS INVOLVING CHWS AND TEACHERS

Of all the collaborative paths discussed in this section, CHWs and teachers mainly rely on collaboration with social actors from outside of the health and education sectors to address VAW/G. Additionally; current collaboration between CHWs and teachers is quite informal and generally done on an ad hoc basis.

## 6.2 FACTORS INFLUENCING CURRENT COLLABORATION

During the group discussions and the drawing activity participants identified and discussed a number of factors they perceived as influencing their current collaboration with one another. The results presented here represent a picture of the findings that emerged from the data analysis. The first part of the fourth and final step of the analysis process involved listing the findings according to the hybrid framework presented in this manuscript. Although the factors are grouped

according to the categories of factors presented in the framework, the relationship between these factors and categories is discussed in the following chapter.

When placed alongside the six categories of factors from the framework, a number of findings were found to have relevance to multiple categories. Such overlap was to be expected given the way these categories are defined. Thus, while the categories of *opportunity* and *planning* are not explicitly outlined in the findings below, there are a number of findings in the other four categories that have relevance to these two categories as discussed in more detail in the following chapter. Following the same approach to presenting the findings as used in the preceding section, the table below maps out these four categories of factors and presents in parentheses the codes from which these categories emerged during the data analysis process.

**Table V - Factors Influencing Collaboration involving CHWs and Teachers**

<table>
<tr><th>Motivation to Collaborate</th><th>Capacity to Collaborate</th><th>Nature of the Relationship</th><th>External Environment</th></tr>
<tr><td>The actors' perception of their own role/responsibilities (IR, DIR, INDIR)</td><td rowspan="3">The actors' perception of their own influence (INF, IC, FIN)<br>• The actors' perception of their own status (STAT, SCH, HOME, COMM)</td><td>Status differential and power dynamics between actors (STATD)</td><td rowspan="2">Community's capacity to report violence (REP)</td></tr>
<tr><td>Perception of each other's capacity (EOC)</td><td>Actors' attitudes towards each other (REL, ATT)</td></tr>
<tr><td>Perception of potential rewards and presence of a shared goal (SG, REW)</td><td>Official recognition and support for collaboration (COMMU, TIME, INFO)</td><td>Community's capacity to enforce consequences on perpetrators (COMCAP)</td></tr>
</table>

### 6.2.1 MOTIVATION TO COLLABORATE

#### 6.2.1.1 THE ACTORS' PERCEPTIONS OF THEIR OWN ROLE/RESPONSIBILITIES

Through an analysis of the transcripts and drawings, the participants' perceived roles emerged as a factor influencing their motivation to collaborate. As would be expected given their different professional roles and responsibilities, the CHWs' and teachers' perceptions of their own responsibility to address

VAW/G were marked by a number of differences; however, a few similarities were also found to exist.

***The CHWs' Role***

The CHWs' illustrations and their analysis of them revealed that they perceived their role in addressing VAW/G, as well as other health-related issues in the community, to be a very important one. They saw their role as requiring them to act on two different fronts: first, to provide accurate health and human rights-related information to educate households; and second, to directly intervene within households to end violence and to promote community health and well-being.

For example, in *Drawing 1*, a CHW illustrated a situation of VAW/G within a family that she was called on to address. In this image, a woman returns from an ANC check-up where she has just been informed that she is HIV positive. The woman's husband reacts by threatening her and her unborn child's life using a knife while their eldest child watches. In *Drawing 2*[7], this same CHW illustrated herself visiting the household and educating the family about HIV and AIDS. When she analyzed her drawings with the group, this CHW described her role as a health-related educator in the following way:

> I am…going to teach them about HIV and AIDS so they can be enlightened. It doesn't mean that because the mother is positive that the child is also positive... I'll teach them what's happening so I can shed the light. *(CHW B, 32 yr. old, F.)*

7To preserve the anonymity of the family in question, the name included in drawing 2 has been crossed
out using a black line.


***Drawing 1***


***Drawing 2***

*Drawings 3* and *4* illustrate the CHW intervening more directly: having witnessed violence in a household, a CHW warns the husband to stop the violence and encourages the wife to report the violence. A participating CHW explained the situation depicted in this picture:

> I'm telling the husband not to beat his wife because he is going to be arrested. I tell the wife to report abuse and I warn the husband not to promote gender violence in the community. If one man beats his wife, then the other one is going to beat his too *(CHW C, 57 yr. old, F.)*


*Drawing 3*


*Drawing 4*

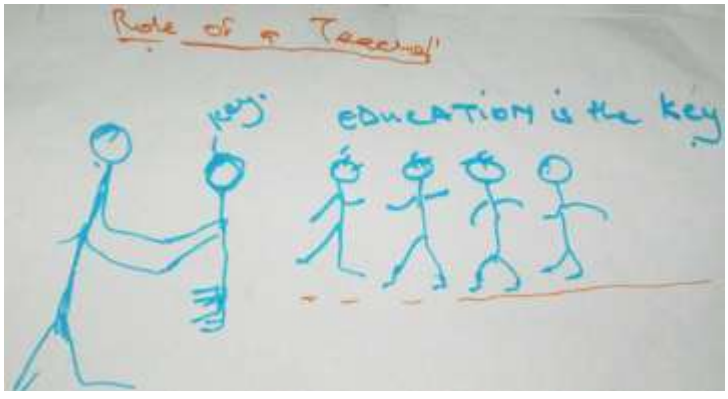
When asked to compare their drawings as a first line of analysis, the CHWs pointed out that all of their illustrated intervention scenarios take place within homes; a finding that prompted them to note that their role is primarily to act within the community households. More specifically, as was stated by one of the participating CHWs, their role is to act in the community, outside of formal health facilities.

> It's big problems, it's hard. Us being there [in the community] is help because we go to the house, we see the home…We come and advise, then the family is living nicely *(CHW B, 32 yr. old, F.)*

In addition to working within households, the CHWs mentioned their responsibility to educate the community in different settings despite not portraying this in their drawings. This included primarily speaking about VAW/G at schools in order to reach the community's youth. Through their drawings, the CHWs demonstrated their belief that addressing VAW/G is an integral part of their role: a role that they describe as very important. Overall, the CHWs showed a clear motivation to work in different settings and with different actors to build successful interventions addressing VAW/G.

***The Teachers' Role***

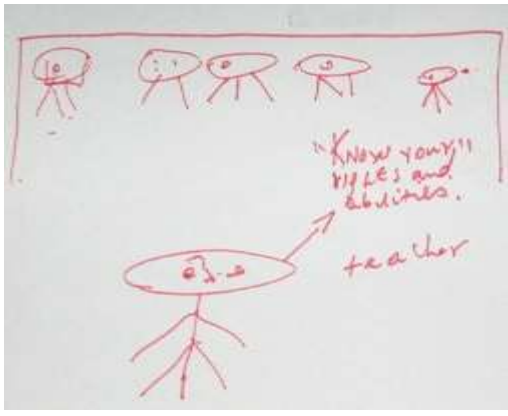
A central idea expressed in the teachers' analysis of their drawings was that education is the key to ending VAW/G. Through their drawings, as shown in *Drawing 5* and the quote that follows it, teachers demonstrated their belief that all forms of violence in general can be addressed and prevented through the education of the community and of the youth in particular.



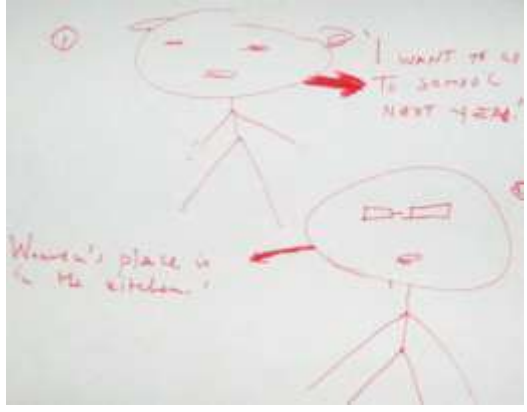

***Drawing 5***

> Here I've got a class and the teacher here, just telling [the students] about education, telling them that education is a key, so [the teacher] is holding a key. *(Teacher E, 49 yr. old, F.)*

According to the scenes of violence they depicted in their drawings, such as the one shown in *Drawing 6*, the teachers primarily linked VAW/G to the presence of gender inequalities and they believed that these inequalities can be eliminated through education (see *Drawing 7*).




***Drawing 6***



***Drawing 7***

The focus on education as a key means of addressing VAW/G might be taken to imply that teachers felt a strong sense of responsibility for addressing this issue. The general picture that emerged from the analysis, however, revealed that despite feeling some need to address VAW/G, teachers did not perceive this responsibility as an integral part of their role as secondary school educators. While not identifying VAW/G among their core responsibilities as educators, teachers did demonstrate feeling obliged to tackle this issue in their school due to a lack of alternative mechanisms for dealing with VAW/G, such as the lack of an on-site nurse. This sense of responsibility was further reflected through the teachers' analysis of their own drawings. Given that the drawings all depict them intervening in a classroom setting, during their discussion of the illustrations, the teachers only noted their responsibility to address VAW/G within the school environment.

> I've seen that teachers they tend to be flexible because they need to not [only] focus on teaching, but they also have to focus on being a police, being a social worker. You can name it, we do it. *(Teacher C, 35 yr. old, M.)*
>
> When I became a teacher, I discovered that you not only teach, you teach, you advise, you become a social worker, you become a nurse, you become everything by teaching. So now, I'm doing all that as a teacher, a social worker, everything, because this is what you need to do. We try to help, but we are not trained for that. You must use your teaching experience to try to accommodate, while teaching. *(Teacher D, 39 yr. old, F.)*
>
> - We are supposed to have someone in the school that will take care of these things. But we don't in our school there is no psychologists, there is no nurse, you name them, we don't have those, but we're supposed to have them. *(Teacher D, 39 yr. old, F.)*
> - I raised this issue with the people there from the [provincial education] department. I told them that we are working as teachers, and psychologists, and nurses, that you are sometimes a mother, you sometimes feed them, you are everything. So that they can give us one person, but nothing. *(Teacher B, 35 yr. old, M.)*

These quotes above reinforce the fact that teachers perceived addressing VAW/G as an obligation. The teachers conveyed the feeling that they have no choice but to intervene if they want matters to be resolved, in spite of believing that they may not be the most suitable actors to be independently conducting this type of intervention.

### 6.2.1.2 PERCEPTION OF EACH OTHER'S CAPACITY

The participants' perceptions of each other's capacity were found to influence their motivation to engage with each other in collaborative activities to address VAW/G. The CHWs perceived the teacher's capacity to be limited in relation to addressing health-related issues such as VAW/G. During group discussions, the CHWs pointed out that the teachers do not have the knowledge or capacity to effectively address health-related issues. They also pointed out that despite having this health-related knowledge, they as CHWs cannot offer support to the teachers in a formal way. While not being open to the suggestion that they could train the teachers, the CHWs did mention that they may be able to build the teachers' capacity in relation to health-related issues with the help of another social actor acting as a broker in this situation, as described in the discussion excerpt below. As recorded in my research journal, the CHWs discussed their relatively superior health-related expertise with confidence, laughing at the situation that renders them unable to educate the teachers due to their unwillingness to be trained by CHWs.

- They don't know! Maybe then, they don't accept [our help]. [But a CHW has] the knowledge to train the teacher...I don't think they [will] agree to be trained about [VAW/G] by us. I'm not sure...Here, we are talking about attitudes. *(CHW B, 32 years old, F.)*
- [It's] too difficult to train [a teacher with] a degree. No you can't have a CHW train a [person with a] degree. No it's too difficult...The teachers they don't want a CHW to train [them]. We can't train teachers. *(CHW F, 50 yr. old, F.)*
- We can't train teachers. We can't train them. Maybe we can talk to someone who is a professional to do this for us. *(CHW E, 40 yr. old, F.)*

In spite of their perceptions regarding the teachers' limited health-related expertise, the CHWs did acknowledge the general capacity of teachers to act within their community. As educated professionals with high social standing, the CHWs noted that the teachers have an influence in the community which they themselves lack. Overall, the CHWs demonstrated the belief that their own capacities and those of the teachers were complementary, and that they were generally motivated to collaborate with the teachers despite barriers that currently prevent them from doing so.

According to the teachers, the CHWs' capacity is among the most important factors influencing their collaborative relationship, with the teachers expressing concern about what they perceived to be the CHWs' limited capacity. These concerns influence the collaboration to the extent that teachers mentioned a reluctance to refer cases to CHWs, which is already among the most limited forms of collaboration.

> We don't know if they can. This is why we don't go to them. We don't know who they are and what they can do. Can they speak to police? Can they speak to women to make them go to police? *(Teacher D, 39 yr. old, F.)*

> When I called the health worker, she didn't come, she didn't come to the school to help. I don't think they can. They don't know how to help with a case…I don't think they can. *(Teacher B, 35 yr. old, M.)*

> If I need help with a learner I will call the social worker to come to the school, or I will go to the house. CHWs, I don't see what they can do to help. We need someone to come who can help, who knows how to help. *(Teacher C, 35 yr. old, M.)*

The perceptions that teachers have of CHWs are further reinforced by similar perceptions regarding CHWs amongst the community in general.

> It's like, in the community they say that the CHWs don't know how to act, they don't know how to keep things secret. It's an issue of confidentiality and they don't respect that. The community knows, and we know that these CHWs don't keep secrets *(Teacher D, 39 yr. old, F.)*

#### 6.2.1.3 PERCEPTION OF POTENTIAL REWARDS AND PRESENCE OF A SHARED GOAL

Ultimately, motivation to collaborate is influenced by the potential rewards from collaboration and whether the actors involved have shared goals. When asked directly about their goals, the teachers and CHWs seemed to have a shared goal that motivated their collaboration. Both the teachers and CHWs named their main objective in collaboration as bringing more effective services to the community to promote the health and well-being of adults, youth and children. Both teachers and CHWs also claimed that increased effectiveness in addressing VAW/G in the community is a primary reward of working together. CHWs in particular recognized that they have different strengths to the teachers and that

these two groups of actors can learn from one another through joint working. CHWs and teachers went on to state that the perceived rewards and presence of a shared goal are the main reasons they keep coming back to each other to work together, despite previous negative experiences and the major challenges that hinder their collaboration. The comments below illustrate these points.

> We are so very happy to work together with the teachers; we are gaining so much from working with the teachers because we learn so much from them. *(CHW E, 40 yr. old, F.)*
>
> It's so very nice to share the ideas especially [with] the teachers. The teachers are high level [educated]. We get more from the teachers about the [community's] challenges. (CHW E, 40 years old, F.)
>
> We get more knowledge from the teachers. And them, they get some knowledge from us because you can't say, I'm ok with this knowledge [I already have], you have to get [more] knowledge from another person. *(CHW B, 32 yr. old, F.)*
>
> With the CHWs we can be able to have a resolution of issues that [affects] the community and that [impacts] the school premises.*(Teacher C, 35 yr. old, M.)*
>
> If we work with the CHWs they will be able to take the cases we don't have time to address. It's good because we are all working together toward the same goal. *(Teacher D, 39 yr. old, F.)*
>
> We are all workers of the community because the children and these homes are the community...If I know a child has been raped, I can go to the teacher and ask the teacher how the child is doing at school. Likewise the teacher will say aunty...what are they saying at the child's [home]? *(CHW C, 57 years old, F.)*

### 6.2.2 CAPACITY TO COLLABORATE

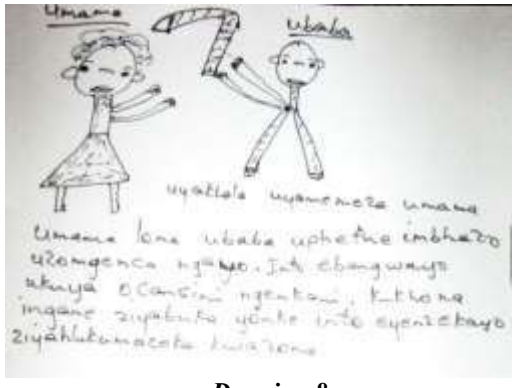
The drawings produced and analyzed by the study participants also provided insights into how the they viewed their own capacity to engage in collaborative activities to address VAW/G. For both CHWs and teachers, these data revealed a high level of perceived confidence in their capacity to successfully address this issue.

#### The CHWs' Capacity

During the presentation of their drawings, CHWs displayed tremendous confidence in their capacity to address VAW/G, both within households and the wider community. *Drawings 8* and *9*, produced by a CHW, illustrate a CHW

adopting a very direct approach to intervention. This drawing suggests that the CHW perceived herself as holding substantial influence in the community and having the capacity to affect change. The quote below is the CHW's explanation of the drawings.

> [I am] walking toward the house not knowing there is violence. I hear a noise, the mother is screaming...I hurry up and get into the house, so much violence in this house, I ask the father to put the axe down, I tell them that I'm calling the police, I take out my phone and threaten to call. He puts the axe away, we sit down and talk. Then he [apologizes]. (*CHW E, 40 yr. old, F.)*



***Drawing 8***

***Drawing 9***

The entry in my research journal relating to the presentation of these drawings further demonstrates this CHWs' confidence around her capacity.

> When presenting her drawings, she speaks with confidence about her capacity to walk into a home and put an end to the violence. She stands with one hand on her hip and the other pointing at the drawing. With a serious demeanor she acts out her entry into the home. She discusses this very direct approach to intervention as though it is effortless and routine. (*Research Journal Entry)*

Other comments made by CHWs demonstrating a high level of confidence in their capacity to successfully and directly intervene to end VAW/G included the following:

> If we come across fighting, we make peace. We just ask the husband to calm down. And then we sit down to talk, to solve the problem. We hear both sides of what they are fighting about. *(CHW C, 57 yr. old, F.)*

> We are using every skill; we've got counseling skills and other skills. We're going to sit down with them and tell them which is wrong, which is right. And we give them…the chance to speak. They are telling their problems. Then we give them a chance to take decisions. You are not going to take decisions for them. *(CHW B, 32 yr. old, F.)*

> If you are a, a confident worker, to speak with a, a family, you've got knowledge to help, for both sides. *(CHW E, 40 yr. old, F.)*

> I'm very important. Because I'm, I'm helping my community. And they will change because of me. *(CHW B, 32 yr. old, F.)*

In addition to the CHWs' capacity to address violence in a direct manner, these actors' drawings also demonstrated their ability to address VAW/G using an indirect approach. Through their drawings and discussion, CHWs noted that they sometimes choose to intervene in a violent situation by tackling the broader situational factors that lead to the occurrence of violence in households. During the first group discussion, CHWs identified the lack of knowledge relating to HIV and AIDS, disagreements regarding household financial planning, the presence of food insecurity, and traditionally defined gender norms that are based on gender inequalities as situational factors that commonly lead to the occurrence of violence. An example of this is given in the following passage which describes the situations portrayed in *Drawings 10* and *11*:

> ... the father gets back from the tavern [and] he asks for food. The mother replies there is no food I didn't cook anything tonight....I [the CHW] came there and the mother had already been beaten...Then I said the mother mustn't cry, instead of them not eating at night they should go to the garden to get spinach boil it and eat. *(CHW D, 46 years old, F.)*

***Drawing 10***

***Drawing 11***

Interestingly, as the data collection process progressed, the CHWs' confidence in their capacity to address violence directly and indirectly seemed to diminish. Potential reasons for this diminishing confidence are further discussed in later chapters of this manuscript.

***The Teachers' Capacity***

Similarly to CHWs, teachers also expressed confidence in their ability as social actors; however, according to the entries in my research journal, their perceived capacity came through in a more understated way. Although the teachers did not explicitly discuss this point, a number of observations revealed through the analysis of transcripts that they have a certain level of confidence with regards to their influence in the community, which is one determinant of their capacity. First, in contrast to CHWs who emphasized this issue during later group discussions, the teachers did not discuss the fact that they lack influence or status in the community at all. Second, as noted in my research journal the teachers displayed a great deal of confidence in their interactions with each other, with the CHWs, with me as the research facilitator, and most importantly, with the learners within the school's environment. This observation was further evident following the analysis of the teachers' drawings, which portray themselves as important actors who are much larger than their pupils or who are confidently pointing to a blackboard in front of a room of learners (see *Drawings 12* and *13* below).

***Drawing 12***

***Drawing 13***

Despite such illustrated confidence in their influence, the teachers did explicitly acknowledge certain factors that limit their capacities to address VAW/G. Most notably, they expressed the feeling of lacking the opportunities and health-related expertise to effectively address this issue.

> It's a strange thing to try to make sure you integrate and identify social issues, because you want to focus on academics and then the health issues need to be dealt with. *(Teacher B, 35 yr. old, M.)*

> I think that, the role is a big one that is played by teachers. To identify learners that need help that is very important because we're looking at the number that we have, it's about 53 or 60 [students] in one class. To identify anything like abuse it's a huge problem. *(Teacher C, 35 yr. old, M.)*

> The problem is that we don't have the time to just identify these learners [who need help], we try but, we don't have enough time. *(Teacher D, 39 yr. old, F.)*

#### 6.2.2.1 THE ACTORS' PERCEPTION OF THEIR OWN INFLUENCE

Findings from the group discussion transcripts point to the participants' influence as a factor that affects their capacity to collaborate. While CHWs perceived their influence to be limited, teachers recognized that they have considerable influence in the community. The CHWs' concerns regarding their limited influence were discussed on numerous occasions throughout the data collection phase. Teachers, on the other hand, had relatively little to say about this factor. In all, twenty meaningful units relating to influence were coded from CHW discussions, compared to only five meaningful units that were coded from the teachers. It is important to note that this factor was not discussed at the start of the data collection activities, nor during the group discussion which brought the group of CHWs together with the teachers. CHWs only discussed this factor during the third and fourth discussion sessions in the absence of teachers.

Findings show that CHWs perceived their influence as being limited to educating and advising members of the community. They noted a number of examples where despite their best efforts, the advice and information they provide to families do not translate into action, mostly when it concerns addressing sensitive issues such as the presence of VAW/G within a household.

CHWs are typically not taken seriously when they suggest reporting abuse, fighting for ones' own rights or pursuing legal action against a perpetrator of violence. Additionally, CHWs pointed out that even when they provide accurate information about people's rights and the steps required to end violence in a household, most families do not trust this information. Thus, even though families are generally quite welcoming to them, CHWs noted that it can be very difficult for them to address VAW/G due to their lack of influence in the community.

> They [the victims] don't understand their rights. Even, you're going to tell them, maybe they thought you are telling something from your [own imagination]...They don't believe you; they think you're making it up. Unless you've got the book [of rights] and you say look here. *(CHW B, 32 years old, F.)*
>
> - It is not difficult to talk to them, but they don't listen to us. The main problem is that you can talk, talk, talk, and after they still don't listen. *(CHW C, 57 yr. old, F.)*
> - We don't know why they don't listen. But especially the youth, they don't listen at all. *(CHW E, 40 yr. old, F.)*
> - As I said, it's not hard when we are talking, but it's difficult when the violence has already happened because then they don't want to report the violence and they don't listen to us. *(CHW C, 57 yr. old, F.)*
>
> The thing is that if that happens [if there is abuse in their family] they can't do what I tell them to do. They, just keep quiet. They say no, no, no, don't talk to me. Or when I'm talking to them, they close their ears, they listen and we talk and we laugh. But, if there is abuse, even with what I have been telling them about happens, they can't take any action. *(CHW A, 45 yr. old, F.)*

As mentioned earlier, this factor was discussed far less frequently by teachers who perceived themselves as having considerable influence in the community and a great deal of influence within the school's boundaries – their primary intervention environment.

**The actors' perception of their own status**

The actors' status within the community was identified as an important factor affecting their influence and, therefore, their capacity. The teachers associated the influence they hold, both within the school and the wider community, with their level of education. In relative terms, they recognized themselves as being among

the most educated actors within the community because they hold a university degree. This education and their recognized professional role were acknowledged by teachers to confer a certain level on status on these actors from which their influence was derived.

Conversely, in the CHWs' brief discussion about their status, this factor was presented as an important barrier undermining their capacity to serve as social actors. CHWs perceived themselves as having a low social status, which they mainly attributed to the lack of recognition from the health sector and the system that governs it. They also noted that the environment in which they work influences their status as social actors in the community. In comparison to nurses who work in formal healthcare institutions and teachers who work within schools, CHWs perceived the informal setting of their work in community households as undermining their social status and ultimately their credibility and influence.

> I think the CHW is not a high standard [status], CHW work in the community and the teachers are working in the schools. The level of work is not the same you see. *(CHW E, 40 yr. old, F.)*
>
> But at the end of the day we are not recognized, even at the government. I don't know why, because we are so important. *(CHW C, 57 yr. old, F.)*
>
> The department of health needs to recognize community health workers so that we can do our work *(CHW B, 32 yr. old, F.)*

### 6.2.3 NATURE OF THE RELATIONSHIP

#### 6.2.3.1 STATUS DIFFERENTIAL AND POWER DYNAMICS BETWEEN ACTORS

A major factor influencing the nature of the relationship between CHWs and teachers are the power dynamics between these groups of actors, which act as a barrier to the formation of positive relationships between them. The power dynamics between these groups of actors are primarily defined by the presence of a clear and considerable status differential between CHWs and teachers, some of the reasons for which have already been mentioned. When brought together

during the second group discussion, this differential was apparent in the way that the CHWs and teachers interacted with one another. Additional data extracted from my research journal for the most part pointed to the CHWs as being quiet and yielding the conversational floor to the teachers during the discussion. When invited to vocalize their thoughts, the CHWs answered with hesitation and with short responses. Teachers, on the other hand, were the primary voice during this common group discussion, expressing their thoughts freely. This difference between CHWs and teachers implies that they are likely to engage in collaboration on an unequal footing and collaboration is thus hindered by an underlying power struggle.

#### 6.2.3.2 ACTORS' ATTITUDES TOWARDS EACH OTHER

The nature of the relationship between these two groups of actors is further affected by the actors' attitudes towards each other. The teachers were especially concerned about whether CHWs could be trusted as collaborative partners. In particular, teachers expressed the belief that CHWs lack the professionalism to maintain confidentiality where it is necessary.

- No, not now, [we don't work with them] because we don't know each other, there needs to be trust. *(Teacher D, 39 years old, F.)*
- Right now, we don't know, we are not sure about their status in terms of training...the issue of personality, confidentiality and all that...But, if the case needs be, we need to refer to them, because on a serious note, our power is within the school premises. *(Teacher C, 35 years old, M.)*

Teachers also voiced a concern about the CHWs living in the community in which they serve. Given that they don't trust the CHWs to keep information confidential, the teachers considered the fact that CHWs live in the community in which they to be a major issue.

> They live here. They know everyone and don't keep the secrets of the families. They tell everyone. *(Teacher C, 35 yr. old, M.)*

> Here they come to a house and see problems and then they just gossip. They tell the neighbors what they have seen. This is the problem because they don't keep quiet. It's a question of personalities. They don't have the right personalities.*(Teacher D, 39 yr. old, F.)*

> It is better if CHWs are from the next community and come here. Like this we know that our neighbor will not know that we are sick, or have violence because of them. *(Teacher E, 49 yr. old, F.)*

As seen in the quotes above, the teachers all stated that they would be more comfortable working with CHWs who do not live in the community they serve. Findings show that the teachers often bypass collaboration with CHWs all together and opt to work with other social actors who have higher status in the community and also who they feel can be trusted.

> In that case, we counsel [the learners] and sometimes we take them to social workers, to those who are above us. Like, if we need police, we just take them to the police. *(Teacher A, 35 yr. old, F.)*

> We can speak to the police officers or the nurses who can help us with a case. CHWs too, but the nurses and social workers can help more. *(Teacher D, 39 yr. old, F.)*

The CHWs' attitudes towards the teachers were recorded to be largely influenced by how they think the teachers perceived them. In particular, the CHWs voiced concerns around the fact that teachers do not fully appreciate their role or capacity, which created among CHWs a somewhat negative attitude towards teachers.

#### 6.2.3.3 OFFICIAL RECOGNITION AND SUPPORT FOR COLLABORATION

CHWs and teachers also suggested that the health and education departments' lack of recognition and support for this collaboration is a key factor influencing their ability to collaborate with one another. This lack of recognition and support is said to have a number of detrimental effects.

Teachers noted that the current lack of acknowledgement from the participants' departments prohibits them from formalizing and further developing the ties between themselves and the CHWs, which was perceived to be a barrier to collaboration. In particular, both the groups of CHWs and teachers said the lack of formalization limited joint working opportunities. The teachers felt that

the lack of formalization limits their ability to schedule sufficient time to work with CHWs.

> - So, it's the matter of the information that we don't have. If they [the departments] were to help, because I think if the issue of money could be solved, then, then the local government can come in and can give the money or the fare to the health workers so that they can go to visit the homes of the victims that we see. I think the local government must come because there are departments who deal specifically with such issues. *(Teacher B, 35 yr. old, M.)*
> - I think the local government must come…starting from the national, provincial departments who deal specifically with such issues. And [the problem] needs money. *(Teacher C, 35 yr. old, M.)*

> The information must be made, you know how to [say it], but it must be, those who are the policy makers, the departments, must be the one who must allocate time for us to get us to…meet, yes. Because we are working according to the time which is planned by those people [the departments]. Because they are saying it at random that we must [collaborate] but it's not planned, but there's no time allocated. *(Teacher A, 35 yr. old, F.)*

Additionally, CHWs noted that the current lack of support from the departments has created an environment in which they do not feel comfortable initiating collaboration with teachers. The absence of scheduled meetings between teachers and CHWs was itself cited as a problem because such meetings are an important means of improving communication. According to both the CHWs and teachers, improved communication would lead to further formalization of the collaborative process and make joint working more effective. Furthermore, the teachers specifically identified the need to improve communication in the hope that increased communication would lead to a better understanding of each other's roles, capacities, strengths and weaknesses.

> Now, there's no communication. If we've got their numbers, then maybe we know where they stay, and then it's easy because we can call them and say please come. But we need more communication. *(Teacher E, 49 yr. old, F.)*

> We are talking about communication. We can make an appointment with the teacher. It is so that we can learn who they are and speak to them often to see how the learner is doing. *(CHW E, 40 yr. old, F.)*

> Yes, we must talk to each other more so that the teacher can come to me and say, sister in this class there is a problem, can you help him/her. *(CHW D, 46 yr. old, F.)*

> If we knew them it would be easier. We don't know them. We don't talk to them at if we could talk to them, like have their numbers and call them, we could know them more and be able to know when to call them to come to the school. *(Teacher C, 35 yr. old, M.)*

### 6.2.4 EXTERNAL ENVIRONMENT

A number of factors that stem from the community as a whole were identified by CHWs and teachers as influencing their collaborative activities to address VAW/G. These factors included the community's capacity to report VAW/G and the community's capacity to enforce consequences on perpetrators of VAW/G as presented below.

#### 6.2.4.1 COMMUNITY'S CAPACITY TO REPORT VIOLENCE

According to the discussion between CHWs and teachers that took place during the joint group discussion, the presence of a community-based system for reporting acts of violence has a considerable influence on the actors' capacity to successfully address VAW/G in the community. Current community mechanisms for reporting VAW/G were said by participants to be under-developed and in need of considerable improvement. This problem is partly related to attitudes towards VAW/G in the community, hesitation to report VAW/G, and a lack of awareness regarding individual rights. According to CHWs and teachers, these issues are compounded by the fact that police stations, where victims typically report abuse, are unsafe, with law enforcement officers sometimes being perpetrators of violence themselves.

> [The families] don't report violence. They don't go the police to say here there is violence. They just keep quiet. This is a problem because even when I say you must report the violence, they don't listen. *(CHW E, 40 yr. old, F.)*

> The system for talking about violence, for reporting it to the police must be better. It isn't enough for people to want to report the violence, they must also have a place to go to do this. *(Teacher B, 35 yr. old, M.)*

> I'll specifically say that police are perpetrators, because sometimes, when they, when one of the community come and, and report some cases, they might find that they [the police] just sleep around with that person. So, that is another point. *(Teacher C, 35 yr. old, M.)*

> Ya, the police, they are perpetrators in terms of abusing them, the very same victims coming to report *(Teacher B, 35 yr. old, M.)*

The teachers noted that this lack of a proper reporting system is among the reason why they are required to address VAW/G outside of the school environment. They voiced the belief that if the system was stronger and if members of the community used this system to report acts of violence effectively, they wouldn't need to intervene outside of the school to address VAW/G.

#### 6.2.4.2 COMMUNITY'S CAPACITY TO ENFORCE CONSEQUENCES ON PERPETRATORS OF VAW/G

The community's capacity to enforce consequences on perpetrators of VAW/G also has a notable influence on the work of CHWs and teachers. As with the weakness of reporting mechanisms, findings show that this factor is more of a concern for CHWs then teachers; teachers only mentioned this issue as a result of CHWs' prompts during the common group discussion.

In this regard, the participants focused on the capacity of the law enforcement and legal systems in Vulindlela to enforce consequences on the perpetrators of VAW/G. Both CHWs and teachers stated that perpetrators are often arrested after victims report violence and are then released back into the community a few days later. Specifically, the CHWs mentioned that the law enforcement officers sometimes 'loose' or 'misplace' the documents necessary to pursue legal action against perpetrators after which they send the perpetrators back to their households without further sanction.

> - Oh, sometimes, the victims report the case to the police. And the police arrest that person. Tomorrow he [the perpetrator] is out. That is why [the community], they don't care about reporting. *(CHW C, 57 yr. old, F.)*
> - When you follow up the case with the police, the docket gets lost and the case no longer exists. *(CHW E, 40 yr. old, F.)*
>
> A mother tells me she report to police and they took my husband. But some days later, the mother tell me that he has come back and he is violent still. She tells me, going to police doesn't help, it's very bad now. *(CHW A, 45 yr. old, F.)*

According to the CHWs this situation presents a number of challenges. CHWs are often required to intervene repeatedly within the same household as perpetrators return to their homes and continue the cycle of violence once released. Not only does this re-entry of perpetrators create inefficiencies and reduces the credibility of CHWs as social actors (the consequences of which are mentioned above), but CHWs are also exposed to a serious risk of violence while working in these households.

> When the husband comes out of the police, he is back in the house so I can't go back because they will not listen to me. They will not report abuse again. I can't work in this house anymore. *(CHW A, 45 yr. old, F.)*
>
> It's not safe to talk about this. The families they don't listen and when nothing is done the violence don't stop. *(CHW E, 40 yr. old, F.)*
>
> Then I will tell the teacher that we should not involve ourselves in this issue because we will get beaten up if we talk about it. The parents just deny the whole thing. *(CHW C, 57 yr. old, F.)*

## 6.3 SUGGESTIONS FOR IMPROVING THE COLLABORATION

Based on the data extracted from the discussions between CHWs and teachers, four components were identified through the analysis process as ways of improving the current state of collaboration between these actors. This approach is outlined in table VI (p.110) below which displays the four components and the codes from which these components emerged during the data analysis process. Though there are other means of improving their collaboration, those described below were the only ones extracted from the data I collected and therefore demonstrate the participating actors' perceptions regarding ways to improve their collaboration.

**Table VI - Participant suggested improvements**

| Improving the actors' capacity to collaborate | Improving the actors' interpersonal relationships | Improving the formalization of the collaboration | Improving the community's capacity to address VAW/G |
|---|---|---|---|
| (WWSC, ICC, IREF) | (ICOMMU, IREL, IOPP) | (FOR, ICC, IINFO, ISUP) | (CHAN) |

### 6.3.1 IMPROVING THE ACTORS' CAPACITY TO COLLABORATE

By improving their capacity to collaborate, the study participants discussed the potential for actors to address VAW/G while still working within the scope of their roles as defined by their mandates. This strategy was mostly discussed by CHWs, who talked about it as a means of getting their work done without disturbing the status quo. For example, CHWs specifically discussed how to work with teachers without moving beyond the realm of their acceptable intervening role (see excerpt below).

- Ok, so if we didn't say that we are going to train them…not a training. Then we can say a discussion. CHWs and teachers will discuss. *(CHW B, 32 years old, F)*
- Ya, they will find the knowledge [through] us there in the discussion. *(CHW E, 40 yr. old, F)*
- And we are going to tell [the teachers] that we [are] going to take your knowledge, you give me your knowledge. *(CHW B, 32 years old, F)*
- Ya, but in the end, they will gain more from us. *(CHW E, 40 yr. old, F)*

While the teachers agreed that collaboration is necessary, they expressed a firm belief that instead of turning to CHWs, it is better for them to collaborate with social actors with a higher social status than themselves so that their collaborative activities would hold more influence in the community.

> In that case, we counsel [the learners], sometimes we take them to social workers, to those who are above us. Like, if we need police, we just take them to the police. *(Teacher A, 35 yr. old, F.)*

> Ya, we ask the ones who have influence to come to the school. We ask nurses and the FAMSA[8] counselors. *(Teacher D, 39 yr. old, F.)*

[8]FAMSA is a South African Non-profit Organization that functions nationwide to provide support in community development, counseling, training, and education to South African communities and families.

> When we need help for a learner, we must call the nurses or social workers. They will know what to do and they can speak to the police if need be. They can do this because the community, they will listen to them. *(Teacher C, 35 yr. old, M.)*

### 6.3.2 IMPROVING THE ACTORS' INTERPERSONAL RELATIONSHIPS

The teachers identified the need to improve the current state of collaboration by first improving their interpersonal relationships. In response to their concerns regarding the CHWs' capacity and influence, and their concern regarding 'who' the CHWs are as actors, the teachers primarily focused on the need to develop greater trust and familiarity between themselves and CHWs.

> We must know the community health workers, to have a good working relationship to refer cases. And that is what, that is what we have been talking about *(Teacher E, 49 yr. old, F.)*

> We said that the educators must know the CHW. There must be that interrelationship with them. *(Teacher B, 35 yr. old, M.)*

Therefore, the discussion about this avenue of improvement mainly revolved around the need for the actors to become better acquainted with one another as a means of improving their relationship.

### 6.3.3 IMPROVING THE FORMALIZATION OF THE COLLABORATION

The participants identified the need to formalize their collaboration. From the teachers' perspective, they voiced the need to set aside time for meetings and joint planning sessions. Though the opportunity for regular meetings was said to be limited by issues such as time and logistical constraints, both CHWs and teachers agreed such an improvement was necessary for successful collaboration in the future.

Finally, despite acknowledging the need for more formal collaborative efforts, the means by which such formalization could be achieved was hardly discussed by participants. Rather than discussing how they themselves could develop more formal relationships, the participants pointed to the need for

improved support from the sectors they represent. The CHWs pointed to the need for the health sector to recognize their role so that they could increase their social status and influence with regards to both the general community and the teachers. The CHWs noted that this recognition could be achieved in a number of ways, such as through improved compensation for their efforts; recognition of the importance of their role in the communities; and through formal, rather than contract, employment.

- Ya, but at the end of the day we are not recognized, even at the government. I don't know why, because we are so important, we are at the houses. We go house to house and see the problems. Even the Sisters at the clinic they don't know the problems. *(CHW C, 57 yr. old, F.)*
- The Department of Health needs to recognize community health workers *(CHW E, 40 yr. old, F.)*
- And also what they call the stipends. Also we don't have a salary, we have a stipend. *(CHW F, 50 yr. old, F.)*
- We are not registered or employed…it's a contract. *(CHW E, 40 yr. old, F.)*
- It's not permanent, it's a contract. *(CHW C, 57 yr. old, F.)*
- I don't know why the government won't recognize us. *(CHW F, 50 yr. old, F.)*

Similarly to CHWs, in their discussions, the teachers pointed to the need for the education sector to recognize the importance of this collaborative initiative and to ensure that it takes place. According to the teachers, this involves having the education sector recognize that collaborative efforts are part of a teacher's role along with the formal integration of health-related topics into the school curriculum. In addition, the teachers noted that the education sector needs to allocate time to teachers' schedules to work with CHWs and other social actors outside of the classroom and to provide teachers with the support to formalize their collaborative efforts.

> We need time to do this. Our [education] department must do this for us. They must make the time for us to work with others. Maybe they can add it to the books, to the teaching plan. *(Teacher E, 49 yr. old, F.)*

> Maybe they can add it to the year learning outcomes. This way we can teach about gender violence in the class. And people can come talk to the learners in school because it will be part of the curriculum that we have. *(Teacher B, 35 yr. old, M.)*

Both CHWs and teachers expressed that the main source of support should come from macro-level collaboration between the education and health sectors and their policy makers.

### 6.3.4 IMPROVING THE COMMUNITY'S CAPACITY TO ADDRESS VAW/G

Despite not being identified as the primary channel for improvements by the study participants, changing the wider community context was discussed as a key avenue for future improvements by CHWs and teachers alike. In particular, the participants identified the need to improve the context in which violence is reported within the community by enhancing the systems through which victims can report violence, and better enforcing consequences for perpetrators. Despite these recommendations, the participants did recognize that the efforts required to change the context in which they work extend beyond the scope of their influence and would require structural changes within the legal and law enforcement sectors. For this reason, teachers identified the need to improve their collaboration with social actors in the community other than CHWs. The teachers felt that their collaboration with actors in the community should not be limited to working with CHWs; therefore, improving their ties with other social actors such as nurses, social workers, traditional healers, community leaders and law enforcement officers was voiced as necessary in order to have a wider impact in the community and effectively address VAW/G. Despite their interest in such collaboration, the teachers did not discuss details of how they could improve these partnerships.

## 6.4 RELATIVE IMPORTANCE OF FINDINGS

As discussed earlier in this chapter and displayed in table VII (p.114), while a number of similarities were found between the CHWs' and teachers' perceptions of their efforts to collaborate to address VAW/G, there were also some noteworthy differences among what they chose to emphasize during group discussions within this study. Through the enumeration of codes, a portrayal of

what the CHWs and teachers' perceived as most important began to emerge. table VII (p.114) provides a summary of the most emphasized components and thus the relative importance that the CHWs and teachers attributed to them. Additionally, the text that follows provides a description of the main differences displayed in this table.

**Table VII - Relative Importance of Findings According to Participants**

| **Relative Importance According to CHWs** | | |
|---|---|---|
| **Collaborative Paths** | **Factors** | **Avenues for Improvement** |
| CHWs working with social actors other than those in the education and health sectors, such as social workers and police officers. | Actors' perception of their own influence and status | Improving the collaboration involving social actors other than CHWs and teachers |
| Use of other social actors to conduct cross-sector interventions. | The actors' perception of their own role/responsibility | Improve community's capacity to address VAW/G |
| | Status differential and power dynamics between actors | Improve the actors' capacity to collaborate |
| **Relative Importance According to Teachers** | | |
| **Collaborative Paths** | **Factors** | **Avenues for Improvement** |
| Teachers working with social actors other than those working in the health and education sectors, such as social workers, police officers, religious and local government leaders, and traditional healers. | Actors' attitudes towards each other | Improving the collaboration involving social actors other than CHWs and teachers |
| Referral of cases to other social actors, including but not limited to CHWs | Community's perception of the actors' roles and capacity | Improve community's capacity to address VAW/G |
| | Perception of each other's capacity | Improve interpersonal relationships between actors |

### 6.4.1 KEY COLLABORATIVE PATHS

The enumeration of codes relating to the CHWs' and teachers' current paths of collaboration show that collaboration with actors other than each other is the most important type of collaboration they currently take part in. However, CHWs also emphasized conducting cross-sector interventions by acting within the education sector during the discussions and therefore this path is ranked second among their most important collaborative paths. This combination is interesting as it points to the CHWs' use of other social actors, such as social workers, as

brokers to facilitate their interventions within schools. Though teachers also emphasized collaboration with other social actors as their most important collaborative path, they also highlighted the importance of a referral system as a second main collaborative path.

### 6.4.2 KEY FACTORS INFLUENCING THE COLLABORATION INVOLVING TEACHERS AND CHWS

The differences between what CHWs and teachers perceived as the key influences on their collaboration reveal a noteworthy finding. Although the CHWs primarily emphasized their individual capacity among the most important factors influencing their collaboration with teachers, the teachers allocated more importance to interpersonal factors.

That is, CHWs perceived their own influence, status and role/responsibility as defining factors influencing their capacity to collaborate and highlighted the status differentials and power dynamics as a third factor of importance. That is, CHWs were primarily concerned with their own capacity to act and how this capacity influences their potential for collaborating with teachers. In contrast, teachers focused on the CHWs' capacity to collaborate and the relationship that define their collaboration with one another. The specific factors most emphasized by the teachers according to the findings from the enumeration of codes were the CHWs' personalities, the CHWs' capacity to act as social actors and to engage in collaboration, and the community perceptions of the CHWs' roles and capacity.

### 6.4.3 KEY AVENUES FOR IMPROVEMENT

The CHWs and teachers emphasized common paths for improvement, such as the need to improve collaboration involving social actors other than CHWs and teachers, and the need to improve the community's capacity to address VAW/G. However, one difference was present among the key avenues for improvement. Data from teachers pointed to the need for improving the interpersonal relationships between actors, whilst data from CHWs highlighted the need for improving their own capacity. Similarly to the previous section, this difference

partly illustrates the fact that the teachers saw their engagement with CHWs as a key issue that requires attention, while CHWs were concerned about improving their own capacity to effectively collaborate with teachers.

# CHAPTER 7:
# DISCUSSION

The objectives of this study were to document the current state of CHW-teacher collaboration and to identify ways in which this specific collaboration could be improved. This chapter is structured according to these two main objectives, with the first part of the chapter discussing the he findings that relate to the current state of collaboration and the second part discussing the findings that relate to suggested improvements.

## 7.1 DOCUMENT THE CURRENT STATE OF CHW-TEACHER COLLABORATION

### 7.1.1 CURRENT COLLABORATIVE PATHS INVOLVING CHWs AND TEACHERS

Collaboration involving teachers and CHWs takes place through three distinct paths: multisectoral action between the health and education sectors involving CHWs and/or teachers; intrasectoral collaboration involving CHWs or teachers; and multisectoral action involving actors from sectors other than education and health.

On the spectrum of collaborative work outlined by MacIntosh and McCormack (2001), the current collaboration between CHWs and teachers is more characteristic of MSC than of ISC, as most cross sector action involves these actors working independently from one another within each other's sectors. Although these actors sometimes refer to each other for support, this type of collaboration is poorly developed and seldom occurs, particularly in comparison to the many other types of collaboration and cross sector action these actors engage in to address VAW/G. This understanding that ISC between CHWs and teachers is still in its formative stages has two implications. First, close attention must be paid to the factors associated with initiating collaborative activities, such as motivation and opportunity. Second, the possibility that it may be better not to proceed with promoting ISC must be considered (Harris et al., 1995).

Despite the participants acknowledging the need for collaborative engagement to address VAW/G, there are no well-defined systems to guide such collaboration. Consequently, the CHWs and teachers engage in a wide variety of unplanned, informal collaborative activities with a range of community-based social actors. Though it has been acknowledged that different levels of formalization may be appropriate given different collaborative contexts (Harris et al., 1995), the current lack of formalization was identified by participants as a barrier to the effective functioning of their collaborative systems. The implications of this lack of formalization will be expanded upon later in this chapter.

The different emphasis placed on specific collaborative paths by teachers and CHWs highlights another important point. The two collaborative paths most emphasized by CHWs were collaboration with social actors other than teachers and cross sector interventions in the education sector that do not involve teachers. This combination of paths implies that the CHWs use their collaborative relationships to surmount the barriers that prevent them from engaging directly within the education sector to address VAW/G. That is, they perceived collaboration with other social actors as a means of becoming more actively engaged with the education sector to address VAW/G. That CHWs make these efforts to engage with the education sector despite the barriers preventing them from doing so illustrates that they are relatively motivated to initiate such collaboration. In contrast, after collaboration with social actors other than CHWs, teachers place the second most emphasis on the use of a referral system. Thus, the teachers see collaboration with social actors other than CWHs as a means of becoming less actively involved in addressing VAW/G. In part, these attempts to defer the responsibility for addressing VAW/G to other social actors illustrate the teachers' lack of motivation to address this issue. The teachers` and CHWs` motivations for engaging in ISC are further discussed in the subsequent section.

### 7.1.2 FACTORS INFLUENCING COLLABORATION BETWEEN CHWs AND TEACHERS

#### 7.1.2.1 MOTIVATION

Motivation is a fundamental aspect of collaboration, especially, though not exclusively, in relation to the initiation of collaboration (Harris et al., 1995). Given that CHWs and teachers in Vulindlela are yet to properly initiate collaborative working, an analysis of this factor is particularly important. Although previous research has examined collaboration between these groups of actors in Vulindlela, the motivation of these actors to collaborate was not explicitly analyzed (De Lange et al., 2011). Without any evidence, we have no reason to believe that teachers or CHWs in Vulindlela are motivated to collaborate with each other to address VAW/G.

In this section, I analyze the actors' incentives to collaborate using the three step process outlined in the framework. With regards to their motivation to address the issue, CHWs strongly emphasized addressing VAW/G as an important part of their core responsibilities, suggesting that they are highly motivated to address this issue. CHWs believe both that VAW/G is important and that they are responsible for addressing it at the community-wide level, including in schools and homes.

Although initially displaying a strong sense of belief in their professional capacity, the CHWs ultimately expressed a lack of confidence in their ability to address VAW/G. Given their claims that this lack of capacity is deeply rooted in social constructs of status and power, the CHWs' limited capacity was seen as a major constraint undermining their ability to address VAW/G. This constraint was also taken to be one that the CHWs themselves could not influence.. In contrast, the CHWs recognized the potential gains of collaborating with other social actors to address VAW/G. Thus, we would expect CHWs to view collaboration as a relatively more effective means of addressing VAW/G than working alone.

Finally, while the CHWs' relationships with teachers are often characterized by mistrust and negative perceptions, the CHWs still viewed the teachers as potentially valuable collaborative partners. In particular, despite mentioning that teachers lacked health-related expertise, the CHWs were also very aware that the teachers have a much greater influence in the community than themselves and that this influence enhances the teachers' capacity as social actors. Thus, the economic and sociological analysis of CHWs' motivation to collaborate with teachers illustrates that there are conflicting forces influencing their motivation (Gazley, 2010). On the one hand, the CHWs perceived the teachers to have resources that are scarce and complementary to their own resources; on the other, the CHWs have a non-utilitarian preference not to collaborate with teachers. The CHWs also expressed positive sentiments regarding the shared goals and expected rewards of their collaboration with teachers.

Overall, the CHWs' comments suggested that while their collaborative relationship with teachers is marred by some difficulties, they have a strong incentive to collaborate with teachers to address VAW/G. It is possible that a desirability bias may have influenced the CHWs' responses; however, the consistency of the findings regarding their motivation suggests that CHWs are genuinely motivated to engage in this collaboration.

On the other hand, the findings regarding the teachers' motivation to collaborate are somewhat contradictory. With regards to their motivation to address VAW/G, the teachers do not see addressing VAW/G as part of their core responsibilities. While there are times when they take responsibility for addressing this issue, such a responsibility is only taken on because other channels for addressing these cases are either non-existent or ineffective. That is, teachers feel obliged to address VAW/G because of the constraints of environment in which they operate. Furthermore, this obligation to address VAW/G is largely limited to the school context.

With regards to their general motivation to collaborate, teachers recognized the value of collaborative activities in addressing this issue. They expressed a relatively nuanced awareness of the limitations of their capacity to address VAW/G, most notably in terms of their limited health-related expertise, and had a favorable view of the potential benefits of collaboration. Therefore, it is expected that teachers perceive collaborative activity as a more effective means of addressing VAW/G than working alone.

Finally, the teachers expressed mostly negative perceptions of CHWs as collaborative partners and showed a strong preference for collaborating with social actors other than CHWs to address VAW/G. In this case, both the economic and sociological analyses of teachers' motivations to collaborate with CHWs are consistent (Gazley, 2010). From the economic perspective, the teachers' reluctance to collaborate with CHWs stems from their perception that the CHWs' lack of capacity means they have little to contribute to collaborative work. From the sociological perspective, the teachers also expressed a lack of trust in the CHWs' professionalism. The teachers' comments did, however, lack some consistency in relation to their motivation to collaborate with CHWs. Most notably, when questioned about the shared goals and perceived benefits of their collaboration with CHWs, the teachers expressed notably more positive attitudes.

This apparent contradiction in the findings could be explained by a desirability bias. When asked more directly about their motivation to collaborate, the teachers may have felt some need to meet my expectations as the research facilitator; thus, they expressed a more optimistic interpretation of their collaborative efforts with CHWs. This interpretation of the findings is further supported by the teachers' limited efforts to actively address VAW/G through cross sector interventions. Therefore, the evidence suggests that teachers lack some degree of motivation to collaborate with CHWs.

The issue of the teachers' and CHWs' motivation to collaborate is interesting not only because of how fundamental this issue is to a comprehensive understanding of ISC between these two groups of actors, but also because this issue was not explicitly investigated in previous research involving these groups of actors in Vulindlela (De Lange et al., 2011).

#### 7.1.2.2 OPPORTUNITY

Both groups of actors mentioned that they lack sufficient opportunities to collaborate and identified inadequate formalization of their relationships as the underlying cause of this lack of opportunity. The participants also identified different mechanisms by which the lack of formalization limits their opportunities to collaborate. The CHWs cited this lack of formalization combined with an unfavorable social environment as the primary issue limiting their opportunities to collaborate, while the teachers cited the effect of insufficient formalization combined with the organizational context in which they operate as the main reason for their lack of opportunities.

For CHWs, the informal nature of their collaboration with teachers means that they are not comfortable initiating collaborative activities. This discomfort stems from the relationship between the CHWs and teachers, which is characterized by a power imbalance and negative attitudes between the participants. As the actors with less power in this relationship, the CHWs feel uncomfortable approaching teachers. Although the CHWs' ability to engage in collaboration is not entirely limited, as they are still able to collaborate with teachers when teachers initiate such collaboration, an essential element of what it really means to collaborate is lost (MacIntosh and McCormack, 2001). It is worth noting that CHWs make some attempts to work around these limited opportunities by initiating multisectoral action in the education sector without actively engaging with teachers. While such an approach has some merits, it cannot be considered a substitute for ISC given that the lack of joint working means that synergies cannot emerge (Costongs and

Sprignett, 1997; Lasker et al., 2001). A shortage of time and logistical constraints, two issues that are commonly cited as limiting opportunities to collaborate, are not mentioned by CHWs (Harris et al., 1995; Lasker et al., 2001). Despite the CHWs not acknowledging these factors as areas of concern, they are still worth bearing in mind, particularly due to the fact that CHWs have often been found to be overburdened with work and unrealistic expectations (Berman et al., 1987; Bhattacharyya et al., 2001; Lehmann and Sanders, 2007; Walley et al., 2008; Walt, 1990). Given the substantial commitment of time required to effectively engage in ISC, a commitment that the CHWs might not be fully cognizant of due to their limited experience of actively engaging in ISC, time constraints may be an important factor limiting CHWs' opportunities for collaboration.

In contrast, the teachers expressed the belief that an absence of formalization is an issue because it means they lack the time and logistical support necessary for collaboration with CHWs. It is interesting to think about the teachers comments in the context of what appears to be their limited motivation to engage in ISC with CHWs. While opportunities are certainly structured by external factors, the opportunities to collaborate are also a function of the individual actions an actor takes to enable such opportunities to emerge. Thus, although the teachers' comments are supported by findings regarding the insufficient time and resources available to teachers in resource-limited contexts (Bennell and Akyeampong, 2007; St Ledger, 2001), it is also plausible that the teachers' relative lack of motivation prevents them from fully exploiting those opportunities that are available to them.

#### 7.1.2.3 RELATIONSHIPS

From the perspective of what is needed for ISC, the relationship between CHWs and teachers is far from ideal. There are two fundamental components underlying this issue. First, there is a considerable status differential between CHWs and teachers that in turn leads to unequal power relations between these

actors. Second, the actors' attitudes toward each other are often characterized by negativity and mistrust.

The dynamics between the teachers and CHWs during the data collection phase confirm the expectation that the voices of the most powerful actors will dominate the collaborative process (Ashman, 2001; Harris et al., 1995). CHWs were unwilling to talk about certain issues, such as their lack of influence in the community, in front of the teachers, and the teachers' voices were dominant during the combined group discussion. That CHWs were unable to engage with teachers on an equal footing during the data collection process is a particularly worrying sign that the participatory dynamics required for successful ISC will not emerge (El Ansari and Phillips, 2001b). As the facilitator of the common group discussion, the participants engaged with each other in a space that I contributed to creating. If anything, one would expect that the normal dynamics between these groups of actors may have been somewhat mediated by my attempts to create a truly participatory research environment. Thus, I expect that in a collaborative setting structured only by the independent interactions of teachers and CHWs, the power dynamics between these actors would be at least as present as they were during the data collection process.

This power imbalance does not bode well for any future collaborative activities between teachers and CHWs for a number of reasons. First, diversity is the key to creating the synergies that make collaboration more effective than just the sum of its individual parts (D'Amour et al., 2005;Lasker et al., 2001). As illustrated in the rest of this study, the CHWs and teachers have a diverse set of attitudes and beliefs, and potentially complementary capacities. If CHWs' voices are not adequately heard, such diversity is effectively reduced and synergies are also expected to diminish. Second, participation is an important influence on the satisfaction of those involved in the collaboration as it breeds a sense of ownership and the participants feel that their contributions are valued. Where

satisfaction is diminished, actors become less motivated to continue engaging in collaboration and the sustainability of collaborative activities is undermined (El Ansari and Phillips, 2001; El Ansari and Phillips, 2001b). Further exclusion of CHWs from collaborative engagement would only serve to reinforce the CHWs' current feelings of dissatisfaction thereby weakening an already fragile relationship.

The negative attitudes between the participants stem largely from the teachers. The teachers do not trust the CHWs as professionals and have a negative view of their previous collaborative experiences. While the CHWs' attitudes towards the teachers are also somewhat negative, these attitudes are largely defined in response to the perceived negativity from the teachers. Aside from creating an environment that is not conducive to the open exchange ideas (the consequence of which have been discussed in the previous paragraph) positive relationships also ensure that a collaborative partnership is sustainable (Harris et al., 1995; O'Neill et al., 1997). In the case of CHWs and teachers, the opposite is currently occurring, with negative past experiences creating negative relationships which further undermines future collaboration.

Experiences from CHWs' relationships with the formal healthcare sector provide insights into how negative relationships can undermine joint working. Previous studies have shown that a distinct hierarchy between CHWs and nurses has a negative impact on their professional relationships (Doherty and Coetzee, 2005; Van Ginneken et al., 2010). These findings are echoed in this study. The participating CHWs expressed dissatisfaction with the hierarchical nature of their relationships with local nurses. This dissatisfaction has led to CHWs being reluctant to engage in collaboration with nurses. Instead of collaborating when it is most appropriate and effective, CHWs only collaborate with nurses when absolutely necessary. These dynamics between CHWs and nurses illustrate how negative relationships can undermine collaborative working.

Overall, the findings relating to the participants' relationships closely mirror those of the Learning Together project as the unequal power dynamics, negative attitudes and mistrust between CHWs and teachers were also key findings of this study (de Lange et al., 2011). While Learning Together involved different individual participants, the same groups of social actors were studied in the same context. Thus, the findings from this study are supported by those from the Learning Together project. In particular, the findings from Learning Together support the notion that community perceptions and other structural factors play an important role in shaping the relationships between teachers and CHWs in Vulindlela.

#### 7.1.2.4 CAPACITY

One notable inconsistency in the findings related to the CHWs' perceptions of their own capacity. While the participating CHWs initially expressed a high level of confidence in their ability to address VAW/G in the community, this level of confidence diminished substantially as the data collection process continued. There are two possible explanations as to why such a large inconsistency emerged. First, it is possible that an initial disconnect between the CHWs' perceptions and reality gradually diminished as they were forced to critically engage with their perceptions of themselves. Second, there may have initially been a desirability bias that was reduced as the CHWs became more comfortable with me and the research environment.

If we consider the findings regarding the CHWs' capacity in their entirety, they illustrate that both CHWs and teachers believe that CHWs have very limited capacity to deal with VAW/G. The belief that the participating CHWs' lack of capacity is rooted in their lack of influence and power corresponds to the debates in the literature regarding the limitations of CHW programs as agents of change (Rifkin, 1996; Standing et al., 2008; Werner, 1981; Walt, 1990). In particular, the findings illustrate that the CHWs lack adequate connections to both the

community and the formal healthcare system to play a bridging role between the two. As mentioned above, the CHWs expressed negative attitudes towards the nurses and only collaborate with them when absolutely necessary. Furthermore, the limited recognition of CHWs and the community's lack of trust in them as social actors place notable constraints on the CHWs' engagement with the community. Thus, CHWs in Vulindlela are generally not in a position to play the sort of broad linking role that advocates of CHW engagement in ISC expect.

In contrast to the CHWs, the teachers provided a more understated and consistent portrayal of their own capacity which included an acknowledgment of their limitations and intervening limits. This nuance gave the impression that these perceptions were more honest and accurate. The main capacity constraint that the teachers acknowledged is their lack of health-related expertise, which is consistent with the evidence presented in the literature review (St Ledger, 2001). The capacity that they do have to address health-related issues is primarily derived from their status and influence in the community. A notable capacity constraint that was not explicitly acknowledged by the teachers is their lack of capacity to collaborate. Given the teachers' limited understanding of the capacities of the CHWs, it follows that the teachers are not in a position to effectively identify situations in which they can work productively with CHWs to address VAW/G (Harris et al., 1995).

Although these individual capacity constraints place major limitations on CHWs' and teachers' ability to address VAW/G through their individual actions, this does not imply that these actors would not have the necessary capacity to engage in successful ISC. Synergies lie at the heart of collaboration, and a successful collaborative initiative is more than just the sum of their individual parts (D'Amour et al., 2005). The individual capacities of teachers and CHWs, limited as they may be, are certainly complementary to each other and could produce such synergies. CHWs expressed confidence in their human resources

(such as health-related knowledge and experience) while simultaneously showing an acute awareness for their apparent lack of social resources. The teachers, on the other hand, were said to have relatively strong social resources coupled with a weakness in health-specific knowledge. The suggestion that CHWs and Teachers could forge a mutually beneficial relationship is very speculative, of course, and the individual capacity constraints, particularly with regards to the CHWs, are certainly not trivial. The point, however, is to acknowledge that the individual lack of capacity outlined in this section does not necessarily imply that these actors cannot collaborate effectively with each other.

#### 7.1.2.5 PLANNING

Overall, there was very little in the findings that related to planning. This lack of data is largely due to the fact that collaboration between teachers and CHWs is currently unplanned. Given that I did not initiate any discussions around this topic and that the participants were liable to focus on what was most immediate and tangible, the planning, or lack thereof, was not a topic that was often discussed. The teachers did, however, acknowledge the need for greater planning. The teachers' lone acknowledgment of the need for greater planning could be explained by their greater familiarity with planning activities due to the nature of their profession.

The current lack of planning could be problematic for a number of reasons. The combination of a notable power differential between the teachers and CHWs in addition to the lack of planning is one such issue. Planning is an important means of addressing the problems associated with divergent interests and power dynamics within a collaboration as systems can be established that counter such dynamics (Harris et al., 1995). For example, given the lack of rules currently governing collaborative decision-making involving teachers and CHWs, it is expected that the teachers' voices will dominate future decision-making just as they did during the data collection phase. However, if the actors engaged in a

planning session to develop rules for decision-making based on the participatory and democratic principles underlying collaboration, such systems could be leveraged by CHWs to give them a greater voice. As stated in the framework, the process of planning is as important as the outcomes and this process occurs in the context of the same power relations that create the need for planning in the first place. Despite such problems, the nature of the current collaborative partnership between teachers and CHWs does have some positive elements that are expected to facilitate the planning process. Most notably, there are a small number of actors involved and a lack of bureaucratic obstacles, which is expected to make reaching a consensus relatively easier than it would be in the case of planning ISC between large organizations (Geneau et al., 2009). Planning could also help these actors systematize the current complex web of collaborative relationships that they engage in to address VAW/G.

#### 7.1.2.6 EXTERNAL ENVIRONMENT

The external environment is defined by both community characteristics and public and organizational policies (Lasker et al., 2001). As with all of the other factors analyzed, the external environment influences the effectiveness of collaboration directly and indirectly through the influence it has on other factors. The indirect effects of the external environment have already been discussed in the sections pertaining to the other factors. Community characteristics indirectly influence collaboration between teachers and CHWs through their influence on the CHWs' capacity, the nature of the relationships between teachers and CHWs, and the teachers' motivation to collaborate. Public and organizational policies were said to influence collaborative activities indirectly through their influence on the CHW's capacity, the CHWs' opportunities to collaborate, and the relationships between teachers and CHWs.

In terms of direct influence, the participants focused exclusively on community characteristics: the lack of effective reporting mechanisms for

VAW/G and the inability to enforce consequences on perpetrators of VAW/G. Overall, the picture that emerged is that both the CHWs' and teachers' individual and collaborative efforts to address VAW/G are undermined by these community-level factors. While both teachers and CHWs are affected, these issue have a larger impact on CHWs. . CHWs have a regular need to refer victims of VAW/G to systems for reporting and dealing with violence. When community members do listen to CHWs and attempts are made to use these systems to report VAW/G, their actions are unlikely to lead to any meaningful outcomes. Thus, the already limited credibility of CHWs is further eroded, which in turn affects their capacity to address VAW/G in the community. Furthermore, the inability to enforce consequences on perpetrators of VAW/G increases the chances that CHWs will become victims of violence themselves Of course, these issues do affect the manner in which teachers are able to address VAW/G; however, the extent to which teachers are affected is not nearly as notable given that their core role is as closely linked to addressing VAW/G.

## 7.2 IDENTIFICATION OF WAYS IN WHICH CHW-TEACHER COLLABORATION COULD BE IMPROVED

The participants' suggestions for improving their collaboration provided further insights into the current functioning of their collaborative partnerships. In particular, the differences in what these actors were most concerned about improving provided evidence to support the notion that CHWs are more motivated to engage in collaboration than teachers. While the CHWs were focused on the need to improve their own capacity so that they could better engage in collaboration with teachers, the teachers were focused on the CHWs' limited capacity. Furthermore, when questioned explicitly about how they could improve their collaboration with CHWs, the teachers spoke almost exclusively about collaborating with other social actors, such as the police and social workers.

This seemingly misplaced emphasis on other social actors reflects the fact that teachers see these actors as more suitable collaborative partners than CHWs.

Overall, the participants' suggestions reflect the participants' belief that they are unable to address the core issues that undermined their ability to collaborate successfully. While the participants were very aware of their lack of capacity (particularly the CHWs), the poor state of their relationships, and the underlying causes of these issues, the suggestions they made regarding possible improvements focused on the need for external intervention from the departments of health and education.

In terms of the actual content of their suggestions, a number of the participants' suggestions correspond with my own views and were in-line with the recommendations in the literature regarding how to improve ISC. In particular, the need for greater recognition and better role definition for CHWs as a means of increasing their status within the community; more organizational support to initiate and sustain collaboration; greater formalization of collaborative relationships; and engagement in joint planning have all been cited as important elements of successful ISC (Bhattacharyya et al., 2001; Clarke et al., 2008; Gilson et al., 1989; Harris et al., 1995; Schneider et al., 2008).

In general, however, the participants did not seem to fully grasp some of the more fundamental issues limiting their current state of collaboration. Firstly, all of the actors' suggestions revolved around the assumption that they were sufficiently motivated to make this collaboration effective and sustainable. Second, although the actors emphasized the formalization of their collaborative ties as the key means of improving their relationships, it is not clear that such a measure would really get to the heart of these deeply-rooted issues. It is possible, however, that this focus on formalization is a pragmatic response to an issue that the participants believe they are unable to address. Third, the focus on scaling up organizational

support and formalization also runs the risk of ignoring some of the benefits that that can be leveraged from informal, small-scale working, such as flexibility and ease of decision-making (Geneau et al., 2009). Finally, it is critical to be aware of ISC in its totality and that partial improvements may lead to no real change if critical bottlenecks are not addressed simultaneously (Harris et al., 1995). For example, even with an increased opportunity to collaborate, teachers will not necessarily engage in collaboration with CHWs if they are not motivated to do so.

## 7.3 SUMMARY

As mentioned previously, ISC has proven to be difficult and costly to implement effectively as it requires a considerable investment of time, resources and institutional capacity; the benefits, on the other hand, tend to be uncertain (Dormady, 2012;Fear and Barnett, 2003; Harris et al., 1995; Lasker et al., 2001). Given the numerous challenges facing collaboration between CHWs and teachers in Vulindlela, it is not clear that such collaboration would necessarily lead to effective outcomes. Each of the six factors analyzed highlighted a range of problems, many of which critically affect the functioning of this collaboration and are not easily resolved. As Harris et al. (1995, p.48) state, 'if conditions are not in place, then deciding *not* to proceed may be the best approach'. This is not to say that all hope of fostering a successful collaborative initiative in Vulindlela to address VAW/G and other health-related issues should be abandoned, but rather that we must keep the option of not developing collaboration in mind. If the CHWs and teachers are sufficiently motivated to collaborate and they recognize the extent to which the current nature of their relationships limit the potential for collaborative working, they might be able to build a strong enough foundation upon which external support can successfully build. However, in the absence of sufficient motivation and a realistic awareness of the challenges from the actors themselves, external initiatives to foster collaboration are unlikely to be successful.

# CHAPTER 8: CONTRIBUTIONS AND CONCLUSION

# 8.1 STUDY CONTRIBUTIONS

## 8.1.1 CONTRIBUTIONS TO PRACTICE

Studies that make use of participatory research methods have the potential to yield important contributions to practice given the opportunity these methods provide for active engagement of study participants. Given the scope and aims of the present study, the initial potential for contribution to practice was modest in scale. Based on my discussions with the study participants and the findings found in this study, the practical contributions provided by this study are on two different levels. First, according to the study participants, contributions were made to their practice through their active engagement in the research process. Second, study findings have the potential to positively impact the future practice of study participants and similar groups of actors attempting to engage in ISC to address health-related issues such as VAW/G.

Through the research process, the participants began to critically analyses their community based roles and their collaboration with each other. This provided the means for improved self-awareness. In turn, the participants' increased self-awareness was reflected in the greater depth of their responses as the data collection progressed.

The final group discussions during data collection specifically addressed the CHWs' and teachers' feelings regarding their participation in this study and provided insight on how they perceived the benefits accrued through their participation in the study. During these sessions the CHWs and teachers commented directly on how the study had contributed to their personal and professional development. They stated that a better understanding of their collaborative practices and of their role as social actors, as well as a greater confidence in their abilities to address VAW/G were the most important gains

they made from participating in the study. Additionally, the actors voiced pride in the work they felt they were able to accomplish through the research process, notably in relation to discussing with each other during the second group discussion and their co-authorship of the recommendations guide. This joint group discussion contributed more directly to the exploration of collaborative working between CHWs and teachers. Findings show that under ordinary circumstances, it is unlikely that these actors would have come together in this manner to critically reflect on their opportunities for joint working. While this is certainly a small step in a lengthy process, it has the potential to be meaningful given that the existing lack of communication between these groups of actors is a large obstacle to their collaboration.

As noted earlier, in addition to the research process making a contribution to practice, the study findings also have the potential for yielding some practical contributions. The factors discussed by study participants as influencing their collaboration with one another help to contextualize the complexity of the collaboration system between these actors. This contextualization has the potential to help inform future efforts to foster collaboration between these specific actors and other actors in similar positions attempting to engage in ISC. Additionally, potential avenues for the improvement of collaboration were highlighted through the study findings. These suggested improvements emerged from the participants' voices. Although these suggestions were found to be far from complete they provide a foundation for future efforts to improve this collaboration.

While this study was specific to a particular case of collaboration within Vulindlela, these findings hold potential relevance to other similar rural contexts, especially rural South African communities where there is a degree of similarity in the roles and functions that teachers and CHWs play within their respective communities.

### 8.1.2 CONTRIBUTIONS TO RESEARCH

Given the orientation of this study towards practical investigation, the contribution to the wider research context was expected to be somewhat limited. Furthermore, the restricted context of this study is potentially limiting in terms of its external validity. Within such considerations, however, the study still makes a contribution to the current literature by providing a snapshot of current ISC between CHW and teachers aimed at addressing VAW/G at the community level. This snapshot has the potential to serve as a useful building block to a number of different lines of research.

When analyzing a specific case of ISC such as in this study, there are a number of different levels at which the collaboration can be analyzed. One can consider different combinations of context, types of collaboration, actors involved, and issues addressed by the collaboration. Within the broad aims of this study, the general nature of ISC, the dynamics of ISC between teachers and CHWs, and the CHWs' individual capacity and role were the different levels that emerged most prominently from the findings.

With regards to the general functioning of this collaboration, this study contributes to an understanding of how ISC collaboration is implemented in practice and the factors that affect its functioning. What makes this understanding of particular interest is the relatively unfavorable context in which such collaboration was studied: the collaboration occurred in a rural, resource limited setting, with a general lack of institutional support, and in the midst of social constructs that substantially hindered the collaborative relationships and the capacity of one group of actors. It is my belief that it is essential to study ISC in these contexts given that it is here that the potential benefits of ISC will be most needed if they can be realized. This study of ISC is also of relevance given that it studied a collaborative partnership that was very much in its initiation stage, a stage of collaboration that is often neglected in the literature. From a theoretical

perspective, this study also further validates the relevance of Harris et al.'s framework of health-related ISC.

Additionally, the study provides useful insights in the functioning of ISC between teachers and CHWs. The roles and position of these actors in the community was found to have a substantial influence on the nature of their collaboration. Given the broad commonalities in the role of CHWs and teachers in a number of rural areas of South Africa due to the common policy frameworks that structure these roles, it is expected that this study will have some degree of transferability in this regard. This contribution is particularly relevant given the current knowledge gap regarding collaboration between these two key groups of social actors at the community level.

Although further developing an understanding of CHWs as social actors in their individual capacity was not explicitly defined as one of the aims of this study, the focus on their collaborative roles also brought their individual role into perspective. While the individual CHWs have been the topic of a wide range of research in their individual capacity, this study still represents a useful contribution given the on-going debates regarding the role and capacity of these actors.

Finally, the study builds on the findings from the Learning Together project and provides a foundation for contextualizing findings from the EVC project. The Learning Together project worked with the same groups of actors in the same context and utilized very similar methods. As noted in the discussion chapter, the findings from this study support a large number of the project's main findings from Learning Together reinforcing, and to a certain extent validating, the findings from this previous research. This study also provides and important foundation for future research activities of the EVC project, particularly the fourth

study area as mentioned in the introduction chapter of this manuscript which targets teachers and communities addressing gender based violence.

## 8.2 STUDY LIMITATIONS

The data, findings and conclusions resulting from this study are subject to some limitations. A first limitation, possibly the most noteworthy, pertains to how the subject was approached. By assuming the presence of current collaboration between CHWs and teachers and asking participants to discuss the collaboration taking place between them, the factors that influence this collaboration and the means of improving it, participants were presented with a preconceived assumption that collaboration had been fully initiated. This may have biased the data collection in that it may have not occurred to CHWs and teachers to discuss the need for officially initiating this type of collaboration and how to go about doing so in a formal and planned way.

Also, it is possible that question and answer biases were introduced during the data collection phase. The manner in which questions were posed during group discussions may have influenced the way respondents answered. That is, some questions may have been misunderstood by participants during discussions due to the presence of some language barriers. As per answer biases, dominant respondent and social acceptance biases may have occurred during the second data collection phase, which brought together the participating CHWs and teachers. As discussed in earlier chapters, this was likely due to the status differential and power dynamics present between the CHWs and teacher within this context. In the presence of teachers, CHWs were far more subdued and would rarely contradict comments made by teachers; and so, CHWs may have chosen to answer in a manner they believed would be more socially acceptable. Profession-specific grouping for subsequent group discussions and the frequency of these discussions are likely to have minimized such potential biases and given sufficient

opportunity for authentic responses and perspectives to emerge. Similarly, separating the group of CHWs into two smaller groups according to their ages for one of the group discussions helped to minimize the self-imposed censorship among younger CHWs during at least one session – insuring that they were provided with the opportunity to voice their thoughts and opinions with fewer constraints. Also, as presented in the discussion chapter, the presence of a desirability bias may have created the context for some inconsistencies to emerge in the data. For example, the inconsistencies in the CHWs' perceptions of their capacity and the discrepancies among the teachers' motivation may be partly explained by a desirability bias that motivated the study participants to provide answers they thought might be aligned with what I was hoping to hear as the research facilitator.

An additional limitation of this study is that it has a restricted scope as it is based on the CHWs' and teachers' perspectives alone. Though basing the data on participants' perspectives was seen as a study strength as defined by the participatory research methods used, including a wider range of social actors' perceptions may have provided a more comprehensive understanding of the current collaboration paths involving CHWs and teachers. For example, the perspectives of social workers, local and religious leaders and law enforcement officers could be studied to generate a more complete representation of the collaborative network. In addition, the specificity of the context of this study may once more compromise the external validity of the findings. However, given the need for context specific evidence to improve collaboration between these actors at the community level, this can be regarded as a necessary limit.

Finally two biases may have been introduced through my role as the research facilitator. First, my personal history may have skewed both the way I approached the subject and participants, and the way that the data was analyzed and interpreted. No doubt my personal experience of violence had some influence on

the way I approached this study; however, as stated by Gilfus et al. (1999, p.1210) survivor-informed research 'encourages ethical and responsible research'. Second, given the context of post-Apartheid South Africa, age, gender and ethnic background differences between me and the research participants may have given way to a moderator bias. My engagement with the isiZulu speaking research participants was likely shaped by my own and the participants' perception of the cultural and linguistic differences present between us. However, this study did not yield any evidence of the ways in which or the extent to which these differences influenced my interactions with the participants.

## 8.3 CONCLUSION

This study set out to inform future attempts at addressing VAW/G through ISC between CHWs and teachers in a rural community of South Africa by documenting the current state of CHW-teacher collaboration and by identifying ways in which this collaboration could be improved. The CHWs' and teachers' current paths of collaboration with one another pertaining specifically to efforts aimed at addressing VAW/G were documented – with particular attention to the factors influencing their collaboration. Additionally, through participatory methods, avenues for future improvement of the collaboration were identified by the research participants.

The findings from this study illustrate that the current state of collaboration between these specific actors is poorly developed and unplanned and have yet to be initiated on a regular basis. There are multiple barriers that currently impede the emergence of more effective collaboration between these actors. Notably, the lack of teachers' motivation to collaborate with CHWs is a potentially problematic issue that unless resolved will undermine attempts to initiate and sustain collaboration. Similarly, the relationships between these groups of actors are not currently conducive to fostering inclusive and successful collaborative

partnerships. Additionally, the underlying issue of the CHWs' apparent lack of capacity as social actors could ultimately undermine any efforts made to improve the collaborative activities between these actors. Finally, additional research is required to determine whether proceeding with the development of this collaborative partnership is in fact an effective means of addressing VAW/G in the Vulindlela community.

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# APPENDICES

## APPENDIX 1: Participant Consent Form

We invite you to read this form attentively and to ask any questions you may have prior to signing this form.

**Date:** _____

Understanding the Service Delivery of Rural Community Health Workers: The Example of Addressing Violence Against Women and Girls in Vulindlela, South Africa

**Lead Researcher:**
Ms. Jessie K. Hamon, MSc Student

**Research Directors:**
Dr. Vinh-Kim Nguyen, MD, PhD and Dr. Claudia Mitchell, PhD

**Funding Source:**
Funds are provided by the *Field grant of the capacity development program for global health* (bourse de terrain du program de development des capacités en santé mondial) obtained through the *Unité de Santé International*.

**Description of the Project:**
The study aims to enhance what we know about the challenges faced by community health workers when addressing violence against women and girls (VAW/G); and thereby, discern new paths to improve the quality of services rendered and improve their collaboration with other social actors, namely teachers. This study acts as an extension to earlier initiatives of the *Every Voice Counts* project that works to integrate the efforts of social actors to build up rural community engagement in addressing local gender based violence and HIV and AIDS issues.

**Procedures:**
This study will encompass a community based participatory action research approach. Data collected will be of a qualitative nature combined with visual methodologies. The study activities are built around focus group discussions and interviews with the participation of approximately ten community health workers from the Vulindlela sub-district and local teachers. The study will draw on prompts such as video documentaries produced by the local youth and community health workers about their perception of the social issues pertaining to the community. Research participants will take part in each research phase and

be key stakeholders in the development of conclusions and recommendations. Essentially, participants will take part in at most ten days of activities during the data collection phase between the months of September to November 2009.

**Advantages and Benefits of the Research and to Participants:**
Community health workers taking part in this study will gain knowledge and empowerment through prompted reflection and group discussion of their roles as community workers. Teachers who will engage in the data collection phases will gain knowledge about the situation as perceived by community health workers and will provide important information to their health worker counterparts. Together they will generate valuable conclusions and recommendations that will increase the quality of services rendered and strengthen community engagement between teachers and community health workers.

**Risks and Inconveniences:**
We do not foresee any risks or discomfort from your participation in the research. As all participants will be recruited from the same district, there is the possibility that despite anonymity in data reporting, participants will be recognized by their peers due to the content of their comments that may be published. However, if the research discussions do affect participants due to the sensitive nature of the subject, a referral system will be in place. A counseling service will be made available to participants who should request it through the FAMSA counseling organization. Also, in the eventuality of disclosure of personal gender violence experiences, referral to the Taylor Halt Police Community Service Centre will be provided. Finally, participants interested in being tested for HIV/AIDS as a result of their participation in this study will be referred to the CAPRISA clinic testing center where adequate pre and post-test counseling will also be provided by specialists.

**Exclusion Criteria:**
In the eventuality that you no longer hold a position which falls under the study's definition of a community health worker within the Vulindlela sub-district of KwaZulu-Natal, South Africa you will not be eligible to participate in the study. As per local teachers, you must be a recognized teacher practicing your profession within one of the sub-district schools. During the focus group discussions, participants who refuse to be recorded by audio and video will be excluded from the study; however as long as one means of recording is permitted by the participant, he or she will remain admissible.

**Confidentiality:**
All information you supply during the research will be held in confidence and unless you specifically indicate your consent, your name will not appear in any report or publication of the research. Your data will be safely stored in a locked facility and only research staff will have access to this information. Upon completion of the data collection phase, the data will be compiled and transported back to Canada with the lead researcher at which point no one other than she, her

supervisors and other research staff (who will all have signed a confidentiality form) will have access to the documents. In order to respect the archive norms of the Université de Montréal and the University of KwaZulu-Natal, all documents pertaining to the study, including all rough data will be conserved for seven years following the completion of the study. Following this period, all documents will be personally destroyed by the lead researcher. Confidentiality will be provided to the fullest extent possible by law and will be required by all fellow participants. However, in order to ensure adequate control of the research project, your file may be consulted by a mandated individual from the Research Ethics Committee of the Faculté de Médecine of the Université de Montréal; as well as by such an individual from the Research Ethics Committee of the University of KwaZulu-Natal.

**Eventuality of Suspension from the Study:**
Your participation in this study may be interrupted by the researcher if there is belief that it is in your best interest, or for any other reason.

**Participation and Withdrawal Freedom:**
You can stop participating in the study at any time, for any reason, if you so decide. If you decide to stop participating, you will still be eligible to receive the promised pay for the days you participate. Your decision to stop participating, or to refuse to answer particular questions, will not affect your relationship with the researcher or any other group affiliated with the study. Ultimately you can decide to withdraw at any point without any penalty or judgment and you will not be obligated to justify your decision. In the eventuality that you do decide to withdraw any information that you have shared prior to this decision will be kept by the researcher and can be used toward the betterment of this study.

**Compensation for Participants:**
All participants will receive the amount equivalent to R45.00 for every day spent working on the research. This includes activities in the data collection, verification and analysis phases of the study. Refreshments and transport will also be provided on participation days.

**Resource Personnel:**
If you have questions about the study in general or about your role in the study, please feel free to contact Ms. Jessie K. Hamon or Professor Naydene De Lange who will be available upon request by telephone or via email.

All complaints relating to your participation in this study can be addressed to the ombudsman of the Université de Montréal or by communicating via email (the ombudsman will accept collect calls). If you wish to file a complaint locally you can contact by telephone a representative of the University of KwaZulu-Natal.

Complaints filed locally will also be communicated to the Université de Montréal in Canada.

**Adherence to the Research Project and Signatures:**
I have read and understand the content of this present form. I certify that its contents have been explained to me verbally. I have had the opportunity to ask all questions pertaining to this research project and have received answers that I judge satisfactory. I certify that adequate time was provided to me to reflect and take my decision to participate in the study and I am aware that I can withdraw at any time.

**Please circle your answer (yes or no) to the following statements.**

- I give my permission to be photographed during data collection activities. (yes/no)
- I give my permission to be audio-recorded during data collection activities. (yes/no)
- I give my permission to be video-recorded during data collection activities. (yes/no)

I undersigned accept to participate in this study.

_____ _____ _____

Participant's Name Participant's Signature Date

I certify a) having explained to the signatory the terms of the present consent form; b) having clearly indicated that he/she is free to terminate his/her participation in the study at any point in time and that a copy of this signed form will be provided to him/her.

_____ _____ _____

Researcher's Name Researcher's Signature Date

# APPENDIX 2: Group Interview Breakdown

## Phase 1: Visual Methods

**Participants:** CHWs and teachers in separate groups on different days

**Duration:** Two hours

**Session objective:**

Participants will be asked to produce a drawing depicting their perspective of VAW/G in the community and another illustrating their role as social actors within this situation and to discuss similarities and differences.

**Activities:**

**Icebreaker**

Introduce yourself to the group.

**Questions:**

- Who you are?
- Where are you from?
- How long have you been working as a teacher/CHW?
- What made you decide to start working as a teacher/CHW?
- What do you believe are the benefits of working as a teacher/CHW?

**Introducing the study**

As presented in the consent form this study aims to find out about how you as CHWs/teachers address VAW/G with people in the community and how you can work with teachers/CHWs to make it easier to address this issue.

**Introductory Discussion**

We would like to start by asking you about VAW/G in the community. What we mean by VAW/G is:

> any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such

> acts, coercion, or arbitrary deprivation of liberty, whether occurring in public or in private life. (UN General Assembly, 1993, Article 1)

**Questions:**

- Do you think that VAW/G is present in this community?
- Who is most vulnerable to VAW/G in the community?

**Drawing production**

Our main activity today is to make two drawings and then talk about them together.

-The first is of how you see VAW/G in the community.

-The second if of yourself as a CHW/teacher addressing VAW/G.

**Discussion**

You are now invited to share your drawings with the group and explain what they mean to you.

**Questions:**

- What similarities or differences do you see in the drawings about VAW/G?
- What similarities or differences do you see in the drawings about your role?

**Conclusion:**

Summary of the points that were brought up during the session

**Question:**

- Is there anything you would like to add to what has been said today?

**Phase 2: Group interview involving all participants**

**Participants:** CHWs and teachers in the same group on the same day

**Duration:** Three hours

**Session objective:**

Explore the service delivery of CHWs and teachers pertaining to VAW/G and the status-quo of their collaborative efforts.

**Activities:**

**Introduction:**

-Introduce the session's objective.

-Participants introduce themselves to the group, stating their name, occupation and years of experience in their respective work domain.

-Review the main ideas that emerged during the first sessions.

**Question:**

- Is there anything you would like to add to these ideas or comments you would like to make?

**Introducing the video:**

-The video was made by students, teachers, CHWs and parents at the Kuhlekonke Senior Secondary School in Vulindlela a few years ago. Participants of this video project were given cameras and asked to make a short video in small groups about a social issue they thought was important in the community. Five out of six of the groups of young people who made the videos chose gender based violence as their topic.

-The content of the video might be shocking; if you do not wish to watch it you are free to leave the room at any time until the viewing has ended. No one will be judged or penalized if you choose not to watch it. After the viewing, we will have a short discussion about your thoughts on it.

**Viewing of the video**

**Post-viewing discussion**

**Questions:**

- How do you feel about what you have just watched?
- What did you like/not like about the video?
- What would you change about this video if you could?

- As you can see, VAW/G is an issue that youth also recognize in the community.

**Service Delivery Discussion**

-Discussion about the CHW/teacher's role in addressing VAW/G.

-Individually reflect and record your answers to the following questions on the paper that you have been provided.

**Questions:**

- What is a challenge that you have when trying to address VAW/G in the community?
- What helps you or supports you when you address VAW/G in the community?
- What would make it easier for CHWs and teachers to work together in addressing VAW/G in the community?

-Present your thoughts to your peers (CHWs discuss together and teachers are together)

**Discuss and record additional comments**

**-**A spokesperson presents to the entire group what has just been discussed by each of the small groups.

**Whole group discussion**

**<u>Conclusion</u>**

-Introduce the concept of drafting a recommendations guide during the next phase based on what was discussed during these last phases.

## Phase 3: Drafting of a recommendations guide

**Participants:** All teachers together and CHWs divided into two groups according to age of participants.

**Duration:** Two hours

**Session objective:**

Response validation of past sessions and drafting of recommendations guide

**Activities:**

**Introduction:**

-Recall the objective of the recommendations guide:

The guide we are working on today will be given to the Songonzima clinic and the Gobindlovu school once it is finished so that future CHWs and teachers can read your suggestions and ideas about what makes it possible to address VAW/G issues in the community and how CHWs and teachers can work together to do this.

**Discussion about the drafting process**

**Questions:**

- How does it make you feel to work on developing a recommendations guide that other CHWs and teachers will read?
- How do you think this guide could be used to help other CHWs and teachers talk about VAW/G in the community?

**Drafting the recommendations guide:**

Participants are asked to write out anything relevant they judge appropriate while keeping in mind the following questions.

**Questions:**

- When you try to educate the community about VAW/G, what makes it difficult for you to do this as a CHW/teacher?
- When you try to educate the community about VAW/G, what makes it easier for you to do this as a CHW/teacher?
- What do you think needs to change in order for it to be easier for you to do this?
- What could you do to work more with teachers/CHWs to prevent and respond to VAW/G in the community?

## Phase 4: Final group interviews

**Participants:** Teachers and CHWs in different groups

**Duration:** Two hours

**Session objective:**

Discussion about the recommendations guide and thoughts about participating in the participatory action research process.

**Activities:**

**Introduction:**

-Recall the objective of the recommendations guide.

**Discussion about the Guide:**

**Question:**

- Is there anything you would like to change or add to the draft?

**Specific questions for final version of guide:**

- What are your title ideas for the guide?
- What image/picture would you like on the cover of the

guide?

- Would you like to put down your names? (all participants must agree if names are to be added and must sign the consent form)
- Explain the consent form and allow time for participants to ask questions and to reflect individually on their decision to sign or not the consent form.

**Conclusion:**

**Discussion about the action research process**

**Questions:**

- How did it make you feel to be part of this study?
- What did you like/dislike about meeting together to discuss VAW/G?
- What would you have changed about the sessions and content we discussed?
- What have you learned while participating in this study?
- Now that you have participated in this study, how do you feel about talking about VAW/G with the community?

## APPENDIX 3: Recommendations Guide Produced by Participants

# STOP ABUSE: TOGETHER WE CAN END VIOLENCE IN OUR COMMUNITY

**Community Health Workers and Teachers**

**Speak Out About Violence Against Women and Girls**

**-2009-**

## Acknowledgements

This guide was produced through a collaborative effort by a few community health workers and teachers working in the Vulindlela sub-district community. It is their commitment to initiating social change in the community that has made the production of this guide possible.

For making this study possible and for their guidance throughout our work, we wish to thank the Every Voice Counts researchers Dr. Naydene De Lange and Dr. Claudia Mitchell. Finally, we wish to acknowledge the work of our translators who helped produce this guide

*This guide is dedicated to all the community health workers and teachers working within South African communities to make a difference. As agents of change who shape the community's future, your efforts are sure to leave a legacy.*

This guide was produced by community health workers and teacher. It aims to empower community health workers (CHWs) and teachers to speak out about violence against women and girls (VAW/G), in the hopes that the community will come together to talk about VAW/G and other gender based violence (GBV) issues.

## Introduction – What is Violence Against Women and Girls

The World Health Organization defines VAW/G as 'any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring in public or in private life' (UN General Assembly, 1993, Article 1).

People living in poverty are more susceptible to this type of violence. Therefore, the level of poverty that is present within rural communities of South Africa compounds people's risk of being victimized. And so, it is important to address this issue in the Vulindlela community.

## VAW/G in the community according to us

### Who is vulnerable?

- Women and children are most vulnerable.
- It can happen to children and adults of any age.
- Youth recognize gender based violence and VAW/G as a serious problem in their community and fear being victims or seeing their peers become victims.

### Where does it happen?

- VAW/G can happen in the private sphere such as at home and it can also be present in the public sphere such as in and around schools.
- It can happen in the workplace.
- It can also happen in nightclubs or taverns where there is alcohol abuse.
- It can happen anywhere and at any time of day or night.

### How does it happen?

- VAW/G can happen in many different ways. It can be an intimate partner who is violent, or a family member, a friend or a stranger.
- VAW/G can be physical violence, or sexual violence including rape and incest or even verbal violence.
- VAW/G can be psychological violence such as threats, teasing and intimidation.
- VAW/G can also take on passive forms such as not sharing equal responsibilities in the household and not caring for loved ones based on gender.

### Why does it happen?

- Violence is not a sign of love between partners, friends or family.
- Gender roles that recognize men as the decision making authority make women more vulnerable to VAW/G.

- Women are not recognized as equal to men in the community despite being granted the same rights according to the South African Rights Charter.
- People do not disclose their experiences of VAW/G to family or friends because they are worried that they will not be believed or are afraid of the stigma of being a victim. These people continue to live with the violence in their lives.
- People do not report VAW/G cases to the police so perpetrators do not face any consequences to their actions and the violence continues.
- People do not seek help to deal with the individual consequences of this type of abuse so the cycle of abuse continues and is passed down to younger generations.

## What CHWs and TEACHERS can do to prevent VAW/G

Prevention of VAW/G is important not only to stop abuse before it starts, but also because current victims will gain awareness about their situation. They will be more likely to disclose the abuse they have experienced once they have more knowledge about this type of violence.

### Educate

- Teach women and men of all ages about their rights according to the South African Charter of Rights.
- Educate men and boys that VAW/G is not acceptable, in order to end the cycle of violence.
- Teach mothers to recognize signs of abuse in their children. Encourage them to have a good dialogue with their children about VAW/G and other forms of GBV and to be open to listening to their children.
- Repeat prevention messages as often as possible for everyone to hear it. Some people have difficulty listening because it is a difficult issue to talk about.
- Use interactive methods to educate youth about VAW/G, e.g. drama, role playing, sketches, use of technology and inclusion of different forms of media.
- Address the influence of the media and how it does not portray an accurate image of reality and can sometimes promote VAW/G.
- Encourage learners to peer educate each other in the school and prompt them to discuss VAW/G and other forms of GBV with their family members and other community members.

### Promote Disclosure and Reporting

- Counsel potential victims to disclose a situation of VAW/G in order to break the cycle and to show the community that VAW/G is not acceptable behavior.
- Inform people that if they are being abused they must report it and go to the hospital to seek medical attention and counseling. They should also go straight to the police after a rape to prevent evidence on the body or clothes from being lost.

- CHWs and teachers can advise families and youth to disclose VAW/G to others and to report cases to the police. But, they can't force people into taking action because the decision to disclose or report must come from the victims.
- Inform women and girls that they can report any cases of VAW/G to the community clinic, social workers, police, or even to CHWs and teachers so that they can refer them to other professionals for more help.

### Communicate and Cooperate

- Increase communication between parents, learners, teachers and community health workers.
- Encourage mothers and parents to discuss the issue of VAW/G with CHWs and teachers in order to prevent new issues of violence, or to adequately address a current situations.

### Refer

- Have a reporting line which refers victims to a counseling network.
- Refer to social workers.
- Teachers can refer learners and their families to CHWs so that they can counsel them appropriately within their home.
- Refer families to the police to officially report the violence.

### Remain Professional

- Answer questions, educate or provide counseling to families and youth in a respectful and professional way by being open to listening, non-judgmental, honest and by ensuring confidentiality to anyone who discloses an experience of violence.

## How CHWs and teachers can work TOGETHER with youth

### Working together is important because…

- Youth may not want to disclose to a CHW but will feel comfortable speaking to a teacher at school.
- Teachers can discuss VAW/G with CHWs because CHWs have experience and training on how to counsel people in the community about abuse.
- Teachers and CHWs can share information about potential or current cases of VAW/G.

### How we can work together…

### Encourage communication

- Encourage communication between CHWs and teachers to share information about how to prevent and respond to VAW/G..
- Teachers and CHWs can work together to foster a good working relationship-this can enable referrals from school to the home and vice versa.
- Enhance communication between CHWs and teachers by scheduling a weekly meeting time with certain CHWs in the school. Teachers can then discuss with CHWs about VAW/G issues and how to best to prevent or respond to them.

### Working together at school

- Have awareness days in the school that bring together CHWs, teachers and members of the community to educate youth and parents about VAW/G.
- Invite local Non-Governmental Organisations or Faith Based Organisations to go along with CHWs to schools to discuss with youth about VAW/G.

### Working together in the community

- Develop programs that give community members a chance to discuss VAW/G.
- Teachers and CHWs can visit homes together.
- Teachers and CHWs can also work with social workers who specialize in VAW/G and other forms of abuse.

## How the COMMUNITY can get involved

### Listen

- Listen to the youth; don't ignore their efforts to talk about VAW/G and GBV or to disclose their experiences of abuse.
- Parents can make themselves more available to meet teachers at school when invited for a meeting.

### Speak out

- Speak about VAW/G issues in community meetings.
- Discuss GBV issues and the importance of disclosure during religious gatherings or during motivational gatherings or teachings.
- Traditional healers can address VAW/G prevention with their patients.
- Talking openly in the community about the possibility of VAW/G happening to people of all ages can end the stigma and help victims feel more comfortable to speak out.

### Work together

- Community leaders, such as counselors and chiefs, can meet with CHWs and teachers to talk about issues of VAW/G that affect youth and their families.
- Community members can intervene when they hear about the presence of VAW/G.

Ignoring the situation will not be favorable for the community as a whole.

## What can be improved to better address VAW/G in the future

### In the community

- Identify specific trustworthy people in the community to whom to disclose experiences of VAW/G, who will work with social workers and the police.
- Have harsher and more immediate consequences for perpetrators of VAW/G and other forms of GBV by the community and the authorities.
- Authorities can attend to the cases in a timely manner and protect the victim's integrity and confidentiality.
- Increase police availability to quickly address cases by employing more police officers.
- Make police stations a safe and welcoming environment for victims of VAW/G to report their abuse.

### For teachers and CHWs

- Have better, more appropriate recognition of the work of CHWs in the community.
- Include VAW/G in the education curriculum in secondary school at all grades.
- Have health specialists available at school, so that students have someone to ask questions to about VAW/G who will be able to provide proper counseling.

**For help or more information, please call:**

**Childline**

**Safeline**

**Lifeline**

Hamon, JK. 2009. Understanding the Service Delivery of Rural Community Health Workers: The Example of Addressing Violence Against Women and Girls in Vulindlela, South Africa. M. Sc. Dissertation, Université de Montréal.

Images on front cover: (top left) Image UNI52114: © UNICEF/NYHQ1992-0099/Pirozzi
(top right and bottom left) Gobindlovu School Children 28 July, 2009/Hamon
(bottom right) Tanzanian youth 10 July, 2008/Hamon

## APPENDIX 4: Recommendations Guide Consent Form

I, _____, accept to have my full name printed in the recommendations guide produced through my involvement with Jessie K. Hamon's study entitled *Understanding the Service Delivery of Rural Community Health Workers: The Example of Addressing Violence Against Women and Girls in Vulindlela, South Africa.* I understand that the guide will be distributed in and outside of the Vulindlela sub-district community for professional and academic use by Ms. Hamon or the *Every Voice Counts* project at the University of KwaZulu-Natal (UKZN). I also give my permission for the guide to be posted in a PDF version on the internet by Ms Hamon.

_____ _____ _____

Participant's Name Participant's Signature Date

I certify having explained to the signatory the terms of the present consent form.

_____ _____

~~Researcher's Na~~me Researcher's Signature Date

## APPENDIX 5: Research Stakeholder Confidentiality Form

I, _____, understand the sensitive nature of the information that I have access to through my involvements with Jessie K. Hamon's study entitled *Understanding the Service Delivery of Rural Community Health Workers: The Example of Addressing Violence Against Women and Girls in Vulindlela, South Africa.*

I agree to keep all information I come across or transcribe confidential.

_____

_____

Stakeholder's Signature Date